OVERCOMING DEPRESSION

Patients' experiences with psychiatric and ayurvedic settings

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GLOSSARY

Abhivinesha, the fifth klesha, is the senseless fear (of death) or the fear of the unknown.

Abhyanga is a whole-body massage with medicinal oils.

Agni or "fire" are enzymes responsible for digestion and metabolism.

Asmita, the second klesha, is an exaggerated egoism where the ego is the center of the world.

Avidya, the first klesha, is a wrong knowledge or subjective perception.

Dhatus are tissue elements; there are seven categories.

Doshas are bioenergetics principles that govern psychosomatic functioning. There are three doshas: vata, pitta, and kapha. Each dosha is compound of two elements and has three aspects: subtle, physical and morbid.

Dwesha, the fourth klesha**,** is an exaggerated reluctance or the feeling that something is not wanted anymore.

Gunas or mind-sets are natural psychological tendencies or three energies (sattva, rajas, and tamas) in the brain and the main factors affecting the mental state and health of the individual.

Kapha dosha is formed from earth and water and is the bioenergetic principle of binding and lubricating.

Klesas or afflictions area specific chain of five unconscious mental constructs. They are a source of emotional pain and suffering.

Malas is by-products of digestion and metabolism.

Nasya is a nasal administration of medicinal oils.

Panchakarma therapy (PKT) is one of the fundamental concepts of Ayurvedic disease management that eliminate toxic materials (vitiated doshas) from the body in order to cure a disease.

Pitta dosha is a combination of fire with a minute amount of water and manifests in living organisms as the bioenergetic principle of heating or transformation.

Prakriti is individual's constitution given at birth; it can be physical (saririka) and mental (mansika) prakriti.

Raga, the third klesha, is an exaggerated attachment or the wish for something we need to have again.

Rajas guna is the activity of the mind.

Sattva guna is balanced and calm. Ayurveda tends to increase sattva.

Shirodara is a technique of streaming of medicinal oils on the forehead.

Svedana is a herbalized steam treatment.

Tamas guna is darkness, inertia and ignorance.

Unmada is a general term for all mental disorders in Ayurveda.

Vata dosha is a combination of space and air, manifesting as the bioenergetic principle of expansion and movement within any living organism.

Vikrti refers to the current imbalance or altered state of doshas in the body and mind representing a deviation from prakriti.

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PREFACE

According to Okely, the anthropologist's past is relevant only insofar as it relates to the anthropological enterprise, which includes the choice of area and study, the experience of fieldwork, analysis and writing (Okely, 1992: 1). The anthropologist has to change or superimpose new experience, gained during fieldwork, upon past embodied knowledge and come to terms with a changing self-embodied knowledge in new context (Okely, 1992: 16). As the research process has been made transparent, personal experience is being transformed into public, accountable knowledge (Finlay, 2002: 210). In this manner the full research history (insofar there is space) is offered as both a confessional tale and a transparent account of the research.

Why depression, why Ayurveda? Growing up with a depressed person experiencing also other co-morbidities (borderline personality disorder, addiction and as such, being extremely complicated) encouraged me as well as the selection of the topic for my research. Towards the end of my teen years, the situation worsened, suicidal thoughts became more frequent, and hospitalizations in a psychiatric facility as well. After numerous hospitalizations and medication therapies, the situation did not change significantly. For many years, I avidly sought different solutions and in my early twenties I developed a very negative attitude towards psychiatry – only a sheer volume of prescribed medications, with no effect in the long run. In addition to that, the reasons for the depression and its understanding were alien and all blurred. Today my attitude to the psychiatry has changed, as well the understanding of depression.

While studying anthropology at the undergraduate level, I attended lectures on Medical Anthropology and Anthropology of Asian Religions. The first gave me an insight into the basic concepts of medical anthropology, especially in the plurality of medical practices. Plurality is present in every society and culture and thus access to traditional forms of therapy and complementary medicine is available and not restricted. Today, as a defender of pluralism of medical practices I believe a person should have the right to freely choose his method of treatment. A host lecturer Nena Židov presented the results of her research on alternative medicine in Slovenia. This was my first encounter with other treatment options that had given me new hope.

The Anthropology of Asian Religions course offered insights into Indian philosophy and Ayurveda. Within this course I compiled a seminar paper later elaborated into an article titled *Approaches, Attitudes and Interpretations of Mental Illness in India* (Kolarević, 2008), which attempted to provide a comprehensive understanding of mental illness in India through historical, religious, social, medical, cultural and political contexts, with special focus on and detailed insight into the plurality of medical practices in that country (Ayurvedic medicine, Unani medicine, Oraon shamans, Tantric healing, etc.).

The topic was very appealing, as the approach, understanding and treatment of mental illness appeared much simpler, logical, natural and ecological. At that time, I had already been consuming ecological food for two years and practising ecological farming. The approach seemed strikingly different from psychiatry, mainly because the medications were not in the forefront, although at that time the psychiatry concepts were still unfamiliar to me. After further in-depth study my undergraduate thesis was compiled titled *(De)constructing our knowledge of mental illness: European and Indian approaches* (Kolarević, 2008), which thoroughly examined the psychiatric view of mental illness. I began to favour Ayurveda on the grounds that it has much more to offer than psychiatric medication therapy, although today I know that sometimes medication treatment is needed and that Ayurvedic approach in acute phase of depression is not so effective.

Ayurveda has multiple therapeutic approaches that are based solely on the natural ecological basis. At the same time, I was also influenced by a premise that Ayurvedic medicine is the oldest logical and conceptual medical system with a nearly six thousand year long tradition. I took up yoga – I attended classes for three years and later further developed my knowledge of yoga in the Ayurvedic therapeutics training as well as during my research visit in India. Still, I practice yoga as well as meditation.

I have been deepening my understanding of Ayurveda throughout my undergraduate studies and through some comparative studies on the treatment of Ayurveda and biomedicine. In practice Ayurveda turned out to be a very effective medical practice, both for myself and others. Soon the decision has been made to undertake postgraduate study of medical anthropology with the aim to explore Ayurveda and depression in depth.

In 2008, in the first year of postgraduate study I was invited by my mentor to help organize the first international scientific conference on Ayurvedic medicine in Slovenia: *Ayurveda: As a new way of healthy life in Europe* (2009), where I had the opportunity to learn about Ayurveda in even greater detail. This turn of events prompted me to launch this research project, and at the same time explains my decision to explore Ayurveda and not some other medical system, and my reasons to study depression.

The field in front of the home doorstep …

In the beginning of 2009 I started to investigate Ayurveda in Slovenia with the aim to gain an insight into its scope and accessibility, as well to simply experience it. There were Ayurvedic doctors available in Ljubljana and in the Primorska region and I eventually decided for the latter mainly due to the proximity. The consultation with an Ayurvedic

doctor was arranged with two objectives: 1.) to make contact with potential informants[1] for my research, and 2.) to receive answers and solve personal problems (fear of public speaking, fear of failure, self-confidence issues).

Upon my three-hour long consultation with an Ayurvedic doctor in February 2009, for which I paid € 80, I was explained that my problems originate in my upbringing and family relationships. After revealing all the details of my life, I expressed also my great interest in this topic and my wish for potential cooperation with him. The doctor (**A#1**)[2] was delighted at the invitation and immediately agreed to participate in the study. We started to intensively/actively collaborate and delivered our first joint project in four months' time – a summer school of Ayurveda, to which all of his patients and my potential informants were invited. There he introduced me and invited them to collaborate in the research.

After that I started to prepare for the fieldwork. I outlined some basic scenario or research phases for participant observation and the interviews. I formed five groups of informants: ten psychiatric patients, ten Ayurvedic patients, ten psychiatrist, Ayurvedic practitioners in Slovenia (as many as can get) and Ayurvedic practitioners in India (as many as can get). Then I prepared five questionnaires (some were quite similar) with the basic and small number of starting points questions. For approaching to different research groups I had some kind of frame work, but it started to collapse very soon. Sometimes it was very hard to get the informants.

Participant observation in Slovenia was conducted at Ayurvedic counsulting room where I went on consultation between December 2010 and May 2011. In the meantime Ayurvedic doctor moved his practice to another location, quite far away in the nature where it also belongs. The surroundings itself was very therapeutic. In this respect I partly took the role of a home anthropologist which placed me in line with contemporary research trends. As is the case with home anthropologists,[3] I too was empowered and restricted in a unique way (Clifford

1 Currently, in anthropology, "controversies" over the appropriate use of the word "informant" are present, as it may have neo-colonial overtones. As a new term the word "interlocutor/co-speaker" is suggested, but, in my opinion, it is not suitable, because it gives a false impression of "equivalence" between the two involved in the scientific research process, which, however, is not the case. The researcher has not only "a step advantage", because he/she leads the conversation (interview), but also the exclusive power and responsibility of the translation and the final transcription, analysis and interpretation of the conversations.

2 All Ayurvedic practitioners are coded as **A#** and the number of informant, while Ayurvedic practitioners in India are coded as **AI#** and the number of informant. Psychiatrists are coded as **P#** and the number of informant.

3 According to Clifford and Marcus (1986: 9) a division exists between mainstream anthropology, traditionally oriented towards outer societies, and anthropology at home, as an inheritance of the colonial binary segregation.

and Marcus, 1986: 9) – anthropologists researching in their home country supposedly cannot attain full "objectivity".

However, as Oakley (2000: 291-306) points out, it must not be forgotten that researchers reflect their own ideologies each having various interests, desires and values, accompanied by the production of a specific behaviour. From this point of view, no researcher is fully objective. Consequently it can be presumed that the strengths and weaknesses of anthropology at home or in outside societies are all relative. A significant advantage of home anthropology is by all means the familiarity with the language and culture.

My fieldwork observations were carried out concurrently with my training for Ayurveda therapist. In the first three months, from Wednesday till Saturday between 8 am and 1 pm I took theoretical Ayurvedic lessons, and in the afternoons between 2 p.m. and to 9 p.m. I observed the whole therapeutic process as a therapist and researcher. I observed Ayurvedic practice, namely the methods of diagnosis (first visit, the content of conversation, physical and psychological assessment, the relationship between the Ayurvedic practitioner and the client, as well as clients improvements) and different therapeutic approaches – from massages, marma therapy to clay therapy, breathing techniques, meditation.

From February till May 2011 I have been working at the clinic as a therapist and a researcher, where the familiar patient-researcher relationships were established. Consequently, I did not only play the role of the "participant observer" in the research, but also gained "participant experience" (Muršič, 2011). As I played a double role of researcher and therapist, I needed to pay more attention to my self-reflection. The role of Ayurvedic therapist has obviously influenced my findings, which brought some advantages and also disadvantages. One of the advantages was certainly my ability to create a friendly and confidential atmosphere – informants relatively quickly accepted me, began to trust me and opened up to me later in the narratives. As a result strong friendly relationships were established. All patient informants were prepared to speak openly about their lives and some often hardly waited their turn to speak.

But like Knipper (2003) says, only "participating" turns into "treating" observation, and from a methodological perspective, the corresponding activities of the researcher may be seen as a disruptive factor that substantially changes the research setting. The methodological consequences of this act of inclination are very relevant in the research context of medical anthropology. It should be considered as an example of a researcher being in an "extreme" situation of a double role as a therapist doing ethnographic research. The question is whether and in what way interventions in a therapeutic process or other kinds of helping "disturb" the observation of social processes and thus influence the results. However, disruption of scientific work can be used in a methodologically creative way. In order to compensate for the disadvantages (or even reduce them), I controlled myself in terms of my comments

and guidance during the interviews to the best of my efforts.

Even though my training was merely coincidental with the implementation of the research work it could be argued that I was involved also in autoetnography. Autoethnography is an approach to research and writing that seeks to describe and systematically analyse personal experience in order to understand cultural experience. This approach challenges canonical ways of doing research and representing others and treats research as a political, socially-just and socially conscious act. A researcher uses tenets of autobiography and ethnography to do and write autoethnography (Ellis, Adams, Bochner, 2011: 1).

One form of autoetnography that I have used is narrative ethnography, which refers to texts presented in the form of stories that incorporate the ethnographer's experiences into the ethnographic descriptions and analysis of others. Here, the emphasis is on the ethnographic study of others, which is accomplished partly by attending to encounters between the narrator and members of the groups being studied, and the narrative often intersects with analyses of patterns and processes (Ellis, Adams, Bochner, 2011: 4). With that form of autoethnography I also searched for consistency between patients' narratives. I was interesting in what patients have disclosed in their interviews, and what I have observed that was actually going on in the Ayurvedic counsulting room.

Patient's narratives …

The illness biography or "pathography", as some prefer to call it (Loewe, 2004), has emerged as a popular literary form as well as a primary data source for medical anthropologists. Through vivid, personal stories, seriously ill patients have attempted to educate medical professionals and the general public about the impact of disease on their work, family life, identity, and self-image as well as to recount their experiences with impersonal and bureaucratic medical institutions (in this case also with Ayurvedic medicine). While such narratives have been written by people from various walks of life, and cover a variety of different medical conditions, the stories share many common narrative elements: mystery (disease is unexpected or difficult to diagnose), body betrayal, conflict with medical professionals or medical bureaucracies, the failure of medical science to heal, the need for self-reliance, and, generally, but not always, the restoration of health (Loewe, 2004: 42-43).

Although it can be dangerous to attempt to identify a single source for this pervasive trend, it seems safe to say that the emphasis on illness narratives and the hermeneutic tradition within medical anthropology more generally, can be traced back to the work of Arthur Kleinman. By arguing that disease narrative is an "explanatory model", and, thus, part of culture rather than nature – or at least the result of a complex interaction between the two – he helped to open

a discursive space. Here, alternative explanations of the aetiology, course, and treatment of disease became worthy to be explored through patient accounts. In his work, *The Illness Narratives: Suffering, Healing and the Human Condition* (1988: 130), Kleinman continues his effort to persuade physicians to "listen to the patient, he is telling you the diagnosis". The first section of his study notes that the illness narrative is a cultural phenomenon. As always, social theory follows social life.

Narrative interviews were conducted in Slovenia among two groups of patients of both sexes: (1) depressed persons primarily seeking help within the official medicine (psychiatry) and later within the Ayurvedic medicine; (2) depressed persons seeking help only within the official medicine (psychiatry). The entry criterion for all interviewees was biomedical diagnosis of major depression. The Beck questionnaire[4] 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. When persons with higher values were participating in the discussion, the effects of severe depression needed to be taken into account, since the extent and severity of symptoms are associated with patient processing.

In cooperation with a psychiatrist employed at the Policlinic in Ljubljana access to psychiatric patients was gained. In addition, patients were also contacted via non-governmental organizations and my own social network. Six informants were recruited with the help of a psychiatrist, one informant via NGOs and three informants via my own network. Eight women and two men, ranging from 26 to 64 years of age, volunteered to participate in the study.

All informants received diagnoses of depression between 2004 and 2010, although some informants had experienced depressive symptoms much earlier. Half of the informants experienced a single episode of depression, while the other half had had several episodes: three informants' two episodes and two informants' three episodes of depression. At the time of the interviews, all informants were receiving medication therapy. After the concluded treatments

4 The Beck Depression Inventory (Beck and Steer, 1978) is a self-assessment questionnaire measuring the degree / severity of depression. The questionnaire has high reliability (α between 0.76 and 0.95) and validity (discriminatory validity of the separation of depressed patients and outpatients). It consists of 21 items, each describing symptoms (on a 4-point scale from 0 to 3) characteristic of depression; for example: pessimism, dissatisfaction with yourself, changed body image, altered body weight, insomnia, fatigue, and change in libido. The task of the individual is to indicate symptoms that appeared in the previous week for each item. The final score is the sum of all the values that the individual marked for the 21 items. Values between 0 and 9 are normal or asymptomatic, 10–18 indicate mild or moderate severity of depressive symptoms, 19–29 indicate moderate to severe depression, and over 30 reflect severe depression.

four of them stopped with the medication therapy, but after the second or third depressive episode they started receiving medical therapy again. Two were advised to attend self-help groups, and two were advised relaxation techniques. Beck values between 0 and 9 (considered to be normal or asymptomatic) were assigned to six informants (**Alma, Nana, Nela, Milena, Metod, Leja**). Values between 10 and 18 (showing moderate symptoms of depression) were assigned to three informants (**Zoja, Marija, Adam**) and values between 19 and 29 (indicating moderate to severe depression) to one informant (**Tanja**). Values above 30 (reflecting severe depression) were not assigned to any of the psychiatric informants.

On the other hand, Ayurvedic patients were obtained in two Ayurvedic consulting rooms and via an Ayurvedic therapist who is working at home. Six informants were recruited in the consulting room where also my research fieldwork was conducted, one informant in the other consulting room and three informants via a therapist. Although all Ayurveda practitioners in Slovenia were contacted and invited to participate, which would have allowed a larger selection of informants, only a few agreed to participate. However, due to the unregulated and poor control of complementary methods in Slovenia, none of them kept records and documentation about patients.

Six women and four men, ranging from 29 to 64 years of age, volunteered to participate in the study. All informants received diagnoses of depression between 1996 and 2010, although some informants had experienced depressive symptoms much earlier. Five informants experienced one episode of depression, while all the others experienced two depressive episodes. Informants began receiving treatment with Ayurvedic medicine between 2010 and 2012. Upon starting the Ayurveda treatment four informants were not receiving any other form of therapy; four abandoned psychiatric therapy in the course of the Ayurvedic treatment. At the time of the interview one informant was still receiving psychiatric therapy. During the psychiatric treatment all informants received only medication therapy. Beck values between 0 and 9 (normal or asymptomatic) were assigned to seven informants (**Tea, Angela, Karmen, Sandra, Martin, Bobi, Bor**). Values between 10 and 18 (moderate symptoms of depression) were assigned to two informants (**Silvester, Tomi**) and values between 19 and 29 (moderate to severe depression) to one informant (**Beti**). Values above 30 (severe depression) were note assigned to any of the Ayurvedic informants.

To both groups of informants were offered the interview be conducted at their homes or at the Sociomedical Institute in Ljubljana. Eleven informants requested the interviews to be conducted in their own homes, six of them wanted to meet in a peaceful coffeehouse, two in their offices and only one preferred the Institute. I had become acquainted with some of the informants before the interview, i.e. three psychiatric patients and six Ayurvedic patients. The latter I met in the Ayurveda summer school and during

my participant observation in the Ayurvedic consulting room. The psychiatric patients were introduced by mutual friends.

Suitable time frames were arranged in order to ensure minimal interruptions. Perhaps the most important part of the interview process was establishing and developing a good rapport before the actual interview and data analysis began. Before the actual interview my research was briefly discussed, whereby the informants were encouraged to ask any questions in this regard.

Interviews lasted between 90 and 180 minutes on average and were carried out in a relatively informal and supportive manner. The interviews were initiated with a request to the informants to introduce themselves and to provide their basic demographic characteristic. Then patients started to narrate their stories about childhood experiences and relationships with close relatives. Patients chronologically described their major life events (schooling, first job, marriage etc.) that had happened before first problems related to mental health emerged. At this point the interview changed its course and focused on mental health problems, circumstances, ways of seeking help, first diagnosis and the course and outcome of treatment. Special attention was payed to their experiences with both medical systems: Ayurvedic and biomedical. Five informants mentioned this was their first opportunity to tell their entire life story and, as such, they found it a thought-provoking and positive experience.

The narrative interview covered the entire life path of the patient, i.e. life before depression, psychiatric treatment, reasons for seeking help in Ayurvedic medicine and their satisfaction with the treatment with Ayurvedic medicine and biomedicine / psychiatry. Narrative interview is not only culturally acceptable to patients, but their stories about depression fit into a clear perspective of time and allow the examination of "critical moments" in their lives (Bauer, 1996). The main points of my interest were the relationship between psychiatrists / Ayurvedic therapists and patients, the role of the patient within the psychiatric and Ayurvedic process, and the perception of successful treatment from the point of view of a psychiatrist / therapist and the patient.

The interview was designed in such a way that the informants had the opportunity to raise anything they considered important rather than imposing any pre-conceived notions of what I presumed as important. To this end a small number of open-ended questions were set. Additionally, clarification were sought where needed in order to avoid making assumptions on my part about how the informants made sense of, and felt about various aspects of their experiences.

The question under consideration was how individuals (psychiatry / Ayurvedic medicine) understand the factors and circumstances leading to the emergence of major depression on the basis of their diagnosis? Depression is currently understood in the context of bio-psychosocial model that observes the disorder on all three levels. Here, the biological factor is not the solely important factor, as the biological factor is presumed to be the

result of the psychosocial impacts that on a long-term upset the chemical balance in the body. This model allows us to understand how the understanding of an individual's own life story can be changed. This allows us to explain how *in concreto* the process of medicalization is running.

Furthermore, the question at hand was how this mood disorder is understood by the patients. To what extent the bio-psychosocial model is used in psychiatrists' interpretation of major depression and to what extent only the biological model of interpretation? How and to what extent individuals take the bio-psychosocial model or biological model of interpretation?

I was engaged also in how are people with depression on the one hand diagnosed by the modern medical practice and how on the other hand are they searching for solutions to their problems in the modality with which the official medicine does have some features in common. According to Giddens (1991) this modality is also significantly opposed to medicine. Consequently, the following questions arose: to what extent and why one does not persists with the medical discourse but engages in an Ayurveda discourse. Here, the black-and-white explanations were not satisfactory and focus was placed on the extent people with depression adopt one or other interpretation. How do the interpretations / diagnoses of one and other medical practices affect the individual's self-perception?

In this respect a number of questions were addressed: Do patients diagnosed with major depression turn to Ayurvedic medicine because of their disagreement with the diagnosis or the treatment? What are the key factors for deciding for a different model of treatment? Were individuals affected by depression merely looking for a complement to the psychiatric practice, or have they started to fully engage with the Ayurvedic treatment? On what basis do they choose the appropriate method? Why exactly did they choose the Ayurvedic medicine? Did they turn to other methods because of their body-friendly and natural orientation, or because the psychiatric treatment may convey more stigma compared to the complementary treatment? Were they looking for Ayurvedic therapists due to inadequate or lack of health care in Slovenia? And finally, can Ayurvedic holistic approach effectively identifies the causes of specific diseases / disorders, so the treatment brings a positive outcome?

All interviews were audio-recorded and transcribed on paper by me personally. In the transcription process a special focus was placed on the originality of the informants' wording. In the analysis pseudonyms were assumed for the informants' names and italics are used to indicate the speech of the informants.

Talking to psychiatrists and Ayurvedic practitioners

The review of literature, studies and researches from the fields of psychiatry and Ayurvedic medicine gave me a theoretical framework for understanding depression and a basic knowledge in depression treatment. I identified the gaps between theory and

practice and I was interested in the conceptualization of depression within biomedicine and Ayurvedic medicine from the perspectives of their practitioners in Slovenia.

Psychiatrists were recruited via acquaintances and the internet. Contacts were made via telephone or e-mail whereby the purpose of research and the need for their participation were explained. Most psychiatrists responded via e-mail, either positively or negatively. A few psychiatrists did not responded at all and one requested € 50 for the starting hour of the interview.

Four female and six male psychiatrists, ranging from 38 to 66 years of age, volunteered to participate in the study. Nine of them worked in public institutions, all of them in outpatient facilities and five also in hospitals. Two informants had private offices. Participating psychiatrists had between 10 and 22 years of experience. Six of the psychiatrists requested that the interviews be conducted in their own offices; three preferred a coffeehouse and one of them the Institute.

Semi-structured interviews lasted between 30 and 90 minutes on average. They were focused on the definition of depression, its treatment procedures, its prevalence, the role of the patient and the patient's responsibility, the involvement of relatives and the problems they can detect during their work. Special focus was put to their attitudes toward complementary methods.

I was interested in how psychiatrists understand "depression" and to what extent is the bio-psychosocial model of major depression interpretation used by them and to what extent only the biological model of interpretation? The issue in question was also the gap between psychiatric theory and practice, i.e. the extent of treatment with other forms of therapy instead of pharmacological treatment offered to a depressed person, and the extent of the consideration of psychological and social causes in the major depression diagnosis. A depressed patient may also experience his disorder in light of the strong social stigma arising from lay perceptions of depression ("sissy weaklings" suffer from depression) which, however, is excluded from the medical interpretation of depressive disorder, as being defined primarily as a physiological disorder.

Furthermore, I was interested in what extent does psychiatry uses other treatment modalities for treating depression? Due to the lack of accessibility and availability of health care services in Slovenia (Kurbos, 2008) patients in mental distress often have only the possibility to receive a prescription for a pharmacological substance (Kores Plesničar et al, 2006) or nothing. Such an approach implies the prevailing interpretation that the patients' perception of their mental distress is primarily of chemical and biological nature.

With the interest I also talked about their attitudes toward using complementary methods and Ayurvedic medicine and I was surprised about psychiatrist support to CAM, regarding it as a logical complement. Because in short, the politics and the official medicine as such have adverse attitude toward using CAM compared to psychiatrists. Due to the absence of regulations and verified registry, psychiatrists have difficulties

to give advice to the patients interested in these methods. Besides that I was curious if depression can be treated naturally, without medication and if there is any need for cooperation between official biomedicine and CAM.

On the other hand I was acquainted with the majority of Ayurvedic practitioners prior to the interview, except with one informant, an Ayurvedic doctor working in one of the hotels. I met the first practitioner at an Ayurvedic consultation about my fieldwork, the second one at a conference on Ayurveda in Slovenia; and the third one during my fieldwork in the Ayurvedic consulting room.

Three male and one female informant, ranging from 34 and 55 years of age, volunteered to participate in the study. Two of them owned private consulting rooms, one was working in a hotel and one was working from his home, made home visits in Slovenia, Bosnia and Germany, and worked part-time in a hotel in Germany. Three of them were Ayurvedic doctors; one of them also a doctor of biomedicine, and one was an Ayurvedic therapist, who was also a systemic therapist[5] and a reiki master[6]. Informants gained their education in India, Slovenia, Serbia and Germany and have been practising Ayurvedic medicine between 8 and 13 years.

All of them requested that the interviews be conducted in their offices, except the Ayurvedic therapist who was interviewed at his home. Interviews lasted between 60 and 120 minutes on average. In addition to the interviews, the majority of informants were prepared to clarify some issues and thus deepen my understanding of Ayurveda.

I was interested in how depression is conceptualized within Ayurvedic medicine, so the interviews were focused on the understanding and definition of depression, its treatment modalities, its prevalence, the role of the patient and the role of a patient in a recovery process, the involvement of relatives, and other issues related to their work. What are their experiences? And can Ayurvedic holistic approach effectively identifies the causes of specific diseases / disorders, so the treatment brings a positive outcome?

Furthermore, I was interested in the transfer of Ayurvedic medicine into the different environment that is not as supportive as the original environment. I tried to identify the limitations and problems of practising Ayurvedic medicine and patient treatment in a foreign culture. They all exposed that when you tried to incorporate not so familiar medical system like Ayurveda in new environment, the culture of new environment should be considered very carefully.

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5 Systemic therapy is a form of psychotherapy which seeks to address people not on individual level, as had been the focus of earlier forms of therapy, but as people in relationship, dealing with the interactions of groups and their interactional patterns and dynamics.

6 Reiki is a Japanese technique for stress reduction and relaxation that also promotes healing. It is administered by "laying on hands" and is based on the idea that an unseen "life force energy" flows through us and is what causes us to be alive. If one's "life force energy" is low, then we are more likely to get sick or feel stress, and if it is high, we are more capable of being happy and healthy.

The fieldwork in India …

My fieldwork in India was conducted at two institutions in the state of Kerala, i.e. at an Ayurvedic psychiatric hospital in the town of Kottakkal, and at the Cherian Ashram in the city of Kottayam, between December 2011 and January 2012. My visits to both institutions were arranged in advance before my arrival to India. The Ayurvedic psychiatric hospital was contacted with the help of the Ayurvedic doctor in Slovenia who is working in one of the hotels. Within two weeks after a letter of intent and an application explaining the purpose and objectives of the fieldwork were sent, my application was approved. As the fieldwork in the hospital did not include work with the patients, an approval from the Indian ethical committee was not required.

At a conference on holistic medicine (Second International Conference on Holistic Medicine (ICHM-2011)) held from 11 to 13 September 2011 in Kottayam I met Mr John, the manager of the Cherian Ashram. I attended the conference with the purpose = to make contacts for a later research visit to India. The Cherian Ashram integrates Ayurvedic medicine with biomedicine and for this reason this institution has been much more appealing to me. At the end of the conference I arranged my visit and an observation of Ayurvedic practice at Mr. John's institution.

The fieldwork primarily included a visit to the traditional Ayurvedic doctor but it was cancelled due to my health problems. Thus, in both institutions I observed the process of Ayurvedic practices (diagnosis methods and treatment modalities) in order to obtain data for a comparative analysis of the Ayurvedic practice in its original environment (India), and in the environment to which it has been transferred (Slovenia). I was interested whether or not the practices of Ayurvedic medicine in Slovenia and India differ and to what extent is the treatment adapted to the Slovenian culture?

The meetings with Ayurvedic doctors were also arranged in advance, before my arrival in India. Three female and four male informants, ranging from 25 to 61 years of age, volunteered to participate in the study. Six of them worked in an Ayurvedic psychiatric hospital in Kottakkal, one in the Cherian Ashram. Five informants were Ayurvedic doctors and two were Ayurvedic therapists. Informants have been practising Ayurvedic medicine between 1 and 37 years. The interviews were conducted in their offices at hospitals and ashram. One to three interviews were carried out with each informant, each lasting between 120 and 180 minutes on average.

When I landed taxi took me to my first destination – the Cherian Ashram, which is a family operated and eco-friendly holistic centre, located in the city of Kottayam, in the Indian state of Kerala. It is located about 10 kilometres

from the main road into the wild nature. I arrived to ashram about 4.30 in the morning. Everything was fogy and there were a lot of noises from the animals, so it was a little scary. I was very dehydrated so I asked the girl who accepted me to get me a glass of water. She answered unclearly that I should wait in the room. I waited 5 minutes, 10 minutes, after 20 minutes she knocked on the door. I opened and saw a little glass of hot water of brown colour as some root was in it. I thought for a moment how I will survive here. I experienced quite a shock.

I went to bed and two hours later Mr. John knocked on the door. "*Good morning, doctors are waiting for you*", he said. Of course I replied that I arrived two hours ago and I want to sleep a little more, so I will come later. "*No, no, come, they are waiting, you will rest later*", he replied. He was very persistent so I had no choice. I dressed myself, grab the papers and Dictaphone and went down to the reception office. When I came down there were already a lot of patients all around. As I was the only European they were staring at me like I felt from the Mars, but it was not so annoying like my first time in India.

When I came to the office and sit down, Mr. John introduced me to two doctors, Ayurvedic and Biomedical. When we start talking and I start asking question there were so pleasant and relaxed atmosphere. It is very hard to put these feelings into the words, and as I noticed later with the others Ayurvedic doctors that I talked to, it was the same feeling. We were talking very freely, like I was talking with some good old friends.

But there was also some interesting moments and only with the Ayurvedic doctor from the ashram, the only one with the traditional education of Ayurveda. That is mean that he did not gained Ayurvedic knowledge on the college but it was passed to him within his family, from their parents. When I explained why I am here he immediately started listing the books I need to read and learn first. I tried to explain him in many ways that I already read the collection of Charaka Samhita and many other books and that I am familiar with Ayurvedic concepts, so the work of anthropologist is to combine how each individual doctor comprehend and understand those concept and for example, how doshas affect depression or why a man become depressed, but he did not understand me.

We had three conversations and each time he was listing books and I was explaining over and over again why I am here. He was acting like learn first, and then ask. However, at the end he gave me precisely and in-depth explanation on my questions.

In the ashram I stayed for two weeks and came back after two weeks for almost another week. Every day at a sunrise I woke up and together with staff and the patients we performed a ritual, called *Agnihotra*, after that we practised yoga with pranayama. Then we all had breakfast. The breakfast was very spicy and was soon replaced with the fresh fruits and eggs. One hour after the breakfast I observed treatments and massages (rise treatment, chelation therapy, massages), the preparation of oils and medicines for a

long-term cooking, I also talked to the patients who spoke English. At one a clock we all had lunch, and always talk a little after. In the afternoon I observed again and at the sunset we perform *Agnihotra* again. After a dinner some patients went home, some were in-patients.

After two weeks I moved to the town of Kottakkal where Ayurvedic psychiatric hospital is located. I stayed there in some sort of the hotel on the main road of Kottakkal, which is full of crowd, traffic, every car and rickshaws were beeping and on every two hours they were calling to prayers. Compared to ashram it was quite stressful experience. Although Kottakkal city is the home of Ayurveda, it is a Muslim city with almost no green area.

Every day at 8 am I went to the hospital by rickshaw, because it was located some kilometres away. Although it was psychiatric hospital I found peace there, since the outside was too noisy. Already on my first day in the hospital I also felt strong acceptance of the staff and the patients. The doctors were very opened and rich of information. Sometimes I had the feeling like they were enjoying sharing their knowledge with me, like they hardly wait to speak, to explain and to show greatness and also weakness of Ayurveda.

They showed and explained me every corner of the hospital and its meaning, also therapist who was performing particular therapy he has passionately describing what he is doing. Here, in Ayurvedic psychiatric hospital I mainly observed three sorts of therapies that are applied on the head and had cooling effect on the brains. Ayurveda postulates that due to the mental health problems the head become too heated, so it needs to be cool down.

Very interesting was also one of the interviews with the main doctor at Ayurvedic psychiatric hospital. We were talking and suddenly one of the female patients comes in, because she was very interesting in why I am here and what we two are talking about. The patient was very currious and the doctor gently and briefly explained that we are talking about depression and if she can give us a little more time and space. The patient has quite soon understood situation and left the office. I asked the doctor whether this is a common practice and said it is. Patients are allowed to come to the office whenever they want. There is different culture in psychiatric hospital; there are much more informal relations between patients and employee staff.

Because of more flexible relations I had the opportunity to speak also with some patients who spoke English. There were two very interesting stories of two men diagnosed with depression at the age between 30 and 35. The first one is about a biomedical doctor who only trusts in biomedicine and science and living quite modern or western way of life. He came to Ayurvedic psychiatric hospital due to the failed attempts of biomedicine. He was taking antidepressant for many years, but he became even more depressed. The other story is about a man who is happily, but at the same time not happily married.

He is happy for having the opportunity to pick the wife on his own, but now because of the television and the internet he is suffering as he wants European or American life-style. A life-style in which he can dates different girls and get married later. Now he is unhappy, because he does not wants to be tied to only one woman. Those two stories demonstrates how globalization affecting Indian social life and also changing it.

The parts constitute the whole …

The fieldwork was finished in the autumn of 2012. Then I used a multi-layered thematic analysis approach that comprises a comprehensive data material from different informants' perspectives: (1) psychiatric patient, (2) Ayurvedic patients, (3) psychiatrists, (4) Ayurvedic doctors and therapists in Slovenia, and (5) Ayurvedic doctors and therapists in India. Thematic analysis approach, based on the "grounded theory approach" (Strauss and Corbin, 1990), was conducted as the main method of analysis of the narrative interviews, semi-structured interviews, field notes and written texts.

Since the 1980s, some anthropologists and other social scientists have been questioning the degree to which participant observation can give valid insight into the minds of other people (Geertz, 1984; Rosaldo, 1986). At the same time, a more formalized qualitative research approach known as grounded theory, initiated by Glaser and Strauss, began gaining currency within American sociology and related fields, such as public health. They compile a book on methodology, where four stages of analysis were described (Glaser, Barney, Strauss, 1967: 105-113):

Coding	Identifying anchors that allow the key points of the data to be gathered
Concepts	Collections of codes of similar content that allows the data to be grouped
Categories	Broad groups of similar concepts that are used to generate a *theory*
Writing theory	A collection of explanations that explain the subject of the research

Narrative and semi-structured interviews and anthropological notes were transcribed verbatim into documents. Then the coding and thematic analysis of materials (Boyatzis 1998, Silverman 2005) was carried out, whereby semantically similar parts of the narrative interviews, fieldnotes, focus groups and written texts were organized into similar themes. To reduce arbitrariness and increase the uniformity of coding the first few interviews, narrative interviews and field notes were independently coded and organized by my mentor, with whom I later compared the codes and themes. A consensus was developed to avoid any discrepancies in the coding and topics. On this basis a comprehensive comparative and contrasting analysis of the relationships between individual subjects was conducted. Data were also analysed within each theme and vertically across the themes.

Besides, I also used focus groups approach. Irrespective of the current research interest in focus groups as the principal or sole method of data collection, it is a method that increasingly plays an important role as an auxiliary method that is complementary to other research methods (Hennink, 2007). In my research, focus groups were utilized in the final stage of the research process with the intent to expand and build upon research findings of narrative and semi-structured interviews and anthropological notes, where individuals suffering from depression recount their opinions and experiences with the Ayurveda therapists and psychiatrists as clients of their services. Focus groups were organized in accordance with the generally established phases (Puchta, Potter, 2004): creating focus groups, implementation of focus groups, completion of the results based on the revised results of focus groups.

Focus groups were an important source of information for the research, because they enabled the identification of the underlying patterns in relation to the treatment of depression with psychiatric and Ayurvedic practice, and to the medical care in general. First of all, an analysis of the interviews and field notes was made, and a review of the results of the baseline study and research questions. Then, the reference literature was consulted to determine what is comparable and what opens new questions; on that basis, thirteen topics / issues for discussion in the focus groups were developed.

These topics / issues were not oriented towards generally accepted facts (except preliminary and warm-up), but towards addressing particular problems in detail and obtaining backgrounds, interpretations, personal points of view, experiences. The questions were designed to pose a challenge triggering a discussion and not just yes-no answers. To that respect I also had ancillary sub-questions prepared which helped directing the interview. Therefore, a scenario of focus group discussion was drawn up beforehand and consisted of the general and the structured part.

The first focus group was designed to examine views and experiences of depressed people who sought help in psychiatric care and under Ayurvedic practice. The second focus group, which included Ayurveda doctors and therapists and psychiatrists, was intended to inspect their views and experiences related to Ayurveda and the medical paradigm of treatment for depressive disorders. The topic guide for both focus groups was the same.

The following questions were raised: Is depression a very common disorder? Is the general public talking about depression too much or too little? Do people know what depression is? Is the wider environment (e.g. colleagues or acquaintances) treating the person suffering from depression differently? Do patients often face doctor's doubts about the reality of their problems? Does this affect their further openness to the doctor? What is the quality of professional help for people encountering depression for the first time? What are the problems of depression treatment with antidepressants? Can depression be treated only with medication? Are mental disorders an expression of an individual's attempt to adapt to a constantly changing psycho-social environment? What is the responsibility of the individual? Does adhering to the principles of Ayurveda provide

a higher quality of life? How can a depressed person help himself to maintain a stable mood? Are there any tools affecting the ability to control the mood of depressed people? Is it necessary to treat also the family members and not only depressed individuals?

INTRODUCTION

Depression is classified in a psychiatric categorization as a mental disorder, most often with a chronic course; the beginning of each episode can be linked to stressful events. Those individuals who have a family history of depression, have their own tendency to depression, a traumatic experience at an early age, and/or a chronic physical illness, are more vulnerable to depression (Kandel, 2000). 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 (American Psychiatric Association, 1994). 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.

The monography examines the differences between the two approaches of treatment for depression arising from the different concepts of understanding its causes, its course and consequently its therapeutic intervention. It investigates the gap between psychiatric theory and practice, i.e. the extent of treatment with other forms of therapy instead of pharmacological treatment offered to a depressed person, and the extent of the consideration of psychological and social causes in the major depression diagnosis.

The main focus lies on the advantages / disadvantages of compared practices as experienced by patients with depression. This issue is particularly important because, according to health statistics, depression today ranks among one of the most common forms of mood disorders, and its incidence is on the rise. This is not necessarily a reflection of the increased cases as such, but might also be attributed to the better recognition and greater awareness of depression by healthcare professionals and the general public.

The monography consists of a personal and narrative preface, introduction, eight chapters and conclusion. In the preface I want to present to the reader my personal field experience and theoretical position. After a brief history of depression, the first chapter describes theoretical considerations on understanding and treatment of depression in the 20th and 21st centuries. In the first half of the twentieth century, Kraepelinian views on depression dominated, which also provided a continuing interpretation for many of the signs and symptoms. Emil Kraepelin was an influential German psychiatrist who lived in the late 19th and is widely considered to be the founder of modern psychiatry and psychopharmacology. At this time, the psychological explanations came to have a more significant place, but the biological and social models of understanding depression were also present. After World War II, a revolution in drug therapy took place when the strongest evidence came from the observation that the administration of pharmacological agents acting on the brain's monoamine system could either increase or decrease mood levels (Leo, Lacasse, 2008).

Concurrently, in the United States the development of the classification of mental disorders took place, because psychiatry strove to provide explicit diagnostic criteria that would guide researchers (Houts, 2000: 935-967). In the 1970s, psychiatry had maintained its value in the medical model of interpretation (Cacioppo et al, 2007) and the concept of "major depression" was coined. Anthropological literature indicates that (after schizophrenia) depression is the most biologized mental disorder in the West (Gaines, 1992; Kleinman & Good, 1985; Marsella, 1980). A wide body of anthropological literature has shown and described the influence of social, cultural and economic backgrounds on the aetiology and epidemiology of all forms of mental disorders. As well psychiatric literature has shown and described variety of factors most likely related to depression, so the current understanding and treatment of depression is based on the bio-psychosocial model (Walker, 2008; Ghaem, 2003).

The second chapter presents contemporary psychiatric practice in Slovenia, taking into account its (post) socialist heritage and its specificities in understanding depression. After World War II, Slovenia was part of the new Yugoslav state under Josip Broz Tito, the prime minister and the president during 1953–1980. He developed an independent form of socialist rule and declared a position of "self-management" economy (Jeraj, 2005). Its solidarity impulses also brought some positive changes for psychiatric patients. In the 1970s the modernization of Slovenian psychiatry was carried out at the expense trans-institutionalization, i.e. relocating patients to social institutions (Milčinski, 1987). During the 1980s when the system of Yugoslavia began to collapse, process of deinstitutionalization took place. Political changes culminated in the disintegration of Yugoslavia in 1991 when Slovenia formed a new state and gained independence.

According to Lorenčič (2011) the transition to capitalism has suppressed many social rights, greatly impaired social relations and some people have encountered poverty and exploitation. These are today well-known factors of depression that correspond to bio-psychosocial model of understanding depression in Slovenia (Kočmur, 2006; Korelc 2005). In 2009, Slovenia adopted Mental Health Act, which according to Flaker (2011) does not bring satisfying solutions of persisting problem of deinstitutionalization, although contains some elements that protect the user's rights (agents) and introduces some community services. Due to the poor accessibility and availability of health care services (Kurbos, 2008), and many economic reasons that support the current psychiatric practice, depressed patients frequently cannot be offered more than just a prescription (Kores Plesničar et al, 2006).

With the third chapter the book moves to another part, where Indian development of comprehensive theory and well-structured mechanisms against psychological distress has been explored. The culture of ancient India, the Vedic culture is approximately 6000 years old and bears the name after the oldest sacred texts called Vedas, which represent the foundation for the early codification of Hinduism, as well as for the development of traditional Indian medicine – Ayurveda. After the golden age of "science and art" which lasted more than three millennia, in the next 1200 years India was the target

of numerous Islamic invasions (Patterson, 1987) and later, European colonization. Consequently, in the early 20th century, practitioners of Ayurveda formed two trends: one that honours the ancient records (purists), and one that supports the integration of biomedical elements in the Ayurvedic medicine (Leslie 1992; Nisula 2006), the latter being common in modern/contemporary India. Prior to my examination of depression understanding the key concepts of Ayurvedic medicine have been outlined.

The Ayurvedic psychiatry knows the notion of unmada, which is a general term for all mental disorders in which 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 (insanity), describes the etiologic factors and the pathologic process, and defines clear diagnostic procedures that are oriented toward the individual and not to the disease. According to Lang and Jansen (2013) drawing on ethnographic fieldwork, Ayurvedic conceptualization of depression is relatively compatible with the biomedical concept of depression. In addition, both concepts understand depression within bio-psychosocial framework, though Ayurveda goes even further including also the spiritual aspect. Ayurveda configures illness as a disruption in delicate somatic, climatic, and social systems of balance (Kakar 1984; Trawick 1991; Zimmermann 1987; Langford, 1995) and offers a range of treatment models (Divine Therapy, Biological Therapy, Psychotherapy, and Yoga).

Today, Ayurveda as a part of CAM gained attention in Europe and also in Slovenia. The fourth chapter describes the cultural-political attitude towards complementary methods and Ayurvedic medicine in Slovenia, and highlights the moments when alternative methods have become increasingly powerful. One of the questions, for example, is why our culture and part of the medical profession are open to other medical systems, and why the other part of the medical profession and the medical politics resist them. Illustrating such cultural openness, the book refers to a number of clients – about 60% of people have already used complementary medicine (Lovrečič, 2004; Plešnar, 2008). In contrast, in the context of current health politics in Slovenia, a certain aloofness and scepticism toward using complementary methods can be observed (Lunder, 2003; Kersnik, 2006).

Slovenia is among those countries that entirely exclude practices not based on scientific medicine, and consequently exclude practitioners not formally or medically trained for such work. Even trained doctors, specialist within official medicine, cannot practice complementary methods because they risk losing their medical license. Although some doctors realize the methods of treatment (medical therapy) are unsatisfactory or deficient (Žagar, 2006), the law prohibits them to use complementary medicine. But in their regular practice many of them are performing practices that were until recently a part of the CAM (eg. autogenius training). There are two visible trends between doctors' attitude toward using CAM – either they resist, or they simply adopt.

Now the book moves to the chapters, where psychiatric and Ayurvedic theoretical framework for understanding depression is refined by the findings of practitioners and

their clients / patients. The fifth chapter deals with the prevalence of depression, with the questions why are we depressed and how we experiencing it, and are we responsible for it? Representatives of both medical systems mentioned broader socio-cultural factors influencing the rates of depression, and something similar is happening in India. Both agreed that this way of modern life outpaces our adaptive abilities. On contrary, patients of both groups mentioned reasons for a high rate of hidden depression. All informants stressed the fact that the rate of hidden depression is high, especially among men and in the rural areas.

Depression was understood as a disease by all informants, whereas only Ayurveda describes a detailed psychopathological mechanism. Both psychiatrists and representatives of Ayurveda stressed that depression is a multifaced condition what supported patients prehistories where four types of depression were found. However, some cultural features of depression in Slovenia were detected between the patient's narratives. All patients understood depression within bio-psycosocial model; however different components of model have been reported and emphasized. With regard to symptomatology, it has been noted that some symptoms were common to several patient informants; others varied from case to case, regardless the gender. The majority of informants in both groups stressed that a person is co-responsible for emergence of depression.

The sixth chapter analyses quality of professional help available to a person first faced with depression. The help seeking path begins with self-care and self-treatment, only later patient informants visit a family doctor or a psychiatrist. Representatives of both medical systems have approached to a depressed patient with an in-depth interview, but Ayurveda is interested in physiological and later in psychosocial factors. In the psychiatry, however, this is not a common practice. Only Ayurvedic patients experienced doubts about the reality of their health issues as diagnosed by a family doctor. Combined treatment (medical therapy plus psychotherapy) in psychiatric practice was not always present in all cases compared to Ayurvedic practice.

Psychiatric patients mainly received only medical therapy. Psychiatric patients noticed changes only after month or later, when antidepressants started to take effect, whereas Ayurvedic patients noticed improvement in their well-being after the first visit/ session. All four groups of informants recognized the problem of help in the excessive medicalization and they all stated how much NGOs can contribute to the field of mental health. Ayurvedic patients did not seek help in Ayurveda intentionally due to the unsatisfying psychiatric help. Rather, decision has been made on the basis of experience of other people. Most patients used Ayurveda exclusively, only one was using Ayurveda complementary to psychiatry. Also, only one had a prior knowledge of Ayurveda.

The seventh chapter explores the course and outcome of treatment using both medical systems. Psychiatric patients were generally satisfied with doctor-patient relationship, compared to Ayurvedic patients, who were less satisfied, although both stressed many disadvantages. Here is about biomedical doctor – patient relationship and not about

Ayurvedic practitioner – client relationship. Psychiatric patients emphasized what they missed in their treatment, whereas Ayurvedic patients pointed out the key differences between both practices. In general, however, most patients of both groups were informed with the diagnosis and that their active role was emphasized, but psychiatry less encouraged individual-problem solving compared to Ayurveda. Ayurvedic practitioners offered techniques to all informants, while provided individual guidelines to each individual patient.

Although cooperation with patient's relatives greatly contribute to better outcome of the treatment, unfortunately, cooperation of relatives is less common in Slovenia than in India. Family members were not involved neither in the psychiatric nor in the Ayurvedic treatment, however, in Ayurveda they were involved separately – family member joined the therapeutic process separately. Besides this problem all four groups of informants stressed many obstacles and difficulties in threatening depression at the following different areas – individual, social, and professional.

However, both groups of patients reported improvements after the treatment and both believed that contact with inner self had been strengthened. Chapter is concluded with a number of approaches and methods on how to maintain a balance in life.

The final chapter analyses the empirical data on the perspectives of Ayurvedic medicine in Slovenia. The first part describes the Ayurvedic practice available in Slovenia in comparison to the one in India. In India, medical integration of Ayurveda and biomedicine can be seen in different areas; however, it is the most evident in the treatment practice. The impact of biomedicine was most obvious in the diagnosis. In Ayurvedic psychiatric hospital the biological approach was much more evident compared to ashram, where the psychological-spiritual approach was more obvious. Although Ayurvedic treatment in Slovenia could be comparable to the Indian in some parts, there are still many obstacles and limitations for establishing Ayurvedic medicine as a serious medical system. Slovenia does not have institutional treatment developed, nor the access to the Ayurvedic medicines.

The second part presents the psychiatrist attitudes toward using complementary methods and Ayurvedic medicine. The majority of psychiatrists support complementary medicine, regarding it as a logical complement. Due to the absence of regulations and verified registry, psychiatrists have difficulties to give advice to the patients interested in these methods. Some of them considered spirituality as an important source of depression treatment and a good reference for doctors treating depression. Here, spirituality is understood as a connection to the larger whole and not as a religion. Majority of psychiatrists also support the cooperation of both medicines, but they warned that this is practically difficult to apply.

I CHAPTER

PSYCHIATRY IN THE 20TH AND 21ST CENTURIES: PARADIGMS OF UNDERSTANDING AND TREATMENT OF DEPRESSION

Mental disorder as such had always been present and is as old as the humankind. Human societies have always had knowledge of mental disorder and ways to deal with it. Since ancient times, depression has been identified and recognized as a disease, although referred to by different names, mostly as "melancholy".

The following paragraphs go briefly back to early civilizations, their interpretation and treatment of the mentally ill, as some of the aetiology and treatments were all present until the seventeenth century, and their influence was retained well into the eighteenth century.

According to Shorter, before the end of the eighteenth century, psychiatry did not exist. Although individual doctors had occupied themselves with the care of the insane and had written manuals about it, psychiatry did not exist as a discipline to which a group of physicians devoted themselves with a common sense of identity. The advent of medical specialism was a phenomenon of the nineteenth century (Shorter, 1997: 1).

BRIEF HISTORY OF DEPRESSION

The term *depression* is a relative latecomer to the terminology for states characterised as intense sadness. Devised originally from the Latin *de* ("down from"), *premere* ("to press"), and *deprimere* ("to press down"), and carrying the meanings from these Latin terms of pressing down, being pressed down, and being brought down in status or fortune, this term came into use with these meanings in English during the seventeenth century. However, it was during the eighteenth century that *depression* really began to find a place in discussions of melancholia (Wolpert, 2008; Jackson, 2008).

As early as 2500 BC it can be said that Ayurveda has had an impact on the medical systems of many early cultures outside the Indian subcontinent[7] and thus had a major impact on the interpretation and the treatment of mental illness. Singhal (1969: 42-43, 82-83) argues that in the first millennium BC, India had established diplomatic relations with Syria, Egypt, Greece and the Roman Empire during the reign of Emperor Augustus (around 20 BC). Several scholars (Filliozat 1970: 67-70, Ifrah 2000, Kak 1999: 1-12, Rawlinson 1975: 425-441) argue that the fundamental concepts of Vedic medicine, philosophy, physics, cosmology, astronomy, music, grammar, geometry and mathematics played an important role in the advancement of these civilizations. In the field of medicine, the so-called tridoshic theory (coming from Rig Veda (i. 34, 6)) was particularly important, as, according to Jee (1895: 99) it formed the basis for Hippocrates's (460-380 BC) humoral theory.

Like Ayurveda, Hippocrates had analogously connected five great elements (air, earth, water, fire and ether) with the humoral theory[8] (blood, phlegm, yellow bile and black bile or melancholy). When one of the accumulated fluids was "full" or started decreasing, a disease appeared. Excess blood and bile led to mania, excess black bile to melancholy and depression (Adams 1849: 61). Black bile was believed to be crucial in the aetiology and pathogenesis of melancholy. An excess of black bile affected the quality of the brain, which caused this "cold" and "dry" disease. Thus, Hippocrates linked melancholy with brain disease:

"Men ought to know that from the brain, and from the brain only, arise our pleasures, joys, laughter, and jests, as well as our sorrows, pains, griefs and tears. Through it, in particular, we think, see, hear, and distinguish the ugly from the beautiful, the bad from the good, the pleasant from the unpleasant... It is the same thing which makes us mad or delirious, inspires us with dread and fear, whether by night or by day, brings sleeplessness, inopportune mistakes, aimless anxieties, absentmindedness, and acts that are contrary to habit" (Porter, 2002: 37).

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7 There is evidence of extensive sea travel from India to Mesopotamia as early as 2500 BC (Gupta, 1996: 126–138; Rao, 1991: 173–223), with Indian sea traders bringing with them many valuable goods, including Ayurvedic herbs.

8 Body fluids were visible and tangible phenomena of physical existence: temperature, colour and texture.

Another explanatory framework derived from Roman sources and associated with Galen, were the *six non-naturals* or the *six things non-natural* (Rather, 1968: 337-347). Although varying slightly, *six non-naturals* were usually (1) air, (2) exercise and rest, (3) sleep and wakefulness, (4) food and drink, (5) excretion and retention of superfluities, and (6) the passions or perturbations of the soul. If properly or proportionately distributed, a person was healthy, if improperly or disproportionately, a person was sick. Till the end of seventeenth century this doctrine alongside with the humoral theory was the predominant framework for explaining diseases in general, and mental disorders in particular.

The treatment of depression (or any other disease) was based on the idea of equilibrium established in two ways: (1) *eliminating an excess*, or *supplementing a deficiency*, in order to re-establish a balance, and (2) *the principle of contraries*, whereby a quality (or qualities) was considered in excessive and therapeutic agents of the opposite quality (or qualities) were prescribed to neutralize the excess and restore a balance. Melancholy was attempted to be cured with the use of laxatives, steam baths, venesections (blood-letting from the veins), physical activity and special diets (Adams 1849: 24-131). Hippocrates prescribed massages with moisturizing oils, and warm and hot baths for the cold and dry diseases.[9] He also suggested regular sleeping regime, a pleasant company and atmosphere, and activities. Descriptions of these methods could also be found in Rg Veda and Atharva Veda (Griffith 1889).

Hippocrates used an extensive range of medicinal herbs in his treatments. In his work Materia Medica, he recommended the medical use of many Indian plants that were mentioned and recommended for similar medical purposes in the Vedas much earlier, namely sesame, turmeric, ginger, black pepper, etc. (Jee 1895: 123). According to some scholars (Keay 2000: 180-199; Mookerji 1947: 71-158), Hippocrates gained his knowledge of medicine in the area of modern-day India. At that time Ayurveda had already been taught at many universities, such as Nalanda and Takshashila (founded about 700 BC).

In the Renaissance, depression was explained within religion, magic, mysticism, and alchemy, in a more naturalistic and demonological way of understanding. Religious beliefs, based on demons, dominated all aspects of life. The demonological explanation understood depression (and other mental illnesses) as a consequence of sin and satanic influence (Porter, 2002). According to Quintanilla (2010) all the tragedies and calamities of humanity were the fault of witches because no one was capable of doing such things if not under the power of the devil. These phenomena had had a significant impact on the treatment of the mentally ill.

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9 In addition to the humoral theory, the warm-cold medical theory represented the basis of Galen's treatment. The theory differentiated between hot and cold diseases, both having certain qualities, and emphasized the necessity to prescribe medicine with opposite qualities. The hot-cold treatment principle is a fundamental concept of establishing a balance in Ayurveda (Jee, 1895:114-124) and many other medical traditions, which Ayurveda did not necessarily influence.

Meanwhile philosophy had been discovering new psychological approaches. In the 17th century the ideas of the philosopher and mathematician Rene Descartes (1596-1650) were the most clearly formulated. According to Scheper-Hughes and Lock (1987: 9) they are the immediate precursors of contemporary biomedical conceptions of the human body. On the basis of his dictum: "I think, therefore I am", Descartes regarded himself as a "thinking thing" (Descartes, 2004: 59) and argued that the body (*res extensa*) and the mind (*res cogitans*) are two different entities. In this way, Descartes was able to preserve the soul as the domain of theology, and to legitimate the body as the domain of science: a rather artificial separation of mind and body, the so-called Cartesian dualism. According to Scheper-Hughes and Lock (1987) this posed the so-called psycho-physical problem. The question of the relationship between the physical and the spiritual was seen as a metaphysical matter rather than psychological, and that became one of the key topics in the history of philosophy.

The Cartesian legacy resulted in a conceptual break. From that point onward, clinical medicine and the social sciences understood the body and its functions in a very mechanical way.[10] Growth of knowledge, which was the result of anatomist studies of the human body inside the mechanistic world view, resulted in multiple aetiologies of mental illness - including spiritual, internal and external, as it is evident from the description of the melancholy of Richard Burton (1577-1640). In his encyclopaedic work *Anatomy of Melancholy* (1621), he added the following possible causes to the classic cause (an imbalance humour): idleness, loneliness, anxiety, excessive learning, passion, excitement, frustration, poverty, strong desire, ambition, and so on (in Foucault, 1998: 52-53). The humoral theory therefore lost its prominent place because it no longer corresponded to the new, mechanistic philosophical thinking. The new understanding of "melancholy" was born. Over the course of the century, it was asserted and reasserted that melancholia (and other mental disorders) was essentially a disease of the brain.

Records of medical practice by the late eighteenth century show a remarkable consistency of therapeutic themes – venesection in moderate quantity, gentle purgatives and emetics, with the aim of relieving the body of its burden of pathological materials, gentle hypnotics for sleeplessness and spa waters containing iron and various remedies containing steel[11] for the purpose of strengthening the nervous fluid (Jackson, 2008: 454). Towards the end of the eighteenth century, the medical profession declared that mental health care is inevitable (Foucault, 1994: 326).

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10 Since Galileo and Newton developed atomistic and mechanistic concepts of nature, medicine has established a brand new look and a completely different language. Mechanicism was not only a method but also a specific view of the world. A scientific approach to medicine was introduced, completely deviated from the reference to the existence of souls and vital forces (Rossi 2004: 191-205).

11 Here, metals are perhaps reflecting the Paracelsian trend supporting the therapeutic use of metals. Paracelsus, a Swiss German physician, pioneered the use of chemicals and minerals in medicine. He took a different approach than his predecessors did, using this analogy not in the manner of soul-purification, but in the manner that humans must have certain balances of minerals in their bodies, and that certain illnesses of the body had chemical remedies that could cure them.

The establishment of the asylum[12], in the 18th century by Pinel and Tuke, established a strong descriptive tradition that was taken up toward the end of the century and carried well into the twentieth century by Emil Kraepelin (1856-1926). Emil Kraepelin was an influential German psychiatrist who lived in the late 19th and is widely considered to be the founder of modern psychiatry and psychopharmacology. He could be the first to use depression as a general term that refers to various kinds of melancholia as depressive states (Davidson, 2006; Millon, 2004: 162).

The Kraepelinian views on depression dominated in the first half of the twentieth century. His extended description of depression provided also a continuation of explanation for many of the signs and symptoms from previously extended descriptions of melancholia: sleeplessness, loss of appetite, loss of weight, constipation, loss of sexual interest, restlessness, irritability, anxiety, self-derogatory concerns, suicidal inclinations, and delusions (Jackson, 2008: 449). Later (after the Second World War), these descriptive trends were refined in various ways.

DEPRESSION WITHIN THE BIOLOGICAL, SOCIAL AND PSYCHODYNAMIC MODEL

Despite the fact that the pioneers of psychiatry, such as Griesinger, Kraepelin, and Bleuler, were all convinced that the major mental disorders eventually would be explained as brain diseases (disruption of brain chemistry), the biomedical model was gradually overtaken by other developments; especially by Adolph Meyer's biosocial theory and by the onslaught of Freudian psychoanalysis (Kiesler, 1999: 20-22). In the twentieth century and beyond, efforts to explain melancholia and depression were often based on psychoanalytic and psychotherapeutic data. Against a background of inadequate or disturbed psychological nurturance in infancy and early childhood, with resultant personality developments entailing predispositions, themes of loss and inadequate or diminished self-esteem have been thought to be of particular significance. Arguments have been put forward for various socio-cultural factors as being instrumental in the development of depression.

The first study on the impact of society on the state of depression was Durkheim's study on suicide (1992) written in 1897. In this work, he developed his famous premise that

12 A predecessor of an asylum is Spital, a form of institution operating in Europe in any major site, not only in the cities. In the 19th century, it was termed a medical institution or asylum (Flaker, 1998: 61). "Total" institutions (According to Goffman, total institution is a place of work and residence where a great number of similarly situated people, cut off from the wider community for a considerable time, together lead an enclosed, formally administered round of life.) were already established in the Middle Ages in the form of monasteries, courts, leprosaria and Spitals. At that time, according to Foucault (1998), courts and monasteries had many features analogical to contemporary "total" institutions. Today people are still removed from their environment, isolated and placed in the position of the undesirable Other.

suicide is inversely proportional to the integration of the social group of which the individual is a part and represents a major milestone not only for suicidology, but also for sociology. In his theory Durkheim emphasized external, social factors (social stress, social class, poverty and urbanization) that contribute to the suicidal tendencies, rather than internal factors of the human psyche. Durkheim attempted to prove that despite the fact that suicide appears to be extremely individual act, it can be explained by social facts. He argued that a collective inclination to suicide of any society depends on basic conditions or social structure of that society and remains fairly constant as long as those conditions remain the same.

The most influential social psychiatrists in the U.S. were Adolf Meyer and Harry Sullivan. Meyer argued for the more modest notions of "situation, reaction, and final adjustment", a scheme of "reactions as part of an adjustment, a response to a demand" (Blazer, 2005: 64-67). Meyer proposed a mixed social and biological framework that emphasizes reactions within individual's lives and believed that it is necessary to use the term "depression" instead of "melancholy". His affective reaction types replaced Kraepelin's disease entities, and became the nosological home for the various melancholic and depressive illnesses. Meyer stressed the importance of the patient cooperation in the treatment process and emphasized the significance of the psychiatrist as a informant observer in the therapeutic process. Both outlined their own versions of psychotherapy.

In 1938, Ugo Cerletti (1877–1963) began applying electroconvulsive therapy (ECT) to alleviate severe depression at his neuropsychiatric clinic in Genoa. The neurologist Egas Moniz (1874–1955) claimed that obsessive and depressive cases could be improved by leucotomy, surgical severance of the connections between the frontal lobes and the rest of the brain. Lobotomy and leucotomy[13] were enthusiastically taken up also in the United States. The neurophysiological advances had shown that specific cortical centres control particular aspects of cognition and affect, and though the front brain remained somewhat of a mystery, animal experiments suggested that it might be implicated in mental balance. Lobotomy held out promise not just for the mentally ill but also for psychiatry itself.

Psychosurgery also enjoyed a vogue from the 1930s onward, as it promised to turn asylums into true hospitals, solve psychiatric problems with a scalpel, and thus bring the discipline back into the mainstream general medicine. With psychosurgery, psychiatry rescued patients from crippling agitation states[14], some were discharged from institutions and went on to hold down jobs and family roles. According to Porter (2002: 205) psychiatry started "taking care" of patients, however, invasive treatments equally reflected the powerlessness of patients in the face of arrogant and reckless doctors, and the ease with which they became experimental fodder.[15]

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13 These two terms are not being differentiated in Slovenia – a leucotomy is a frontal lobotomy.

14 Severe anxiety that can occur in various mental disorders resulting in motor restlessness.

15 Psychiatrists in that time tested many alternative treatments on patients, such as fever cure and neurosyphilis treatment or extended sleep (Shorter, 2002: 205).

PSYCHOPHARMACOLOGICAL REVOLUTION, DSM AND ANTIPSYCHIATRY

Biologically-based theories still remained important in the effort to explain depressive disorder. Depression has been associated with the altered functioning of one or more neurotransmitter systems in the central nervous system. Neurotransmitters[16] are the brain chemicals and the relay signals between nerve cells in small gaps separating neurons; they transmit signals from cell to cell. Some of neurotransmitters are believed to play a central role in the pathology of depression (Nestler et al. 2002). This neurotransmitter model was developed nearly simultaneously with the development of the first effective antidepressant medications.

A revolution in drug therapy took place after World War II when the strongest evidence came from observations proving that the administration of pharmacological agents acting on the brain's monoamine system[17] could either increase or decrease mood levels (Leo, Lacasse, 2008). The new drugs enjoyed phenomenal success. The tranquillizer *Valium*® became the world's most widely prescribed medication in the 1960s.

Gradually, as Wong et al (1975: 804-11) noted, it was established that tricyclic[18] antidepressants have different effects on the functioning of serotonergic systems. Researchers began a process of rational drug design, which would selectively target these systems. At the beginning of the 1970s, Fluoxetine was developed, which (in 1988) became the first commercially successful selective serotonin reuptake inhibitor (SSRI) in the U.S.

Based on these findings, in 1978 Bunney and Davis developed a concept they called

16 A neurotransmitter is a compound endogenous chemical that is synthesized in the presynaptic neuron. It is kept in synaptic vesicles and released upon stimulation nerve ending, by diffusion through the synapse reaches the postsynaptic membrane, which after binding to the receptor stimulates or inhibits the postsynaptic cell.

17 The most thoroughly examined group of neurotransmitters are monoamines, a group of molecules derived from amino acids that are being produced in older, deeper structures of the brain. One of the monoamines is dopamine, a substance thought to be particularly important in addiction behaviour, because it is concentrated in brain systems involved in pleasure or emotional reward. Norepinephrine, a neurotransmitter associated with stress responses, stimulates several brain systems including the sympathetic nervous system. Serotonin has been the most important of all neurotransmitters in psychiatric research. This substance has very broad effects on the brain and is particularly important for the treatment of depression, anxiety, and impulsivity. The theory that serotonin is deficient in many mental disorders has long been current, although research has failed to find any consistent deficiency of this kind (Paris, 2008: 17).

18 The fact that the tricyclic ("three-ringed") compound of antidepressants has important effects and was first discovered in 1957 by Roland Kuhn in a Swiss psychiatric hospital. Within a few years tricyclic antidepressants have been expanded worldwide (Paris, 2008: 116).

the "catecholamine hypothesis"[19] of affective disorders. A lack of catecholamines was considered a condition of depression, while an excess could cause mania. In 1987, *Prozac®* was introduced, a drug raising serotonin levels within synapses and consequently enhancing a "feel good" sense of security and assertiveness. Porter (2002: 206) notes that within five years, eight million people had taken that "designer" anti-depressant, promising to make them feel "better than well".

Nonetheless, the revolution of drug treatment has allowed many patients to leave the institutions. This has reduced institutionalization but sharply increased the medicalization without thinking about the implications. It is a fact that today antidepressants are more selective, with fewer side effects and consequently more attractive for healthcare professionals as well as for the patients (and the pharmaceutical companies that frequently promote this phenomenon). But in some way, antidepressants can also pacify patients who in this way relinquish the responsibility for their own health to the doctors and expect the "magic pill" to save them.

With the psychopharmacologic revolution, the development of the classification of mental disorders[20] took place in the United States. Psychiatry wanted to provide explicit diagnostic criteria that would guide the researchers. In 1949, the World Health Organisation published the sixth revision of the International Classification of Diseases (ICD). For the first time, a chapter on mental disorders was included. The American Psychiatric Association Committee on Nomenclature and Statistics was empowered to develop a version specifically for the U.S. to unify the diverse and confusing use of various documents (Houts, 2000: 935-967). These official nomenclatures established clear operational criteria for diagnostic categories, including the integration and exclusion requirements.

The first two editions of the DSM-I (1952) and DSM-II (1968) were based on Meyer's bio-psychological conceptualization of depression and Freudian psychoanalysis. The diagnosis of depression was either endogenous (melancholic) as a biological state or reactive (neurotic) as a reaction to stressful events (Kendell, Jablensky, 2003: 4-12).

In response to the psychiatry of the first half of the 20th century, social,[21] community and cultural psychiatry began to develop around 1960. World War I, Great Depression, and civil injustices made it clear that social and cultural factors are too important to wait for the full interpretation of biological mechanisms of depression. Social psychiatry explained the effects of the social environment on the mental health

19 The catecholamine system is a set of chemical substances that can act as hormones or neurotransmitters. Most important, as already mentioned above, are adrenaline, dopamine and noradrenalin (Šket, 1997).

20 System of classification has already started in the nineteenth century due to the need for statistical data.

21 In 1919 Fischer described a program of social psychiatry in Germany that emphasized the importance of investigating social causes of mental illness and posited public health interventions as preventive measures, although Southard, an American psychiatrist, was perhaps the first to use the term *social psychiatry* (in 1917) (Blazer, 2005: 63-4).

of an individual and how the mentally ill affects his social environment. Its roots go back to Freud's psychoanalysis (society and psyche were in conflict, and neuroses were the ultimate outcome of this battle) and Durkheim's sociology (the ultimate tragedy of emotional suffering was suicide). In short, the belief that mental illness is a product of civilization had begun to come into force. Social psychiatry had arisen out of a new humanism in psychiatry.

Social psychiatry was led by two objectives: on the one hand, by the field of scientific (social and psychological science) theories of social forces, treatment and prevention of emotional distress; on the other hand, by social activism. Factors such as culture, acculturation, economic status, place of residence (e.g. city more stressful), alienation, family stress (e.g. marriage instability), stigmatization and behaviour were thoroughly examined. The conclusion was that the diseases and disorders are multi-causal and interrelated (Ibid, 68).

Social activism as a movement was directed towards the transformation of society (and its study) in order to reduce emotional suffering. Standardization of psychiatric diagnoses was seen as a major step towards the restraining of individuals, subjectivity and unreliable psychiatric classifications. As Callahan and Berrios (2005: 104) observe, the process of the transfer of science into the art of psychiatric diagnoses instigated a considerable controversy among those who saw these developments as a contribution to the reification of Americanisation and the medicalization of psychiatric illness. This criterion is important because it defines who actually suffers from an illness.

The process of medicalization is one of the main research subjects of anthropology and sociology of medicine and studies the practice and implications of modern biomedicine. Irrespective of the different definitions of individual authors of the term "medicalization" (Lock, 2004), it is just "medicine reaching beyond its borders" (Colucci, 2006) that specifically authorizes and motivates the social sciences and humanities to study the technology and practice of medicine. The term "medicalization" is defined as a sociological concept, which indicates the dominant role of medicine as an institution of social control, to replace the previous conventional institutions, such as law, religion, etc. (Szasz, 1960, Goffman, 1991; Zola, 1972; Conrad, 2007).

Relying on Foucault's concept of biopolitics I argue that this process began long before. The concept implies the authority, which "started to deal with a life; authority included man as a living being, a kind of biological nationalizing". It is understood as "the way of the 18th century attempt to rationalize the problems that are in the form of phenomena, typical for a community of living beings, who make up the population, the authority set a practice: health, sanitation, fertility, longevity, race […]" (Foucault, 2007: 88-109, 132-8). It is these processes that constitute the first objects of knowledge and control the first targets of this biopolitics. With the first early demography they introduced statistical measurement of the above mentioned phenomena, and biopolitics obtained its knowledge, and defined the field in which the authority will intervene.

BIRTH OF MAJOR DEPRESSION – DEPRESSION AS A BIOMEDICAL DISEASE

In the 1970s, biological psychiatry again replaced psychoanalysis as the dominant paradigm and psychiatry returned to medicine. The victory of the biological approach, i.e. the view that major mental illness are housed in substrate disruption of brain chemistry, indicated a return to the themes that were echoed in the nineteenth century during the first era of biological psychiatry. Psychiatry maintained its value in the medical model of interpretation. Social epidemiology has remained significant, while social factors were almost entirely marginalised. A strictly biological approach understood development and behaviour as stemming from evolved anatomical structures and genetic programs that operate within living cells, isolated from social influences, and the brain to be a biological machine (Cacioppo et al, 2007).

In 1980, the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III) was released, representing a "revolution" in the classification of mental disorders (Mayes & Horwitz, 2005). This edition is one of the fundamental elements of a new, currently the dominant paradigm in psychiatric treatment, which began to take shape in the early 1970s (Good, 1992; Spaulding, Sullivan & Poland, 2003; Pankseep, 2004, Mayer & Horwitz, 2005). The new paradigm has radically altered the conceptual frameworks of mental health and illness on many levels: the processes of diagnosis, treatment, interpretation of the origins of mental disorders to the very boundaries between mental health and disease (Horwitz, 2002). The third edition of DSM pushed psychiatry into the scientific framework based on a medical model (Callahan, Berrios, 2005: 128).

The Research Diagnostic criteria had specified subtypes of major depressive disorder,[22] including primary, secondary, recurrent, unipolar, psychotic, incapacitating, endogenous, agitated, retarded, situational, simple, and predominant moods. To maintain consistency, the ICD-10 used the same criteria with minor changes, but using the DSM diagnostic threshold marked depression as mild, moderate and severe episodes (Philipp, Maier, Delmo, 1991: 258-65; Gruenberg, Goldstein, Pincus, 2005: 1-12).

The development of new tools of measurement, in addition to the diagnostic scheme, also brought tools for the identification of psychiatric distress among the general population.[23] Innovations in the methodology of clinical procedures and new methods

22 The term Major Depression was presented by a team of doctors from the U.S. in the mid-1970s as a part of proposals for diagnostic criteria based on patterns of symptoms (Philipp, Maier, Delmo, 1991: 258-65).

23 In 1953, Max Hamilton, a clinical researcher in a small psychiatric hospital in England, developed a scale for anxiety and four years later a scale for depression. The Hamilton depression scale was designed for psychiatrists to assess the intensity and the extent of depressive symptomatology; to work with the scale, one must be specially trained. From 1970s onward, it became a frequently used standard, because researchers were able to compare the outcome of different interventions and clinical procedures.

of statistical analysis had also reached a new stage of progress; randomized clinical trials had become the gold standard for assessing effectiveness of the new treatment. This set the stage for rigorous clinical trials of antidepressants, psychotherapy and anxiolytic for the treatment of patients with major depression (Callahan, Berrios, 2005: 129-31).

The medical-genetic model became attractive for the public in general (Blazer, 2005: 88). The idea of a »depression gene« has become more important than social origins. Genes have become the plan for the body as a machine, e.g. the theory of "one gene, one disease". Thus, the culmination of social psychiatry opened the door to neuroscience, and consequently the general public has lost interest in social interventions.

The individual has played an important and active role in supporting and extending medicalization, as study of Conrad and Leiter (2004) have shown. Study examines the impact of changes in the medical marketplace on medicalization in U. S. society and demonstrates how consumers and pharmaceutical corporations contribute to medicalization, with physicians, insurance coverage, and changes in regulatory practices playing facilitating roles (Conrad, Leiter, 2004:158). While a medicalized account offers some means of validation, ultimately it provides cold comfort to those seeking to legitimize themselves and their depressive experiences.

From the anthropological perspective, the study of another aspect of this process is particularly important: medicalization fundamentally changes how and what we perceive as a disease and alters the importance that has in the everyday lives of individuals. In the process of medicalization more and more phenomena that had previously been linked to other spheres of life come under the umbrella of medicine, thus becoming "medical" "problems". This includes phenomena that were previously seen as natural events and processes (birth, aging, etc.), as social or individual characteristics ("alcoholism", "obesity", etc.) or as personality traits (shyness, laziness, etc.) - or moral failures (alcoholism) (Ablon, 1984; Becker, 2000, Estroff, 1993, Kaufman, 1988).

In addition, biomedicine suppresses human subjectivity and symbolizes the power that forces people to submit to what is commonly known as normal. Foucault's theory records the way identities and subjectivities are formed through this process. When individuals are publicly identified as schizophrenic, depressed, anorexic, infertile, in menopause, having had heart transplants, victims of trauma, etc., the transformation of subjectivity is easily visible (Ablon, 1984; Becker, 2000, Estroff, 1993, Kaufman, 1988). Medicalization acts in a manner that relieves the individual of the blame for that suffering, and only then individuals can actively participate in this process (Lock, 1990; Nichter, 1998). Similar arguments have been developed for clinical depression, as is it currently defined (Kleinman and Good, 1985), and for schizophrenia (Barrett, 1988). This means, as underlined by Ilich (1975), the more the field of mental health promotes its technology as a necessary intervention in almost all areas of life, the more people abandon coping with the disease with their own resources and networks.

MAJOR DEPRESSION IN THE LIGHT OF ANTHROPOLOGY

The anthropological literature gives evidence that depression (after schizophrenia) is the most biologized mental disorder in the West (Gaines, 1992; Kleinman & Good, 1985; Marsella, 1980). There is a wide body of literature that shows and describes the influence of social, cultural and economic factors (poverty, racism, gender discrimination, political violence, malnutrition, and poor physical health) on the aetiology and epidemiology of all forms of mental disorders (Cohen, 1999; Desjarlais, Eisenberg, Good, & Kleinman, 1995; Dohrenwend & Dohrenwend, 1974; Kessler et al., 1994; Patel, 2000, Patel et al., 1999, WHO, 2001).

Arthur Kleinman (1977), an anthropologist and psychiatrist, stated that traditional comparative studies of mental disorders, particularly depression, imposed a Western concept of psychiatric nosology, and therefore obscured the role of culture. Furthermore, he pointed out that cross-cultural studies begin with "detailed local phenomenological descriptions" of mental disorders instead of assuming the validity of the Western psychiatric categories: an approach he called "new cross-cultural psychiatry".

Kleinman's perspective prompted a multitude of anthropological researches, focusing attention on the meanings and cultural expressions of distress (Good, 1977; Nichter, 1981), explanatory models of illness (Kleinman, 1982, Weiss, 1997), cultural patterns of mental health seeking behaviour (Lin et al., 1978), social course of mental illness (Kleinman, 1988), clinical studies of the course and the outcome of treatment (Patel, 1998) and the patients' understandings of depression (Eisenbruch, 1983; Kleinman & Good, 1985; Kleinman, 1991; 2001; Kangas, 2001; Lafrance, 2007).

Such studies highlighted a very important fact that Western psychiatric conceptualization of depression (assumed feelings of sadness and loss, as the main symptoms) is only "a small fraction of the entire field of depressive phenomena" (Kleinman, 1977: 3) and became problematic when considering mental disorders in a cross-cultural perspective. Anthropologists refer to different cultural patterns of symptomatology as "idioms of distress" (Nichter, 1981), which are either relegated to the exotica or marked as culture-bound syndromes. For example, *susto* in South America, which according to Simons & Hughes (1985) corresponds to many, but not all symptoms characteristic of the Western definition of depression; *neurasthenia*[24] in China, *hwa-byung* [25] in Korea (anger (fire) disease – suppressed anger syndrome); *taijin kyofyusho* in Japan (form of social phobia); probably also Inuit *pibloqtoq* (Arctic Hysteria); *amok* (corresponds to psychotic episode) in the Philippines or *semen-loss*

24 Neurasthenia is a disorder characterized by a lack of motivation, feelings of inadequacy, and psychosomatic symptoms. Kleinman (2000) and Lee (1999), showed how the Western depression overlaps with the Chinese neurasthenia. European psychiatry knows neurasthenia, which should be similar to hysteria; Drinka went further and said that neurasthenia in men is hysteria in women (Drinka, 1984).

25 Most hwa-byung patients are diagnosed, according to DSM-III-R criteria, as having major depression or dysthymic disorder combined with somatization disorder.

anxiety[26] in India. The forth (2000) edition of DSM emphasizes the importance of cultural context in the conceptualization of mental disorders and includes a category on culture-bound syndromes.

According to Kleinman (2004) culture influences the experience of symptoms, the discourse (both verbal and non-verbal communication) used to report them and the decisions about the treatment. Results from his study indicated that 87 percent of a sample of Hunan Chinese who had been diagnosed with *neurasthenia* also met criteria for major depression and responded satisfactorily to tricyclic antidepressant medications. Medical anthropologists have played a key role in outlining the cultural construction of depression (Kirmayer & Groleau, 2001, Kleinman, 1986; Kleinman & Good, 1985; Manson, 1995) and at the same time in asserting that the understanding of depression should not only cover the symptoms, but also take into account the social context and cultural forces that shape patients' everyday worlds and give meaning to someone's interpersonal relationships and life events (Manson, 1995).

As Kleinman and Good noted "depression is neither a simple reflection in personal experience of psycho-physiological processes nor a culturally constituted phenomenon free of physiological constraints. Depression is of such interest to anthropologist and psychiatrists alike, because it provides a prime opportunity for exploration of the interaction of culture and biology" (Kleinman and Good, 1985: 31).

An essential step toward culturally informed models of depressive disorders is the investigation of indigenous or ethnopsychological models of dysphoric affects. The constellation of socio-cultural factors mediates how a person experiences and expresses depression and other emotions. Conceptions of emotions vary along a continuum between "egocentric" and "sociocentric". Individuals with a more *sociocentric sense* of self, often associated with non-Western cultural traditions, although there are non-Western societies promoting a strong and commanding individuality much strongly than the Western society (e.g. Buidi in the Philippines) are considered to be more relationally identified with others than individuals with a more *egocentric* sense of self. Individuals with a more *egocentric sense* of self are considered to be more or less unique, separate persons (often associated with more industrialized nations) (Jenkins, Kleinman, Good, 1991: 69-70).

The term "relationally" means that a person is defined in relation to another person, and not as an individual. The Pintupi aborigines of Australia provide an exemplary case of a culture in which the conception of self is essentially kin-based. Similar claims of

26 Semen-loss anxiety describes debilitating vegetative symptoms experienced by men convinced they are losing semen through masturbation, wet dreams, or leakage during urination. The syndrome is explained by an equally "cultural" observation that men's practice is circumscribed by a belief in semen's value, rooted in traditional yoga and Ayurveda. "Indian men", it seems, are either excessively expending or excessively retaining their semen, a Goldilocks predicament in which the "just right" regimen of rational retention and expenditure is implicitly the property of the West (Cohen, 1997).

the primacy of family definitions of self have been made for Hispanic populations. This tendency stands in notable contrast to middle class Caucasian Americans, for example, for whom self-identity, while family-related, is constituted more as a distinct individual who stands apart from others (Ibid.).

Decades of research on mood disorders have shown that depression can be recognized fairly well in almost every culture, as long as researchers and practitioners are aware of the unique differences in how indigenous populations present their symptoms. The focus on somatic complaints as a key symptom of mood disorders in non-Western cultures has also been debated quite extensively. Differences in somatic complaints as key symptoms of mood disorders have been found mostly among Asian cultures (Kleinman, 1982, 2004; Yoo & Skovholt, 2001). Whereas some researchers have argued that cross-national differences exist mainly because of how somatization is defined, others have linked the reported differences to variations between Western biomedical and non-Western traditional (or holistic) medical practices (Bhugra & Mastrogianni, 2004). The general consensus is that each major cultural group seems to have its own way of communicating mood and emotional distress.

Fabrega (1992) goes even further claiming that cultural factors have not only conditioned the basic meanings of psychiatric concepts, but have also influenced the interpretation and application of clinical psychiatric knowledge. In fact, the whole enterprise of biomedical psychiatry itself is rooted in distinctive cultural traditions and hence has a cultural character. The cultural basis of psychiatric practice encompasses not only the content of manifestations of disorders, conventions about the form of disorders, conventions about the way the self is supposed to behave and conventions about the meanings and implications of behavioural breakdowns. The culture of modernity and of capitalism also strongly influences the psychiatric practice. The system of biomedical psychiatry is promulgated by support from a state institutional apparatus that uses its nosology to control and regulate behaviour in other institutional sectors. The criminal justice system, the welfare system and the educational system all interact with the mental health (psychiatric practice) system (Fabrega, 1992: 91-103).

DEPRESSION AS A BIO-PSYCHOSOCIAL DISORDER

The image of psychiatry today is not entirely unambiguous, because current studies are increasingly locating the causes of depression beside biological perspective also within the psychological and social perspectives. The biological perspective follows factors, such as genetic risk and family transmission of depression (Forty, Zammit, Craddock, 2008), changes in neural structures (Ramasubbu, MacQueen, 2008) and the level of neurotransmitters (Anisman, Matheson, Hayley, 2008), sleep dysregulation and related regulatory models (Germain, Thase, 2008). Therefore, within the psychiatric literature, the conceptualization of depression as a bio-psychosocial disorder has appeared (Walker, 2008; Ghaem, 2003).

The psychological perspective follows the cause of depression and mental disorders according to past events (often remote for patients) that affect current feelings and knowledge (Dozois, Beck, 2008), explanatory style: optimism and pessimism (Schueller, Seligman, 2008; Abela, Auerbach, Seligman, 2008), information processing: concentration and memory (Ingram, Steidtman, Bistricky, 2008), negative and ruminative responsive style (Wisco, Nolen-Hoeksema, 2008; Alloy et al, 2008), and social problem-solving (Nezu et al., 2008).

The social perspective tends to focus on the impact of interpersonal and social events that are external to the patient (Nezu et al, 2008). It follows the cause of depression according to early attachment experiences (Moran at al, 2008), life events and hassles (Harkness, 2008), parental psychopathology and parenting style attachment (Essau, Sasagawa, 2008), marriage and relationship issues (Whisman, Kaiser, 2008), low social support (Lakey, Cronin, 2008), stress generation (Hammen, Shih, 2008), and avoidance (Ottenbreit, Dobson, 2008).

The beginnings of bio-psychosocial theory can be found in the works of George Engel[27] between 1980 and the early 1990s, where he criticizes the dualistic nature of the biomedical model (body-soul), the reductionist medical way of thinking (neglecting everything that cannot be explained at the cellular or molecular level, and neglecting patient's suffering) and the impact of the observer on the observed. He argues that complete objectivity is not possible and points out that in any health intervention all three levels (biological, psychological and social) should be taken into account, as any disease, condition or patient cannot be reduced to a single aspect (Brown, 2000).

Engel has offered a comprehensive alternative to the dominant biomedical model. His ideas have been advocated not only as a scientific proposal, but also as a fundamental ideology that tends to alleviate the dehumanization of medicine and the impotence of patients. He wanted to bring more empathy and compassion to the practice of medicine and partly he succeeded, as the model has resonated within some sectors of the medical profession.

New light came from the complex interplay between neurobiological and environmental risk factors, showing both genetic control over exposure to stressful environments, and the profound effects of adverse environments on the structure and function of the brain. As with many psychiatric disorders, there is not a single hormone, neurotransmitter or gene that would provide a complete explanation for the disorder. Depression is a complex entity that combines all three components affecting one another. If an individual is exposed to negative thoughts and feelings for a longer period of time, human biology is affected; they gradually begin changing and upsetting the biological balance in the body.

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27 In 1980 his first records were published in an article on the clinical use of bio-psychosocial model. In the article he presents an example of a man with chest pains which transformed into arrhythmia due to a lack of care of his doctor.

Psychiatric treatment of depression has changed considerably over time. Often it is also adapted to the socio-cultural context and to some actual paradigms in psychiatry – for example, the revival of positive psychology and cognitive-behavioural approaches that are in agreement with the results of the neuropsychological studies of the brain (therapy affects the brain, etc.). However, not all changes are always in favor of the patients – for example, the FDA now allows antidepressants prescriptions to children under the age of thirteen (http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Pharmacy-Education-Materials/Downloads/ad-pediatric-factsheet.pdf) and forms of depression are being invented – (currently DSM-V (2013) lists eight types of depressive disorders).

However, some Eastern practices have already been adopted in psychiatry recently – mindfullness, yoga, meditation, and accordingly an increasing number of techniques and methods are being seriously considered in psychiatry. But these methods are conceptually still quite different – beliefs/ philosophical concepts on one side and mainly ideological models on the other, as well the basis for the implementation of practices. However, positive effects in the treatment of depression cannot be expected soon after the immediate implementation of such therapeutic approaches (SIGN, 2010, Marchand, 2013).

II CHAPTER

PSYCHIATRIC PRACTICE IN SLOVENIA: THE UNDERSTANDING AND TREATMENT OF MAJOR DEPRESSION

In understanding contemporary psychiatric practice in Slovenia we cannot ignore the (post)socialist heritage, its features and effects. In order to understand modern methods of treating depression or the doctor-patient relationship, one has to take into account the influences of politics and economy that shape – amongst other – the public health sector and consequently the understanding and treatment of depression.

My focus was to reflect on how the socialist understanding of mental illness supports or opposes the post-socialist one. Can the existence of many orthodox physicians today be attributed to the fact that under socialist regime doctors were underpaid and as such agents legitimizing the political system? Was the promise of free health care an important legitimating factor through which the socialist state tied its citizens to itself, and underpaid doctors were its agents? What is the role of doctors / psychiatrists in today's (post)socialist economy? What has changed since the fall of the socialist regime when Slovenia was committed to provide free health care? What is the situation now, when the doctors are still underpaid?

LOOK INTO HISTORY

After World War II, Slovenia was part of the new Yugoslav state. Its political structure broke its previously tight ideological connections with the Soviet Union in 1948 and adopted "self-management" economy. This step was of crucial importance in the shaping of social strategies in the following decades. A key Yugoslav political and ideological figure was Josip Broz Tito, a premier and president during 1953–1980. He developed an independent form of socialist rule in defiance of the Soviet Union – the policy of non-alignment. He built ties with other non-aligned states, and improved relations with Western powers (Jeraj, 2005: 130). This social model was in many ways quite specific and a milder[28] version of communist regimes connected to the Soviet Union in post-war Europe.

Socialism promoted the idea of community and collectiveness, as opposed to the harsh realities of capitalist individualism. The community provided support and strength to the poor and the exploited, basically, to all who were oppressed by bourgeoisie. Socialism was actually a continuation of many utopian traditions, present in Europe since the Renaissance. Utopian socialism was committed to socialist ideas of common property, which would prevent exploitation between social classes and create conditions for a new, better and more just society. The concept of "utopian socialism" was introduced by Karl Marx and Friedrich Engels in their *Communist Manifesto* (1848) to highlight the difference between their »scientific« form of socialism and earlier »utopian« forms of socialism.

At that time important social changes, such as constitutional equality between men and women, were implemented. Socialism, particularly in its first stage (1945), attempted to defeat capitalism by establishing a system of rights – gender equality, free education for men and women, free healthcare, full employment guarantee and social security for employed, unemployed and retired citizens (Štih, Simonitti, Vodopivec 2008: 432). Jeraj notes (2005: 122-125) that in socialist Yugoslavia, women were given opportunities to be economically and politically active, yet they were also expected to be mothers and housekeepers at the same time. Consequently, many women found it difficult to combine new possibilities with traditional domestic demands and they did not easily accept the newly acquired rights the socialist state had introduced. This new opportunities put women under considerably pressure, which could be connected with women's mental health problems.

In a critical review of Western studies of depressive disorder, Weissman and Klerrnan (1981: 184) conclude that Western society's greater depression among married females (vs. married males) was illustrative of the conflicts generated by the traditional female

28 Jeraj (2005: 130) notes that in many ways the Yugoslavian socialist ideology did not demand such radical changes in the daily life structures as was the case in the Soviet Union. One of such changes, for example, were obligatory communal kitchens designed to encourage women to actively participate in the restoration of post war industry.

role. Similar assumptions have been argued already by Durkheim (and almost every study afterwards) who introduced the concept of anomie in his book *The Division of Labor in Society* (1897). He used anomie to describe a condition of absence of norm that was evolving in the society. Rules prescribing people how to behave towards each other were breaking down and thus people did not know what to expect from one another.

Fundamentally, socialism had some solidarity impulses that also brought some positive changes for psychiatric patients. A strong wave with irreversible consequences had occurred just before the Second World War, when the concept of "open doors" became common. The upcoming social state supported this concept and promoted its implementation throughout the country. In the fifties and sixties the development of psychiatry has taken three important steps: the establishment of new psychiatric hospitals, an increased number of doctors and the discovery of antipsychotic drugs (before these developments patients were dangerous to themselves and their surroundings). The treatment of the mentally ill was improved: the hospitalization time was reduced, and out-patient psychiatric treatment was developed (Kramar, 1989). Throughout Yugoslavia mental health offices as part of outpatient medical services have started to appear. Professional collaboration between psychiatrists and psychologists in these offices has slowly become a daily need.

According to Flaker (2011) social state was much more instrumental in deinstitutionalization than medication and medicalization. Previously, poor people with mental health problems had almost no chance to survive in an outside world, for this reason they were permanently institutionalized. When people received some sort of social justice, social support and free health care, the dilemma was gone: Why should a person be closed up? The welfare state significantly reduced the reasons for permanent institutionalization.

In contrast, the U.S faces great problems with deinstitutionalization. There deinstitutionalization is linked to the neoliberal agenda to de-fund public sector services and move towards privatized care. Levin and colleagues point out that before deinstitutionalization in the United States, state hospitals provided their clients with various necessities such as food, clothing and education (Lewin et al, 2004: 81). After deinstitutionalization, people with mental illnesses had to rely on separate delivery systems in order to find housing, education and so forth. However, many of these systems are funded by different agencies and organizations, most of which are not designed for the cyclical needs of those with mental illnesses, but rather are driven by the demands of the bureaucracies that fund them (ibid).

The modernization of Slovenian psychiatry in the 1970s was not carried out on the account of new forms of community, but at the expense of trans-institutionalization, i.e. moving frail people to social institutions (Milčinski, 1987). Psychiatry participated

in the first experiments,[29] at that time within social psychiatry, which at least in principle recognized the roles of society, social engagement and social forms in the treatment of mental distress. For this purpose, psychiatry emptied the unit for the "chronically ill" in Ljubljana and established the Centre for Mental Health, which became the bearer of changes in psychiatry (Flaker, 2011: 4). The orientation centre was torn between social psychiatry and psychotherapy, although the latter prevailed. The social therapeutic orientation prevailed only in the "treatment" of alcoholism with support groups for recovering alcoholics and in the community orientated forensic department. [30]

In the 1980s, deinstitutionalization was connected with two actions: the "City Conference" engaged in establishing a bureau devoted to the psychosocial distress of young people; and the "Republican Conference" engaged in reforming youth work actions. Either projects led to the organization of Hrastovec Camp and the establishment of the Social Protection of Madness Committee in 1988 (or the Informalnica in 1985) (Flaker, 2011: 14). The Social Protection of Madness Committee, which together with other sections (ecologists, pacifists, women, etc.) under the umbrella of youth organization represented a "new social movement", became a central gathering place not only for volunteers and young professionals but also for clients seeking legal protection (ibid, 7).

The former Yugoslavia had a diversified system of informal payments in order to provide "better" health care. All practicing physicians were integrated into the socialized sector becoming "tenured" staff employees with regular salaries. For example, private medical practice was outlawed in Yugoslavia with the exception of Croatia, where a small number of physicians were allowed to retain their practices. According to Saric and Rodwin (1993) health care clients decided to donate a certain percentage of their salaries to health institutions. Unfortunately, these resources were reported in national statistics as if they had originated from institutional revenues.

At that time, the socialist medical system was based on an ethos of reciprocal social exchange. For example, many people brought a gift to the doctor. This habit is still present in the present-day socialist Cuba, and Andaya, drawing on collected ethnographic data, determines that: "Nonetheless, as ideologies and practices of gifting and reciprocity encounter an emerging market economy, gifts—whether on the level of the state policies of international humanism or in patient-doctor relations—are open to new significations that highlight the shifting material and moral economies of post-Soviet Cuba" (Andaya, 2009: 357).

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29 The first phase of deinstitunalisation began with experiments in Logatec in 1967; the principle of self-conception of institutions indicated that something had changed, and introduced an innovation into professional discourse and practice.

30 The Vsemirje Club for Prevention of Drug Addiction was established and became a place for psychiatric social experiments (Krese, Ziherl, 1975). There, young people enthusiastic about alternative ideologies and lifestyles gathered and conducted experiments. The club hosted a variety of evenings and workshops to introduce a yoga macrobiotic, massage, as well as new forms of humanistic psychotherapies and experimental theatre (in Flaker, 2011).

The system of Yugoslavia began to collapse in the 1980s. According to Lorenčič (2011) socialism did not fall because of the political dictatorship, censorship, persecution or any other factor argued by the critics. Socialism in Yugoslavia fell apart simply because it was no longer able to survive economically. Socialism was not able to exercise the rights that it had established and defended so eagerly. As a result certain fees were introduced in healthcare, education costs considerably increased – the government began running out of funds. As Lorenčič notes, socialism has lost its legitimacy among the broad masses of people.

Štih, Simonitti and Vodopivec (2008: 140) observe that substantial political changes in Slovenia in the 1980s were promoted through *Zveza socialistične mladine Slovenije* (Socialist Youth Association of Slovenija), which started supporting political dissidents, gay and lesbian initiatives, various spiritual groups and other civil movements. Political changes culminated in the separation of Slovenia from Yugoslavia on 25 June 1991. Slovenia decided for a multi-party parliamentary democratic system and declared itself as an independent republic on a referendum.

SLOVENIA AFFECTED BY TRANSITION

According to Lorenčič (2011: 458–479) in the transition to capitalism, after Slovenia gained independence, many social rights have been suppressed. The economic sector which was in the process of privatization was immediately faced with the loss of a large part of its former market. The new owners reckoned that the easiest way to achieve a competitive position in the demanding Western markets was to save on the labour costs. The state believed a more rational budget needed to be adopted. All governments, whatever their political orientation, seemed to find it easiest to save money on social transfers. The social rights of unemployed people were restricted as well as the rights concerning the lower classes of citizens. Public health began to divide people into two categories: social and self-paying clients.

The impact of privatization and economic restructuring on health care is probably one of the most prominent examples of the furthest-reaching effects of the market on the welfare and the well-being of the population. Leaving aside the above-standard health services, the only difference between social service clients and self-paying clients is the waiting period. The first might have to wait a few months for an examination, the latter might have to wait only a few days. However, this is not a universal rule in Slovenia, as the waiting period depends on the region, the institution and the types of care - for example, in Murska Sobota the waiting period for magnetic resonance imaging is only a few days, in Ljubljana a few months. Payment is therefore not intended for the service but for jumping the queue.

According to Ferk (2006) the position of a consultant in the hospital, in the public health system has remained the same as in the previous socialist system. By placing

physicians on public sector wages, the fate of the doctor in a public institution was finally sealed. Doctors now provide medical service as civil servants on the basis of an employment contract. In this way a certain degree of the freedom of choice and behaviour is taken away from the doctors, which is not in line with the Physician Act. The doctor is not the decision maker of health care activity and is not responsible for either the quality or the quantity of treatment. Today, doctors are still vastly underpaid and a brain drain of Slovenian doctors to foreign countries can be observed. At the same time the rise of foreign doctors from less developed countries coming from abroad to Slovenia has been noticed.

On contrary, some positive changes were continued in the field of psychiatry. After lengthy preparations (financial provisions, obtaining housing, etc.), the Social Protection Committee founded the first group home for people with mental health problems in 1992. It had the support of psychiatry, social affairs ministry, Hrastovec Institution and the profession of defectology. This facility was intended to relocate people from institutions and was the first of the kind in a post-socialist country. It represented an organizational and intellectual breakthrough. The employees were trained in Tempus Mental Health Programme Community Mental Health Study - Training for psychosocial services), a project funded by the EU and organized in collaboration with the psychiatry, Alpe Adria network and English colleagues (London School of Economics, MIND). The programme was conducted through intensive seminars and workshops and the informants underwent a six month practical training in Italy or England (Flaker, 1995).

In addition to skilled experts[31] the program had a dual effect - encouraging the creation of new services and creating a new type of professionalism and expertise (Flaker, Leskošek, 1995; Zaviršek, Flaker, 1995). Students of the program were in fact establishing the advocacy groups, day care centres, self-help groups, support centres for young people, women's counselling offices, groups for relatives, harm reduction services, projects of volunteer work with refugees and the like.

Already during the project the movement began to splinter into groups, which had a productive effect on the distribution of initiatives, but it was also reflected in the pursuit of individual interests of particular movement members. The movement has lost its internal consistency and a common goal. Non-governmental organizations emerged[32] and began to compete among themselves and fight for limited resources available. Individuals endeavoured to gain prestige and influence in the newly established field and partly to retain the "purity of doctrine" (of the community mental health) (Flaker, 2011)

Tendencies to amend legislation in the field of mental health emerged, and the first bill

31 Informants in the study were either people who have participated in the projects of the Social Protection Committee or people interested in this new area, including psychiatrists and clients.

32 In the narrower field of mental health Altra, Šent, Ozara, Paradoks and Vezi emerged, in other areas directly or indirectly related to the training program Stigma, Women's Counselling, Young People Help Centre, the Silva Fund, Fužine Consulting and others.

regulating this field was brought before the Slovenian Parliament in the late 1990s. In that decade community services underwent major developments in the field of social protection but they were almost exclusively the domain of the non-governmental sector. At the end of the 1990s, these developments proved to be a double-edged sword. The practice of establishing new group homes, day centres and other services proved ineffective, as it did not reduce the number of institutionalized patients or vacated beds in psychiatric hospitals.

In 2009, Slovenia passed its Mental Health Act. Flaker (2011: 13) notices that it was a compromise between the proposals and the reactions of psychiatry experts to them. From the legal perspective, the act offers no solutions to the problem of deinstitutionalization, however, it does contain some elements that further protect the clients' rights (representatives) and introduces some community services (coordinated community treatment, supervised community treatment). Soon the practice indicated two things: the necessity of such services and the difficulty of their implementation due to strong resistance from psychiatry and a lack of strong support.

UNDERSTANDING AND TREATMENT - BETWEEN SOCIALISM AND CAPITALISM

In the post-socialist context, a particularly rapid social change and re-negotiation of social relationships can be observed. Epidemiological studies (Durkheim, 1897; Lin et al., 1969; Leighton et al., 1963) demonstrated how rapid urbanization, industrialization and related social changes or social breakdown of a community are correlated with measured rates of mental distress, including depression and anxiety complaints. These studies are complemented by ethnographic and historical accounts of increased hopelessness, despair and demoralization in the wake of community changes that place large numbers of persons under the severe pressures of economic dislocation, unemployment, lack of resources and supports, intensified oppressive relationships and dependency (Jenkins, Kleinman, Good, 1991: 86-87).

In 2001, the first survey on depression in Slovenia was carried out. According to the Institute of Public Health 5.8% of people sought help due to depressive disorders in family medicine clinics, i.e. 2.5 times more women than men. Three times more unemployed people than employed people sought help. After the independence of Slovenia unemployment quickly rises to more than ten percent (in the most critical period even to close to twenty).

According to Modic (2014) the current Slovenian reality is as follows: 124,015 unemployed people were registered in December 2013, which is 3.9 percent more than in November the same year and five percent more than in December 2012. In comparison to 2012 17.2 percent more first job seekers have registered at the Employment Service and 6.1 percent more unemployed people after the expiry of a

fixed-term employment. Educated young people regard the situation in their home country as hopeless and are massively leaving Slovenia (more perception of people than statistical reality[33]), although its economy within the EU is not considered as disastrous as for example in Romania. On the contrary, according to the Eurobarometer results for year 2013 Slovenia is a country with one of the lowest poverty rates and the lowest income inequalities. Unfortunately, the same source also reveals that the residents of Slovenia are among the most pessimistic EU citizens.

Mrevlje (In Modic, 2014), a psychiatrist, explained in his interview that »the liberal capitalism has brought a situation in which the sense of solidarity, the sensitivity to others and patience are disappearing. People act only in their favour, even if that harms others or ruin their chances to succeed. Fear has become a tool for the manipulation of people. Instead of democratic promotion of positive things in people and thus creating a positive atmosphere, we as a society increasingly using negative levers."

The Slovenian Public Health authorities (*Zdravstveni statistični letopis* 2007) report an increase in mental and emotional discomforts. In Slovenia approximately 90,000 psychiatric evaluations are made per year (89,657 evaluations made in 2007; 33,091 males and 56,566 females). According to the Institute of Public Health 13,628 patients visited a doctor due to major depression in 2009.

In comparison to the socialist era and the modern capitalist society there is a large gap in the availability and quality of mental health services, especially for those of low socio-economic status, which can be linked to inadequate funding. Lack of funding affects cost, availability, quality, and quantity of services (Yankovskyy, 2005: 69). Moreover, because of limited funding, much of the mental health budgets are geared towards "emergency stabilization," as opposed to preventive care (Yankovskyy, 2005: 68). In the U.S., deinstitutionalization was intended to provide a more humane system of mental health care, i.e. to end the human rights abuses that were discovered in large, state-run hospitals. Instead, the social and political changes associated with neoliberalism, such as deregulation, privatization and the focus on profit and consumerism have only strengthened private profit and corporate capitalism. As a result, in the U.S. the reality for many who are severely mentally ill is that they have been moved from hospitals to "homeless shelters, the streets, jails, and prisons (NAMI, 2002).

According to Fotaki (2009: 141-144) the transition from socialism to the market economy in the former Soviet Union and post-communist Europe is one of the most radical social transformations of the second half of the twentieth century. Drastic changes set in motion by the collapse of the model that combined planned economy with authoritarian governance have firmly established liberalism as the dominant narrative in contemporary public discourse. This ideology was based on competition

33 According to statistical data (SURS 2014) number of young emigrants have decreased. In 2013, 3,342 young people (in 2012 a little more, 3,392) emigrated from Slovenia.

and consumer-driven choice. Even before the demise of collectivist models, theoretical assumptions originating in the work of Austrian-school economists about governance by the market based on liberty, freedom from coercion and individual property rights were taken up by public choice theorists and the macro-economists of the Chicago school, and were turned into a new grand master narrative.

For public choice theorists and neoclassic economists, the fundamental choice was always between the imperfect market driven by self-interest and inequity on the one hand and the failure of the state economy on the other hand. The recent shift or transition from plan to the market could therefore be seen as the culmination of a series of movements in the long trajectory towards capitalist development.

Mental illness is usually associated with differing levels of stigma and discrimination. Thus far, the major focus of reform for Ukrainian policymakers has been the neoliberal transition from "institutional" to "community-based treatment", a transition from socialized to privatized or insurance-based care, and the adoption of the U.S.-modelled International Classification of Diseases [ICD-10] (Yankovskyy, 2011: 37), similar to Slovenia.

Citizens in societies that become known as transition countries or countries of transition have overwhelmingly opted for the flawed but bearable, and often gratifying, consumerism. The social cost of the radical economic transformation, achieved by means of a quick privatization of state-owned property, deregulation and competition, was identified. For public health, this meant unparalleled deprivation, inequity and a dramatic worsening of health indicators resulting from the fragmentation and collapse of services (Fotaki, 2009: 142).

Early capitalism has greatly exacerbated social relations and some people have encountered poverty and exploitation. These are today well-known factors influencing the development of depression that comply with the understanding of depression in the framework of bio-psychosocial model present in Slovenia (Kočmur, 2006; Korelc 2005).

According to Modic (2014) people losing their jobs or being unable to get a job lose also their social and financial security. In such a stressful situation people quickly grow afraid, they feel alone and utterly helpless. In a family environment, children feel the distress of parents in all aspects. In particular people in these situations would need professional consultation or a useful advice on how to continue with their lives, but the vast majority does not receive professional treatment –professional services in the public sector do not have the time due to saving measures and long waiting periods. However, professional consulting is available in the private sector, but unavailable to many due to high costs and fees. Since also the family doctors are overwhelmed with work (a doctor has seven minutes for every patient) the easiest and the cheapest way to eliminate anxiety states is an antidepressant prescription.

Many economic reasons support the current psychiatric practice. For instance, the time taken by a psychiatrist for diagnosis and treatment is minimal in order to satisfy

quantitative needs. Furthermore, the pharmacological treatment is promoted by the pharmaceutical industry also as an effective and fast way for recovery which on the other hand meets the expectations of people. Blech (2006) argues that the increasing number of people with mental health problems recorded in medical statistics is the product of the lobbying and propaganda efforts of pharmaceutical companies, and is becoming an increasing economic burden for the countries as well. As such, this situation requires economic solutions.

For this reason there is still a regular limitation to just one "ultimate origin" of the disease that is actually treated and financially covered by public social and health services (Pankseep, 2008). As Možina (2010) noted, Slovenia lags behind other more developed countries on the provision of psychotherapy. Slovenia still has not passed a psychotherapy act which would provide professional regulation; integration of psychotherapy with the national health system; and integration of psychotherapy education and training with the academic world. In addition, according to Dernovšek, Oreški, and Hrast (2010) psychotherapy is available free of charge only in the central and north-eastern parts of Slovenia. In central Slovenia there are two psychotherapists for adults and three psychotherapists for children and adolescents; in north-eastern Slovenia there are four for adults and one for children and adolescents. Due to the lack of accessibility and availability of health care services (Kurbos, 2008) patients in mental distress frequently cannot be offered more than a prescription for a pharmacological substance (Kores Plesničar et al, 2006).

Althought new therapeutic models that attempt to treat mental illnesses at various levels (neurological, psychological, social, etc.) have been incorporated in the public health care also in Slovenia (e.g. cognitive-behavioural therapy, transactional analysis, psycho-educational workshops, etc.), the application of new multi-level approaches to the treatment of depression probably cannot be expected very soon.

III CHAPTER

DEPRESSION IN THE CONTEXT OF AYURVEDIC MEDICINE

This part of the book engages with a different aspect, understanding and treatment of depression. The traditional Indian system of medicine - Ayurveda has developed a well-structured mechanism against psychological distress. The definition according to Charaka is as follows: "That (science) is designated as Ayurveda where advantageous and disadvantageous as well as happy and unhappy (state of) life along with what is good and bad for life, its measurement and life itself are described" (Sharma and Dash, 2001: 25).

According to Prathikanti (2007) most scientists consider Ayurveda to be the oldest living medical tradition. The word "Ayurveda" is derived from two Sanskrit roots: *ayu* means "life" or "to live" and *veda* means "knowledge". Thus, Ayurveda is "the science of life" and is related to maximizing the health, vitality and longevity with wise lifestyle choices. Ayurveda offers treatments of thousands of diseases, but its primary emphasis is on the prevention and optimization of health with careful attention to diet, activity, circadian rhythms, seasonal and environmental influences, psychological behaviour and spiritual practices. Ayurveda is a holistic medical system, defining life as an inseparable connectedness of body, mind and spirit. A doctor needs to regard all of these factors in his treatments.

AYURVEDIC MEDICINE THROUGH HISTORY

In 1920 archaeologists discovered vast cities in the Indus Valley: Harappa (in Punjab) and Mohenjo Daro (in western Pakistan), which were one of the first cradles of civilization, contemporaneous with early Egypt and Mesopotamia (Gupta 1996: 16-20, Rao 1991: 324-328). The culture of ancient India is called the Vedic culture and is approximately 6000 years old. It was named after the Vedas, the oldest sacred texts written in Sanskrit, which had long been transmitted orally. The term "Vedas" is usually translated as a set of knowledge for achievement of the highest religious goal (Inden 2001: 98), i.e. moksa or liberation from the cycle of rebirth (samsara). The Vedas consist of four collections: Rig-Veda, Sama-Veda, Yajur-Veda and Atharva-Veda. All four collections together represent *śruti* ("what is heard"), eternal and revealed divine knowledge, unlike the works that are of human origin and are known as *smrti* ("that which is remembered"). Each collection consists of four types of essays: Samhitas, Brahmanas, Aranyakas and Upanishads (Škof, 2005: 13-15).

The Vedas represent the foundations for the early codification of Hinduism and for the development of Ayurveda. The oldest and fundamental work of Indian medicine is Charaka[34] Samhita ("Samhita" means a collection of verses written in Sanskrit) written around 800 BC. There are no reliable and exact data about the origin of Charaka, however, due to the non-Buddhist elements, it can be concluded that it is of pre-Buddhist origin. Today, the knowledge of Ayurveda is derived primarily from the later writers, the physicians Charaka, Sushruta and Vaghbata.

Ayurveda was taught at elite Indian universities, such as Takshashila (founded around 700 BC) with students coming from all over the world (Keay 2000: 180–199; Mookerji 1947: 71–158). Accepted candidates had to follow a rigorous seven-year curriculum that included didactic and clinical components. The future practitioners had to learn three major redactions of Ayurvedic knowledge: Charaka Samhita (collected about 1000 BC), Sushruta Samhita (collected about 1000 BC) and Ashtanga Hridayam (compiled 500 CE). Students became proficient in eight disciplines of Ayurveda and were learning anatomy, physiology, pathology and therapeutic in each discipline: Internal medicine (Kaya Chikitsa), Obstetrics and paediatrics (Bala Chikitsa), Psychiatry[35] (Graha Chikitsa), Ophthalmology and otorhinolaryngology (Shalakya Chikitsa), Surgery (Shalya Chikitsa), Toxicology (Agada Tantra), Longevity and rejuvenation (Rasayana), and Sexuality and fertility (Vajikarana).

Ayurveda influenced the medical systems of many early cultures. As described in the third chapter, the contacts with Europe have been established already in Antiquity and Vedic concepts played an important role in the advancement of these civilizations. Since

34 The word Charak (the root of the word "char" means "to move") was also generally applicable to all physicians at that time, who have travelled and healed (Sharma and Dash 2011: xxxvii-xxxix, I), therefore it would be wrong to consider Charaka Samhita to be the work of only one author.

35 Traditionally, this branch of Ayurveda was about demonology (bhutavidya) but tended to be ignored by the practitioners and theoretician of Ayurveda (Obeyesekere, 1970).

300 BC, Buddhist monks introduced the Ayurvedic wisdom in all the countries where Buddhism was spread (althought Ayurveda belongs to another religion – Hinduism). Thus, it reached Central Asia, Tibet, China, Japan, Sri Lanka, Sumatra and many other regions. Buddhist monks also spread Ayurvedic texts that have had a profound and lasting impact on Chinese medicine [36] (Jaggi 1981; Mookerji 1947; Svoboda, 1995). Clifford describes in his book "Tibetan Buddhist Medicine and Psychiatry" (1984) how Ayurveda and Buddhism were entwined in developing each other. He said it was Buddhism that has been developing this tradition for more than a thousand years.

After the golden age of science and art which lasted more than a millennium, i.e. until 1200 AD, India was target of numerous Islamic invasions. The invaders destroyed many libraries and archives (treasuries of traditional Ayurvedic knowledge) and enforced the use of their own medicine (*Unani medicine*) (Patterson 1987: 120) which is based upon the doctrines of the ancient Greek physicians, Hippocrates and Galen. Nevertheless, the work *Paradise of Wisdom* (850 AD) by the earliest Arab medical scholar Ali bin Rabban summarized the Greek and Indian systems of medicine on the basis of four important Indian medical works: Charaka, Susruta, Nidana and Astanga hrdaya. Unani medicine in India developed further and flourished for eight hundred years along with the Ayurvedic medicine (Quaiser 2001: 321-325). Islamic invasions (and conquests) were followed by European colonialism.

A direct European contact with the Indian medical knowledge and Indian doctors was established through European sailors (Panikkar, 1967: 17-18). The Portuguese were the first; the Dutch followed and in 1615 the British reached the coast of India. Three years earlier they obtained a license for unlimited trading [37] for the East India Company that British had already established on 31 December 1600.

According to Patterson (1987) early traders were faced with numerous health problems in a new environment, and for that reasons they sought treatment in the native medical systems. However, throughout the eighteenth century, British colonizers maintained a dialogue with Indian practitioners and even translated several eminent texts of Hindu and Islamic medicine.[38]

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36 Traders and scholars came to India from the Middle East, China and Greece. They took notes of what they had seen and how the treatments and surgeries were carried out. One of the observers, a Chinese trader called Hue Yen Tsang, wrote about what he observed in India at that time, including politics and Ayurvedic medicine.

37 In 1612, the Mughal emperor Jahangir Salim Nurrudin gave Britain exclusive rights to reside and build factories in Suratu and other areas in exchange for European goods. Eventually, Britain became the owner of large estates and the holder of military power. In the 18th century Britain began to supervise and manage the Indian society via administrative and economic reforms. Its rule ended in 1858, a year before the Indian revolt (Gardner, 1990: 30-46).

38 At that time translated into European languages, the millennia-old surgical procedures of Sushruta Samhita became the basis for reconstructive plastic surgery of Western medicine (Hauben, 1984: 65–68; McDowell, 1977: 65–85), although plastic surgery has already been known in Roman times.

In the meantime, Europe has already asserted a mechanistic view of the world, which strongly influenced medicine (Rossi, 2004: 191-205). Since then, the scientific approach to medicine entered and completely dominated Ayurvedic medicine. Cooperation between the Ayurvedic and the emerging biomedical system completely died out at the end of the eighteenth and in the early nineteenth century. "Blinded" by science and dominance, British colonizers began to persecute and suppress the Indian tradition and impose new, Western concepts, both in medicine as well as in moral and everyday life.

According to some scholars (Ernst, 1987; Mills, 2001) with the establishment of the European total institutions in India (beside dispensaries, licensed brothels, work-houses etc.) – the asylum, the British supressed and slandered Indian well-structured mechanisms against psychological distress. There was a profound difference in the understanding of mental illness between both systems. Mills (2001: 168-170) stresses that there is no evidence of hospitals for the insane, designed on the Western model, existing in India before the arrival of the British. The Indian approaches emphasized the need to reintegrate the individual with his social system, avoiding isolation, and advocated group involvement in the treatment. Studies of colonial medicine in India (Harrison, 2001: 232; Arnold, 1988: 62) showed that although the native community strongly rejected Western medical intervention, the British managed to successfully carry out the majority of biomedical projects with the help of the Indian elite. Following the example of the West, the British have transformed the entire Indian educational program[39] (Patterson, 1987: 128).

From 1920 onward, the increased Indian "nationalism" demanded the re-introduction of Ayurvedic medicine (Patterson, 1987: 129). After Indian independence (15 August 1947), the use of Ayurvedic medicine was again introduced and promoted at least as extensively as Western biomedicine.

BIOMEDICINE AND AYURVEDA IN INDIA TODAY

Ayurvedic medicine, as currently practiced in India, has a variety of local manifestations, which are often not consistent with the canonical textual sources (Leslie, 1976: 356-367, 1977; 1992: 177-208; Zimmermann, 1992: 209-223). As already mentioned, mixing and combining of various traditions was not unusual in Ayurvedic practice. As a result, practitioners of Ayurveda formed two trends: one that honours the ancient records (purists), and one that supports the integration of biomedical elements in the Ayurvedic medicine (Leslie, 1992: 185, 191-195; Nisula, 2006: 211).

Although the Indian state continued to support biomedicine after its independence, in

39 Training was conducted in English which became an official language in two years time. In 1833 all Ayurvedic schools were closed, and for almost a hundred years, Ayurveda was known only as "the medicine of the poor".

1970 it established the Central Council of Indian Medicine as a branch of the Ministry of Health in an effort to legitimize the traditional professionalized medical systems and for the purposes of registering traditional physicians, regulating education and practice, and fostering research (Leslie, 1974). According to Leslie (1992: 205), "[traditional] physicians […] are sometimes painfully aware that cosmopolitan medicine [or biomedicine] dominates the Indian medical system", yet a substantial market exists for commercial Ayurveda [medicine].

In India, medical integration (Ayurveda and biomedicine) as a social and political phenomenon is seen in different areas:

(1) Public health care: In 1971, the Government of India started to propagate a health policy in which Ayurveda, Yoga and Unani medicine as well as the production of traditional medicines play an important role (Sharma, 2001: 1524, Bödeker, 2001: 165-166).

(2) Medical education: This promotes the integration of Ayurveda and biomedicine by teaching the basics of biomedicine to Ayurveda practitioners and vice versa (Sharma, 2001: 1524; Mudur, 2001: 1090).

(3) The pharmaceutical industry: Ayurvedic industry needs to appear on the European market to fulfil the clinical standards, and must follow the marketing strategies after the model of large pharmaceutical companies (Banerjee, 2002: 435-467).

(4) Therapeutic practice: Here integration stands mainly for the use of biomedical instrumentation and diagnostic technologies and concepts, both in the teaching as well as in the practice of Ayurveda (Leslie, 1992: 177-208). Lang and Jansen (2013) drawing on ethnographic fieldwork have shown how the appropriation of biopsychiatric concepts such as depression, and their reframing in clinical and academic discussions, are important parts of the revitalization of Ayurvedic psychiatry. The article explores the process and the controversies of translating and correlating the biopsychiatric notion of depression with Ayurvedic notions. Lang and Jansen argue that biomedical notion depression is relatively compatible with Ayurvedic notions.

Alter and others (1999) made a sharp distinction between Ayurvedic theory as represented in the canonical literature and in contemporary technical, popular, and academic interpretations of that literature, on the one hand, and applied Ayurveda as it is practiced in hospitals, clinics, and research institutes in South Asia and elsewhere, on the other.

BASIC CONCEPTS OF AYURVEDIC MEDICINE

The term *ayus* stands for the combination of the body or *dhari* (preventing the body to decay), sense organs or *jivita* (keeping the body alive), the mind or *nityaga* (serving as a permanent substratum of this body) and the soul *or anub andha* (transmigrating from one body to another). Charaka asserts that Ayurveda is the most sacred of all because it does good to people in respect of their present life as well as the life beyond (*reincarnation*), because all living beings, including spirits and deities, are part of this cycle of rebirth (*samsara*). This conception suggests that the life process itself has no beginning and no ending; every event is determined by its antecedents.

Body, the person and cosmos

The non-Western Indian civilization has developed alternative epistemologies, based on the religious positions of Hinduism, with roots recorded in the Vedic texts. According to Holdrege (1998) and Scheper-Hughes and Lock (1987) the first feature of these traditions is that their understanding of the cosmos and the relationships within cosmos are based on monism, rather than dualism, as in the case of the Western science, although trialistic[40] orientation could be detected. According to one of the most important interpretations of Ayurvedic theory, "life" arises from the union of the body, sensory capabilities, mind and soul (Sharma and Dash, 2011: 42). Mind, body and soul (including sensory capabilities), forming a tripod, constitute "a person". This doctrine holds the soul to belong to the union of the body and the mind, which makes it roughly compatible with trialism. This means that Ayurvedic view on a person is trialistic rather than dualistic.

The person in Ayurveda is seen as simultaneously living and enjoying different kinds of being: physical, psychological, social and spiritual. Ethnographers observe that while biomedicine conceives of the body and person as solid and bounded (Langford, 1995), Ayurveda conceives of the body and person as fluid and penetrable, engaged in a continuous interchange with the social and natural environment (Kakar, 1984; Zimmermann, 1987). Thus, Ayurveda frequently frames illness as socio-psychosomatic distress and understands patients as part of an enclosing social, climatic, or cosmic field (Nichter, 1981; von Schmadel and Hochkirchen, 1987).

However, the boundaries between the kinds of being that are seen in Ayurveda are present also in the Western medical thought. Moreover, the current bio-psychosocial model is much closer to the holistic conceptualization, yet the spiritual aspect remains neglected.

In the Hinduist view (Olivelle, 1996: 2.1-5), the individual is constituted of two other bodies: beside the gross physical, there is the "subtle body" and the "causal body". The

40 Trialism was introduced in philosophy by John Cottingham as an alternative interpretation of the mind-body dualism of Rene Descartes. Trialism keeps the two substances of the mind and the body, but introduces a third attribute, the sensation, belonging to the union of the mind and the body.

causal body is purely a metaphysical construct, the "pure self" of Hindu philosophy and as such, of limited interest. The concept of subtle body constitutes solutions to the mind-body problems. Ayurveda assumes that any disorder, physical or mental, is manifested in both the somatic and the psychological spheres, through an intermediate process of contamination of bodily fluids or doshas (Kakar, 1984: 242). Today, this Hindu idea is well present in New Age.

Constitution (prakriti) – five elements, doshas and gunas

In the Ayurvedic worldview, all aspects of the cosmos, including human beings, supposed to be a manifestation of *pancha maha bhuta* or five great elements: space / ether, air, fire, water and earth. In this context, an element is not a concrete substance, but each element may be viewed as a creative energy with its own special properties[41], which is similar to the Greco-Roman health system or medieval medicine.

The manifestation of these five great elements in countless permutations and combinations gives rise to the cosmos. Thus, all living creatures supposed to embody the five great elements, not only in their physical structures but also in the *doshas* that govern psychosomatic functioning. There are three *doshas*[42] ("bioenergetics" principles[43]): *vata*, *pitta*, and *kapha*. Each *dosha* has three aspects: subtle, through which it regulates the functions of mental activity; physical, through which it regulates the activity of internal organs and other body organs; and morbid, which must be removed from the body.

According to Ayurveda, each human being was given a unique proportion of *doshas* at birth. This unique balance of Vata, Pitta, and Kapha is called the individual's constitution

41 For example, the creative element of space has the attribute of expansiveness; air, the attributes of lightness and mobility; fire, the attributes of heat and luminosity; water, the attribute of moistness; and earth, the attribute of solidity.

42 The word *dosha* is usually translated as humour, while the three *doshas*, *vata*, *pitta* and *kapha* are translated as air, bile and phlegm, respectively. *Doshas* are the principles that are connected through a system of correspondences made not only for somatic processes, but for the processes in the natural environment. The balance of doshas is not manifested only in the physical appearance as the motion of pulse or skin colour, but also in the types of behaviour and astrological elements of air, fire, water and earth (Zimmermann, 1987:119).

43 *Vata* is a combination of space and air, manifesting as the bioenergetic principle of expansion and movement within any living organism. At the somatic level, the inhalation of the lungs, the beating of the heart, and the contraction of skeletal muscle are all manifestations of *vata*. At the mental level, the anxious wandering of the mind and creative flights of fancy are also an expression of *vata's* energy of movement. *Pitta* is a combination of fire with a minute amount of water and manifests in living organisms as the bioenergetic principle of heating or transformation. At the somatic level, thermogenesis, digestion, and metabolism are all manifestations of *pitta*. At the mental level, brightness of mind and flares of anger are also expressions of *pitta's* fiery bioenergetic force. *Kapha* is formed from earth and water and is the bioenergetic principle of binding and lubricating. At the somatic level, *kapha* governs the joining of cells to create muscle, fat, and body mass and controls the secretion of body fluids. At the mental level, the binding force of *kapha* is expressed in emotional attachment and the power of memory.

or *prakriti*. *Prakriti* can be physical (*saririka*) and mental (*mansika*). Mental *prakriti* is based on mind-sets or *gunas*[44], which are natural psychological tendencies or three energies in the brain and the main factors affecting the mental state and health of the individual (Sharma, Dash, 2011: 35-6).

The constitution influences psychosomatic functioning in specific ways, giving rise to individual strengths and vulnerabilities. Biomedicine is built on this concept emphasizing that at birth we are biologically equipped with certain advantages and disadvantages.

Health and illness

Ethnographers (Langford, 1995; Alter et al., 1999) argue that the phenomenology of health in Ayurveda, particularly its formulations of person and illness, is culturally distinct from that of biomedicine. Psychological and somatic components of health, isolated from one another in the biomedical paradigm, are integrated in the Ayurvedic paradigm. In Ayurveda, a healthy person is defined as someone who has balanced *doshas*, *dhatus* (seven categories of tissue elements), *malas* (by-products of digestion and metabolism) and *agni* (enzymes responsible for digestion and metabolism). It is also a person who is spiritually highly developed, having the optimal function of the senses as well as the sensory organs and enjoys the pleasure of the mind (Sharma and Dash, 2011: 414-444).

In Ayurveda, lifestyle greatly affects the balance of the three *doshas*[45], and this medical tradition places great emphasis on individual's responsibility for their health (Alter, 1999). Charaka notes that "one should hold himself responsible for his happiness and miseries" (Sharma, Dash, 2010: 98). An individual who maintains a balance of three *doshas* and the *gunas* has an internal capacity to metabolize and heal a lot of the physical and emotional tensions. Conversely, if a person is in conflict with himself or with the universe and others, then physical, emotional or psychological illness might occur.

Many ethnographers demonstrate that biomedicine configures illness as a discrete entity (Langford, 1995), while Ayurveda configures illness as a disruption in delicate somatic, climatic, and social systems of balance (Kakar, 1984; Trawick, 1991; Zimmermann, 1987). If biomedicine generally understands the body, person, and illness as objects, Ayurveda generally understands them as processes and patterns of relationships.

Today those distinctions could be challenged in many ways. Firstly, biomedicine has

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44 There are three *gunas*: *sattva*, balanced and calm; *rajas*, the activity of the mind; and *tamas*, darkness, inertia and ignorance. At any time, the predominant *guna* affects the person's perception of the world, and Ayurveda tends to increase *sattva.*

45 According to Scharfe (1999) the "faults" (*doshas*) referred to a number of irregularities causing illness in the earliest attestations, and only later, under the influence of Samkhya philosophy (circa 200 AD), the three "faults" became a necessary feature of good health, in parallel with the three "virtues" (*gunas*).

largely abandoned the classic biomedical model and is increasingly "holistically" oriented with its bio-psychosocial model of understanding of disease. Secondly, as already argued above, contemporary biomedicine is becoming aware of the interconnectedness of mind and body, although both Ayurveda and biomedicine make a distinction between mental and physical diseases, as Obeyesekere (1970) observes.

UNDERSTANDING DEPRESSION AND MENTAL HEALTH PROBLEMS

Firstly, Charaka states that mental distress occurs when a person does not get what is wanted (frustration) and gets what is not wanted, which is also one of the key points in understanding depression in the context of biomedicine[46]. Cakrapani, a commentator of Charaka Samhita, observes: when a person gets what is not wanted and is separated from pleasurable things, then grief, etc. arises. Even getting what is wanted should be known as a cause (of mental illness) (in Cerulli & Brahmadathan, 2009). While negative and positive desires cause mental disease, the routes in which they produce disease are different. The acquisition of that which is wanted is initiated by desire (*kama*), ecstasy (*harsa*), etc., whereas the acquisition of that which is unwanted is initiated by grief (*soka*).

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*. The mental anguish that people experience when they do not get what they want and mental elation that people experience when they acquire things that they do want similarly aggravate people's ability to think clearly. Both experiences produce what Charaka and Cakrapani refer to as "a violation of knowledge" (ibid).

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: who they really are and how they relate to others and the world around them.

Ayurvedic psychology

Ayurvedic psychology lies in the philosophy of yoga. Buhrman (2005) argues that the two could be said to be "sisters", since both have been developed by the same sages. In the yoga philosophy, emotional pain and its varied manifestations (e.g. anxiety and depression) stem from certain unconscious universal constructs existing in all un-

46 Two research teams (Schueller, Seligman 2008; Abel, Auerbach, Seligman, 2008) have shown that our beliefs about the future have a strong influence on the perception of the present. Optimists look at the bright side of life and see the future of opportunities, while pessimists fear that the current struggles will lead to the following fall. We strive to achieve things we desire (a goal) or to avoid things that are undesirable (an antigoal). Problems arise, however, when people do not know what they want.

liberated human minds (Buhrman, 2005). According to Bharati (2011: 19) experienced emotional pain is a universal condition of human individualized existence, while its source is a specific chain of five unconscious mental constructs called *klesas*, or afflictions:

Avidya, ignorance or wrong knowledge is so to speak the mother of all suffering. The overall knowledge with which we perceive the world is never objective, but subjective. Human perception is combined with the previously acquired knowledge - especially from life experiences, desires and dreams, certain perceptions and expectations. This subjective knowledge is often treated as objective and real, and serves judging the world.

Asmita indicates an incorrect evaluation of oneself and excessive egoism. Self-esteem is often not an image of true self, because from the childhood it is permeate with the perceptions and opinions of others. These statements are eating into the mind, as long as a man is not convinced that it is really as such as people are saying. From here originate inferiority feelings and overconfidence.

A*vidya* and *asmita* are the first two of five *kleshas*, or universal afflictions, which underlie the individual neuroses of all human minds. This leads to the third klesha, *raga,* attraction, which creates a pattern of acquisition. We begin to pursue human relationships, control strategies, material possessions, knowledge, wealth, status, power, etc. In experiencing an object that gives us pleasure, we become attached to that pleasure, and the desire to experience it again. When the experience becomes unavailable we feel pain.

This is the fourth *klesha*, called *dvesha,* "the hate which follows after experiencing pain" (Bharati, 2011: 21). Dvesha is the opposite of raga, namely excessive rejection of things, which stems from bad experiences or prejudices.

Raga and *dvesha* trigger a tremendous, continual, and habitual outflow of our energies and of our attention, outflowing through our senses and focusing on the objects of the external world. This outflow of all our attention and energies can only increase our identification with our physical bodies and our present physical existence, making it even more difficult to perceive or identify our spiritual nature. The fear of death is present not only because it represents an ending of our ability to fulfil our desires, but also because we have emotionally identified ourselves with our body-mind complex and thus (at least subconsciously, if not consciously) fear that our existence will be terminated with the death of our physical bodies. We want to live forever, preferably in comfort, in our existing bodies, but this is not how the material universe works. This is the fifth *klesa*, *abhivinesha*, the clinging to life, which "dominates even the wise" (In Buhrman, 2005). In this system, the ultimate answer to the pain of existence is always a spiritual response.

Ayurvedic psychiatry

Ayurvedic psychiatry knows the notion of *unmada*, which is a general term for all mental disorders in which an individual loses the power to control his actions and

perform duties in line with social norms and expectations. Hence an assumption follows that there is no room for individualization and personal autonomy in India, but it is incorrect – globalization, technology, industry etc. have been drastically changing the social and cultural life in India as well.

According to Roland (1982) individualization in India stands for an increasing consideration of the person's specific wishes, abilities, and inclinations in the social and work environment and goes hand-in-hand with a much greater individualization among educated urban Indians. Increased ego skills with stress on education are being fostered from early childhood, as the urban middle and upper middle-classes exert tremendous efforts to get training in modern science, technology, management and other business skills. Moreover, East Asian scholars have suggested that the "individualisation without individualism" phenomenon could better describe the situation in several East Asian countries (Quah, 2013). Roland observes that the process of individualization does not involve increased separation, autonomy, and the self-creation of identity (the individualized self). In India the basic familial self remains intact while allowing a certain degree of individualization and at the same time increasing individualization rates.

In Ayurvedic psychiatry, *gunas* and *doshas* engage in the treatment of mood disorders. The *gunas* are the three great energies in the brain. When *rajas* dominates the mind, a person becomes obsessively active and distracted, and complains of having uncontrollable racing thoughts. If this imbalance becomes greater, hyperactivity, insomnia, anxiety, inability to concentrate or mania can manifest. When *tamas* dominates the mind, however, the result is lethargy, depression, dullness, negativity, and lack of motivation. *Satva* brings someone a direct understanding of cosmic consciousness, while *rajas* and *tamas* bring deteriorating human (mis)perception of separation from the cosmic consciousness.

Charak defines insanity as:

"[...] characterized by the perversion of mind, intellect, consciousness, knowledge, memory, desire, manners, behaviour and conduct. Due to the perversion of mind the patient does not think of such things which are worth thinking; on the other hand, he thinks of such things which should not to be thought of. Due to the perversion of intellect, he understands eternal things as ephemeral and useful things as harmful. Due to perversion (loss) of consciousness, the patient is unable to have the perception of burns caused by the fire etc. Due to the perversion of memory, the patient either does not remember anything or remember things incorrectly. Due to the perversion of desire disinclination develops for things desired previously. Due to the perversion of manners, otherwise normal patient gets enraged. Due to the perversion of behaviour, the patient indulges in undesirable activities. Due to perversion of conduct, the patient resorts to such activities which are against the rules prescribed in religious works" (Sharma, Dash, 2010: 88-9).

Charaka classifies *unmada* into five types, which differ in regards to the endogenous

(*vata*, *pitta*, *kapha* and *samnipata* - a combination of all three *doshas*) and exogenous factors. The aetiology of endogenous types of *unmada* is manifested in the following circumstances: (1) when someone is timid, (2) when his mind is afflicted by the predominance of *raja* and *tamas*, (3) when the *doshas* in his body are aggravated and vitiated, (4) when he takes food consisting of unwholesome and unclean ingredients possessing mutually contradictory properties or touched by the unclean hands of person suffering from contagious disease like leprosy, neglecting the prescribed dietary rules, (5) when he resorts to such regimes and actions which are not conductive to good health, (6) when his body is exceedingly depleted, (7) if he is not in proper state of health due to other diseases, (8) when his mind is afflicted over and over again by passion, anger, greed, excitement, fear, attachment, exertion, anxiety and grief, (9) when he is subjected to excessive physical assault.

These causative factors corrupt the *doshas* which afflict *hrdaya* (heart), the abode of intellect, when less *satva* (one of the three attributes of mind representing purity and consciousness) is present and while being located in the *manovahasrotas* (channels carrying psychic impulses) they instantaneously captivate the mind. The heart is the home of intellectual activities. Affliction of the intellect is a result of damage to its substrate, the heart. The vessels emanating from the heart penetrate into different parts of the body to provide blood circulation. These vessels are also responsible for carrying the mental stimulus to different body parts. Similar to biomedicine, Ayurveda sees a strong biological base of mental illness also in this regard. An alternative explanation is the intimate relationship between the mind and the whole of the body, which is afflicted as a result of the affliction of the heart by the vitiated *doshas* (Sharma, Dash, 2009: 410).

General signs and symptoms of *unmada* are intellectual confusion, fecklessness of mind, unsteadiness of the vision, impatient, incoherent speech and a sensation of vacuum in the heart (vacant mindedness). Such a patient with a bewildered mind becomes incapable of experiencing pleasure and sorrow. He becomes incapable of conducting himself appropriately. Therefore, he loses peace of the mind altogether and becomes devoid of memory, intellect and recognition. His mind wavers here and there (ibid, 410-1).

Based on the traditional classification of *unmada* types according to the individual *doshas* or a combination of them, contemporary Ayurvedic doctors (Buhrman, 2005; Buhrman, 1998; Devi, 2011) follow the same principles of classifying depression according to the involvement of *doshas*. Traditional descriptions of each *unmada* type are consistent with the types of depression manifestations in biomedicine. According to Ayurvedic doctors, the *kapha* form of depression would best correspond to the psychiatric conceptualization of depression, although all three forms were detected in the patient informants participating in this book.

VATA DEPRESSION: Broadly, in Vata type depression there are two frequent types of histories: 1) a sudden or unexpected physical or emotional injury or traumatic event, or

2) a childhood history of lack of parental nourishment and/or verbal or sexual abuse. The empty quality of the space and air elements, which make up *vata*, create a despair – a person is unable to meet the basic physical or emotional needs or feels unwanted and unloved and believes he has no place in this universe. The parent's failure to convey divine love to the child leaves an empty place in the child's psyche, which must be resolved in some way, usually by assisting the adult patient to access that quality of love through other avenues than addiction or neurosis.

PITTA DEPRESSION*:* In the histories of individuals with pitta depression, a suppression of significant desires in his life is frequently apparent. The individual has been deprived of something that was wanted badly. That resulted in damaged pride and the loss of self-esteem with emotions of anger, jealousy, rage, and hatred. Control strategies are often well-developed, and occasional manifestations of various types of obsessive-compulsive disorders can appear. Other common histories of patients suffering from *pitta* depression are extreme chronic stress, often job or other responsibilities-related, or perceived or experienced social or personal injustices. Reserves become gradually depleted, and perpetual under-the-surface irritability, a sense of injustice, or smouldering resentment sometimes accompanies other symptoms.

KAPHA DEPRESSION*:* Frequently, *kapha*-type depression develops in homes where parents themselves have some degree of *kapha*-type depression. The parents provide food and material goods instead of genuine love, consequently the child learns to become greedy, lazy, and attached to food, money, and possessions. Excessive television watching and lack of vigorous exercise are highly important factors. Also the use of "downers" such as sleeping pills, sedatives, tranquilizers, and alcohol is frequent and they serve to further exacerbate *kapha*-type depression within the entire family unity. The *tarpak kapha*[47] in the brain can be vitiated also by a lack of stimulus. Children left in institutions without a proper stimulation soon become lethargic and apathetic, displaying a *kapha*-type depression.

DIAGNOSIS OF PSYCHIATRIC DISORDERS

According to Ayurveda medicine should always entirely focus on the person and not the disease, while biomedicine primarily focuses on the disease itself. Ayurveda is based on the assumption of maintaining good health and healing is possible only if the doctor thoroughly understands the person.

The clinical examination in Ayurveda has two objectives: (1) to examine and assess the primary nature of the patient as an individual as opposed to the disease and his or her health, and (2) to examine and assess the nature and severity of the disease. The examination of the patient is done by a 10-point interrogation (Mishra,

47 Tarpaka Kapha is the subdosha of Kapha that governs the cerebral-spinal fluid.

2004): constitution (*prakriti*), morbidity (*vikrti*), quality of tissues, body stucture, anthropometry, adaptability, mental stamina, digestive power, physical strength, and age and aging. It includes an interview with a patient, a reliable attendant, or a relative.

The physical examination of a patient includes the following:

1. A general survey by eight-point examination: pulse, urine, stool, tongue, voice, skin, eyes, faeces.

2. A systemic examination of six parts of the body: head-neck, trunk, and the four limbs along with 13 channels distributed over the entire body. The examination of channels with psychiatric patients must include the examination of mental channels. The clinical data available through the above methods are critically examined and evaluated in the light of the doctrine of Ayurvedic knowledge of clinical description, signs and symptoms, pathology, and diagnostic criteria. The Ayurvedic physician pays special attention to the patient's environment, hereditary and genetic background, and original personality makeup in terms of *tridosa* and three personality properties (*triguna*).

Charaka says that all these factors should be discussed in their entirety as far as possible: "When a physician who even if well versed in the knowledge of the disease and its treatment does not try to enter into the heart of the patient by virtue the light of his knowledge, he will not be able to treat disease" (Sharma, Dash, 2010: 169).

MODELS OF TREATMENT

In Ayurveda, treating psychiatric disorders essentially consists of the identification and elimination of socioenvironmental factors and the administration of drugs, similarly to the biomedicine approach. The Ayurvedic management of a depression (and other mental illnesses) is carried out through four basic forms of therapy:

Divine therapy or Daivavyapasraya cikitsa

The divine therapy includes the use of religious activities (*mantra*), wearing of precious stones and astrology.

Biological therapy orYuktivyapasraya cikitsa

Here the patient is subjected to bio-purification by *panchakarma* in order to cleanse the channels of the body. This is followed by *salisamana* therapy or palliative treatment with the help of *ausadhi* (medicinal herbs and herbal formulas), *anna* (dietetics), and *vihara* (lifestyle).

Panchakarma

One of the fundamental concepts of Ayurvedic disease management is to eliminate toxic materials (vitiated *doshas*) from the body in order to cure a disease; this is called as *Panchakarma therapy* (PKT) and is designed to eliminate the toxic materials. It is postulated that the toxic materials of the body need to be eliminated radically before a palliative therapy is given. The palliative therapy in the form of drugs and diets may not be effective unless the body channels are properly cleansed and toxic materials are eliminated. PKT is believed to purify or cleanse all the body tissues and to bring about the harmony of neuro-humours (*tridosas*) (i.e. *vata, pitta, kapha,* and *manasa doshas* (i.e. *satva, raja,* and *tama*)) and to obtain long-lasting beneficial effects (Mishra, 2004: 43-44).

Common *panchakarma* procedures include whole-body massage with medicinal oils (*abhyanga*), streaming of medicinal oils on the forehead (*shirodara*), herbalized steam treatment (*svedana*), nasal administration of medicinal oils (*nasya*), emesis (*vamana*), purgation (*virechana*), and enemas (*basti*). The specific components and duration of the *panchakarma* therapy vary by individual, medical condition, and the extent of *dosha* imbalance.

Panchakarma procedures have been traditionally used in the Ayurvedic treatment of many psychiatric conditions and many scientific studies (Schneider et al., 1985; Sharma, Midich, Sands, Smith, 1993; Herron, Fagan, 2002; Conboy, Edshteyn, Garivaltis, 2009) support such use and demonstrate positive effects in the field of mental health. Although it was difficult to find studies that would show the opposite, it can be determined that *panchakarma* should be initiated only after a consultation with an experienced Ayurvedic doctor and is contraindicated for children, elderly adults, and pregnant women.

Ayurvedic Herbs and Herbal Formulas

Along with the non-drug approach to prevention and treatment of mental disorders, the Ayurvedic texts describe a large number of herbal and herbo-mineral formulas for treating mental diseases. Many of these formulas are still in popular use by a large number of Ayurvedic practitioners. The scientific validity of many of these herbs and herbal formulas has been tested on scientific parameters, and several of these have been found effective (Mishra, 2004).

The most commonly used plants for depression treatment are Sankhapuspi (*Convolvulus pluricaulis*), Mandukaparni (*Centella asiatica*), Brahmi (*Bacopa monnieri*), Vaca (*Acorus calamus*), Jatamansi (*N. jatamansi*), Ashwagandha (*Withania somnifera*), Sarpagandha (*Rauwolfia serpentina*), Jyotismati (*Celestrus panniculatus*), Yasti madhu (*Glycyrrhiza glabra*) and Guduchi (*Tinospora cardifolia*).

Studies (Mehta and Singh, 1976; Mishra and Singh, 1980; Koirala and Singh, 1992;

Tripathi and Singh, 1992; Dwivedi and Singh, 1997; Trivedi et al., 2011) have shown these herbs have neuro-nutritional effects, high anti-stress effects, anxiolytic effects, antipsychotic effects, antidepressant effects, improve memory, balance mood and improve psychological states of the elderly.

However, safeguards inherent in the traditional preparation and prescription of Ayurvedic medicines have been weakened in modern times, leading to the potential for significant toxicities and adverse reactions. There have been several reports of heavy metal toxicities related to the use of some Ayurvedic medicines (Centers for Disease Control and Prevention 2004; Ernst 2002; Saper et al. 2004). These toxicities appear to be largely the result of contamination or improper processing and preparation of Ayurvedic medicinal ingredients; in some cases, patients were using the remedies in higher doses or for a longer period of time than recommended. As of December 2002, stringent good manufacturing practices (GMPs) for Ayurvedic medicines are in effect in India (Gogtay et al. 2002). Most large-scale Indian manufacturers of Ayurvedic medicines have demonstrated compliance with these GMPs, but small manufacturers may escape regulatory attention and still produce improperly prepared medicines.

Nutritional therapy

Nutrition is of key importance in Ayurveda. As Charaka exposes "complexion, clarity, good voice, longevity, genius, happiness, satisfaction, nourishment, strength and intellect are all conditioned by food. Professional activities leading to happiness in this world, Vedic rituals leading to abode in heaven and the observance of truth are all based on food" (Sharma, Dash, 2011: 30).

The body, like nature with its ceaseless transformation of matter, is in a state of perpetual flux, for "[...] nothing about the body remains the same. Everything is in a state of perpetual change. Although the body is renewed again and again the similarity between the old body and the new body gives the apparent impression of the persistence of the same body" (Sharma, Dash, 2010:426).

Ayurveda has developed a nutrition system for each particular *dosha* according to season and time of the year. *Dosha*-specific nutritional changes are an essential component of every Ayurvedic treatment plan, given that the tastes and intrinsic qualities of different foods are said to affect *vata*, *pitta*, and *kapha* in specific and profound ways (Zisman et al. 2003). Scientific research on Ayurvedic nutritional therapy is virtually non-existent.

Psychotherapy or Sattvavajaya

Ayurvedic psychotherapy is practiced incorporating the principles of assurance therapy (*asviisana*), replacement of negative with positive emotions, and psychological shock

therapy[48]. In addition, it includes encouraging the patient to find or develop a specific goal, purpose, or meaning in life; e.g. to find a job that gives higher satisfaction; to improve relationships with family members; to contribute to one's own share of responsibilities to the household; to maintain a healthy lifestyle with respect to daily routine (sleeping schedule and exercise); and to join some sports activity, fitness club, and volunteer groups to help the community (Mishra, 2004: 431).

Yoga

The word "yoga" is derived from the Sanskrit root "yuj" meaning to control and to integrate mind, body and spirit. Yoga refers to those techniques or ascetic discipline and meditation, which should lead to spiritual experience and fundamental understanding or insight into the nature and the essence of existence. With yoga, one can purify thoughts and feelings, limit them, ego can be transcended in its true identity, which could be experienced (Flood, 1996):

Yoga interventions include *asanas* (bodily postures), *pranayama* (breathing exercises), and *dhyana* (meditation). Both yoga and Ayurveda share the view that a healthy body and mind are important preparatory steps in the journey toward spiritual enlightenment (Prathikanti, 2007).

Yoga opens *chakras* and evokes positive qualities associated with a particular *chakra*. In traditional Ayurvedic thought, the source of mental disorders lies in the "subtle" body, which consists of thousands of nerves or channels of energy and its seven centres (*chakras*). The subtle body links both, the psyche and the body and lies at the root of psychological processes. Along the line of symmetry that divides the body into two balanced halves seven centres or *chakras* are located, which are said to represent different states of consciousness. The malfunctioning of a *chakra* produces typical mental and physical disturbances (Kakar, 1984: 187–190).

After herbal medicines, yoga interventions have the largest representation in the Ayurvedic research database (Prathikanti, 2007). In literature reviews, transcendental meditation[49] (developed for the Western population) and mindfulness meditation are reported to treat symptoms of depression (Brooks and Scarano 1985; Eppley et al.1989;

48 Psychological shock treatment recommend throwing the patient into a dry well and keep him hungry until he / she is emancipated; send policemen to grab the patient and take the patient outside and intimidate him / her with corporal punishment, and threatening him / her in the name of the king; terrify the patient with name lions, elephants or snakes whose fags have been drawn or with knives in ones hands or with tribesman, enemies, or robbers; tie the patient up, flog him, and then cast him / her into a pit or into a completely dark room which has no knives, stones, or people in it; and to friend may comfort the patient with conversations that inculcated virtue and profits (Wujastyc, 1998).

49 In 1950s, the Indian guru Maharishi Manes designed a version of the ancient Vedic teachings accessible for the Westerners and called it Transcendental Meditation (TM). It is a meditation technique based on discreet repetition of mantras twenty minutes in the morning and in the evening leading to an elevated state of consciousness or cosmic consciousness (Avdeeff, ‖ 2010).

Glueck and Stroebel 1975; Cabral, Meyer, Ames, 2011) and help prevent the relapse of depressive symptoms when combined with cognitive-behavioural therapy (Ma and Teasdale 2004; Teasdale et al. 2000). Some studies showed that the practice of meditation primarily decreases ruminative thinking, reducing emotional symptoms and dysfunctional beliefs (Ramel, Goldin, Carmona, McQuaid, 2004). It is useful in chronic depression (Zautra et al., 2008), whereas a large proportion of patients with depression return to normal or near-normal levels of mood (Kenny Williams, 2007). Hence, there are plausible biological, psychological and behavioural mechanisms by which yoga may affect depression (Uebelacker et al., 2010). Yoga can be a promising intervention for depression because it is cost effective and easy to practice (Shapiro et al, 2007).

Ayurveda understands the social environment as an important component of depression which greatly contributes to a more effective prevention and treatment of depression. Current psychiatric treatment focuses largely on the biological and psychological components of depression and more often than not the socio-cultural component is not considered enough in practice. This is actually the main criticism of the modern treatment of depression in the context of psychiatric practice (Pankseep, 2008). Essentially, psychiatric treatment includes an interview and analysis (and supportive medication therapy) to help the psychiatrist reveal the reasons for the emergence of depressive disorder in an individual, but the causes and the understanding of the course of depressive disorders differ in Ayurvedic medicine and modern psychiatric treatment.

IV CHAPTER

CULTURAL-POLITICAL ATTITUDE TO COMPLEMENTARY METHODS AND AYURVEDIC MEDICINE IN SLOVENIA

This part presents the historic section of the occurrence of complementary methods / Ayurvedic medicine and highlights those moments when alternative methods have acquired increasing strength. In the period when Ayurveda has appeared in the socialist society in Slovenia already existed a conflict (80s). But, Ayurveda (or New Age) is in contrast to ideas of socialism or communism, which emphasize social conflict. Ayurveda says that the balance is important. However, society now is also more openly conflict.

One of the questions, for example, it was why our culture and part of the medical profession are open to other medical heterodoxies, yet another part of the medical profession and medical politics is reluctant to them. In the introduction of Isis journal (The Professional Public Journal of the Medical Chamber of Slovenia) the National Medical Ethics Committee ironically argues that "not only gullible naives are susceptible to the growing popularity of various healing practices, but increasingly also intelligent and highly educated people" (Trontelj, 1998: 23). Opponents of complementary methods justify their arguments mainly with the fact that biomedicine is an officially recognized medicine based on scientifically verifiable facts, while complementary medicine(s) are informal, unrecognized systems that are not scientifically evaluated and verified. This argument could be refuted, as a there is a growing number of scientifical studies accumulating scientific evidence for the efficacy of Ayurveda.

The opinions of doctors on the treatment with complementary methods are quite varied. According to Žagar (2006: 10) doctors are generally divided into two poles: On one side a group of doctors strongly believing in the superiority of biomedicine and regarding all other forms of treatment ineffective; and a group of experts engaging in alternative medicine on the other. The first group fights to maintain its dominant

position believing they are the only orthodox holders of medical science. Although some doctors realize that the standard methods of treatment are unsatisfactory they cannot take alternative methods into consideration due to the law limitations.

THE RISE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

Western civilization has trusted for more than two centuries in the strength and completeness of science. Scientific facts, methods and beliefs had the highest position in the value system. In the mid-1960s the first criticisms of science in general began to appear, and were immediately followed by criticisms of the medical science.[50] The most vehement critics questioned benefits (of biomedicine) in general. For example, Ivan Ilich (1975) surprised the world with his provocative book entitled "Medical Nemesis" (Nemesis was the Greek goddess of vengeance). In the book, Ilich claims that medicine has been transformed into a system producing diseases so that they can be treated within this same system. His thesis was partially based on the phenomenon he called "social and cultural iatrogenesis". The term **iatrogenesis** literally means "doctor-generated" and refers to sickness produced by medical activity. Illich argues that official medical system had seriously started to threaten human health. He believes that the damage caused by the medicine is greater than its benefits.

Thus, in 1987 the WHO advised its Member States to include local traditional medical systems in the "Health for All by the Year 2000" project, and expected a critical evaluation of these methods at the same time (Rožman, 1993: 479). Otherwise, already in 1978 WHO has accepted Declaration on the larger integration of traditional medicine into the primary medicine at a Conference in Alma Aty.

Although Slovenia has been a member of the WHO since 1992, it has approached this initiative with great reluctance. In Slovenia, complementary treatment methods began to be regulated only a few years ago. A law defining the position of complementary medicine was adopted in October 2007 and supplemented in November 2011, however, it was on the request of the EU than own initiative. There is a general belief that the law is based on outdated attitudes and has a number of shortcomings, whereas biomedicine still holds a superior position. First of all, the act is inadequately entitled. "Healing" (*Zdravilstvo*) is not the correct term for this field (Europe and the World Health Organization use the term "complementary medicine" or CAM) and is not coherent with the definition of the very concept, methods and systems of complementary medicine. Bringing all practices under one law from crystal therapy to homeopathy, and considering them as a whole is not the optimal approach. The premise of this law is not to seek ways and means for the integration and cooperation between biomedicine and complementary medicine, but to strengthen the dominance of strict scientific doctrine.

50 According to Letica, medicine is not a science, because the work of a doctor is not scientific work and medical practice is not a scientific practice. See: Letica, 1989: 215.

For example, the law prohibits doctors to use or practise any kind of complementary medical methods.

In addition, we are witnessing a change in the doctor's social status due to the changes of patients' attitudes toward them. Židov (1998) argues that patients have become more critical to the doctors. They request more information or data about their illnesses and seek intensive cooperation. Some people want to know exactly what is happening to their bodies, and especially what they can do to recover their health. In this way patients gradually gain more and more knowledge about a specific medical matter, their self-esteem increases, and consequently they no longer fully trust their doctor and his competences. The tendency toward more active cooperation and participation in medical decisions has been noticed among patients wanting more freedom in choosing the method of treatment (Židov, 1998: 26-28). Since most patients are aware of the doctors' negative attitudes towards complementary treatment methods they often do not reveal that they are employing those methods (Židov, 1998; Jelenc, 2011). Doctors have often treated patients who have been visiting a complementary practitioner with reluctance, or even scorn (Bardutzky, Travnik, 2005; Debevec 1998).

Biomedicine has achieved great success in defeating massive epidemics, yet the treatment of certain chronic and difficult diseases proved to be more difficult (Rožman, 1993: 480; Plešnar, 2008). However, its interventions in the body are often complex and invasive, they can even damage healthy tissues, and sometimes it can become a real torture for the patient (Rudolf, 1989: 141). The vast majority of medicines remove symptoms, but this can trigger a wave of new complications. The question of the symptom is also problematic. Biomedicine can relieve symptoms, but often fails to address the core/cause of the problem. Consequently the same or some other symptoms may re-emerge.

According to Zaloker and Zaloker (2010) many theorists believe that frequent use of complementary medicine is linked to the overall change in values and beliefs about health, i.e. the tendency towards a holistic view of health, which includes mind, body and spirit. Biomedicine mainly deals with symptoms, but complementary medicine considers a human being as a whole (lifestyle, physical and emotional health). The individual's responsibility for their own health became more pronounced.

Giddens (1991) also notes a general loss of consumer faith in a reliable scientific body of knowledge in late modernity. Hence, in an era of mass choice, if consumers are not satisfied with a professional service, they change the service provider. According to Giddens's term "high modernity", individuals are forced to negotiate identity and life crises through a diversity of "expert systems" (Giddens, 1991: 4-5). Expert systems consist of "multiple sources of authority, frequently internally contested and divergent in their implications" (Giddens, 1991:3). The reduction of modernist scientific prestige opens the way for a proliferation of new expert systems. However, as Giddens suggests, these changes are not simply related to scepticism about biomedical knowledge; they also relate to lifestyle choices and the search for alternative experiences that CAM might

offer. To opt for a form of alternative medicine might signal something about, and actually contribute to, certain lifestyle decisions which a person then enacts (Giddens, 1991: 141) - lifestyle choices as a means of producing self-identity.

Although the attitude of biomedicine experts toward complementary medicine is predominantly negative, it seems the opposite is true for the Slovenian general public, which does seek help in CAM. The earliest reliable data on the use of complementary treatment in Slovenia can be inferred from the public opinion surveys being conducted among Slovenians since 1994. As the number of clients of complementary methods is growing, these data need to be specially processed and verified. According to some sources (in Lovrečič, 2004: 4), 48% of Slovenes were treated by one of multiple complementary methods by 1999; the number has risen to 57.3% in the 2001 survey and today, the 60% number is cited in the media.

BIOMEDICINE AND COMPLEMENTARY MEDICINE COMPARED

In biomedical institutions, the role of rationality based on objective facts predominates, while in complementary medicine irrationality, as perceived by biomedicine, plays the key role, i.e. its results are nothing more than a placebo effect. However, people experience the placebo effect in biomedicine as well as in any other medical system.

In biomedicine, the tradition of technological progress as a form of control over people could be observed. According to Michel Foucault, a type of new power emerged in the revolutionary France of the late 18th century. The power was implemented through social production and social services, and soon a rising and dominant model of economic production emerged. The new power reformed administration, scientifically documented the population (fertility, mortality, hygiene, sexuality and reproduction, migration, etc.) and implemented social control (Foucault, 1991: 57-74).[51] It can be said that today there is almost no difference between the France 200 years ago and the modern France with established capitalism. Today, however, we are dealing with the power, which requires control over people, whereby scientific knowledge serves as one of the main supports and works closely with the economic system increasing the accumulation of capital. In this way, the discourse of »insanity« is controlled, selected and organized in accordance with the interests of the power. Medicalization imposes the belief that it is necessary and that it resolves psychological distress, and that also leads to the accumulation of capital.

In contrast to medicalization, a process of "paramedicalization" has developed within which human relationships are being addressed in the frame of the complementary

51 This is clearly shown in his *History of Madness* and in *The Birth of the Clinic*, (which relate to psychiatry and medicine), where he discusses (political) authority (although the word hardly used) trying to control the body and behaviour of individuals.

and alternative medicine. In the Western world paramedicalization (increasing number of therapies not belonging to the institution of medicine) has progressed alongside medicalization. In our society (the so-called health-seeking society) many complementary practitioners manage to retain people's faith in better health. In certain environments paramedicalization can also be a consequence of people who »drop out« of the official system, because they do not have the money for it or otherwise cannot afford it. For example, one cannot afford a doctor or the sick leave, and buy the medicine that one can get without a prescription in the pharmacy.

Medicalization and paramedicalization are sometimes contradictory and conflicting, but both ensure that the issues of health and disease remain in sharp focus in the determination of human conditions and problems (Tuomainen and others, 1993). Pessimistic Tuomainen, who has researched the process of paramedicalization in the Finnish society, argues that it has the same features as medicalization: it attempts to increase its power and to create new markets, it is growth-oriented and tends to monopolize expertise. This could be seen as an expected reaction to the biomedicine which is trying to take the dominant medical discourse in all respects.

I argue that when comparing biomedicine to complementary medicine the relations of power cannot be ignored/ avoided. According to Bourdieu (2003), the objective relations of power are often reproduced in the relations of symbolic power. In a symbolic struggle, agents (doctors) use symbolic capital acquired in previous struggles which can be legally protected. For Bourdieu certificates of symbolic property are academic titles that are giving the right for profit. Symbolic capital refers to the honour, layout, respect, prestige or visibility of the ideas. Socially recognized qualifications are one of the most characteristic manifestations of the monopoly of legitimate symbolic violence belonging to the state. The state guarantees for all certificates and has a monopoly on the legitimate symbolic violence (Bourdieu, 2003: 91-93).

As Foucault (2007:100) argues medicine has become a "political intervention technique with typical authoritative effects". Medicine is the knowledge-power, which relates both to the body and to the population, on the organism and biological processes, and it will have disciplinary and regulatory effects. The state interferes with every aspect of people's lives and in this way controls the citizens.

However, complementary methods and complementary healers do not have this prestige certificate and consequently no validity. Otherwise, among them is a very strong »credentialism«, various »diplomas«, »PhD theses« and the like from various "healing schools" having a power within their communities, and many clients. Also Ayurveda enjoys similar powerful advantages in its cultural environment, i.e. in India. According to Marriott (1955:250-53) a vaidya (traditional name for an Ayurvedic doctor) also possess symbolic capital, which is particularly visible in the traditionally oriented village communities, as certain amount of criticism is already present in urban areas. A vaidya is not seen only as a healer but also as a wise man, sometimes as a holy man. He is

expected to guide the patient to the proper meaning of life according to the Hindu tradition. Since he is recognized as a figure of moral integrity, he may provide advice about the physical, social and religious matters of the patient's life. Marriott (Ibid.) concludes that this patients' blind trust places a vaidya even in the omniscient position.

In fact, symbolic capital is of utmost importance among the healers, because it can be turned into money capital. Probably one cannot be a healer without the symbolic and social capital. For example, a lot of people go to healers due to their »reputation« (which is nothing more than a symbolic capital) and on that basis they may charge for therapy. It can be argued that symbolic capital is even more important for the healers than doctors. The doctor needs to finish his degree, someone has to employ him and he will have patients. But the healer must have a lot of symbolic capital in order to obtain clients.

In contrast, Giddens (1991) attributes a completely different role to the movement of complementary and alternative medicine. In his analysis of self-identity in the "late" modernity (or "postmodernity"), he relies heavily on Foucault's analyses of birth of clinics and modernity (Foucault 1981, Foucault 1984, Foucault 1994). According to Giddens, the current "late" modernity is characterized by radicalization and globalization of basic positions of modernity (1991: 243), and "sequestration experience", i.e. "connected processes of concealment which set apart the routines of ordinary life from the experience of madness, criminality, sickness and death, sexuality and nature" (Giddens, 1991: 156). Following Foucault, Giddens argues that "the ontological security which modernity has purchased, on the level of day-to-day routines, depends on an institutional exclusion of social life from fundamental existential issues which raise central moral dilemmas for human beings" (Ibid.).

But, as Giddens emphasizes, the separation of experience is never complete, since the abstract systems of modernity in the "fateful moments" are no longer able to curb the potential moral problems and perspectives. Giddens argues that "fateful moments are times when events come together in such a way that an individual stands, as it were, at a crossroads in his existence; or where a person learns of information with fateful consequences" (Giddens, 1991: 113). Such "fateful moments", might be experiences of illness and death, encounters with mental health problems or crime, and the like. These are the movements, such as the movement for the enforcement of complementary and alternative medicine that strive to reintegrate "sequestration of experience", are against the dominant discourse of science and oppose the main assumptions of modernity, particularly the "exclusion" of meaningful experiences (Giddens, 1991). In contrast to biomedicine complementary medicine reintegrates "sequestration of experience".

YES TO ALTERNATIVE?

According to Feyerabend (1999: 13) events and developments that have happened throughout the history occurred simply because some thinkers either decided not to

be bound to certain "self-evident" methodological rules or because they unknowingly violated such rules. Anyone who will turn to the greatness of the material produced by the history will discover that there is only one principle that holds true in all circumstances. Feyerabend terms this the »anything goes« principle, a principle that does not inhibit progress. Anything goes, but only if the authorities have interest. However, they do not have interest in the complementary methods yet.

Feyerabend implies that the replacement of some conventional rules is not needed, but wants to draw attention to the fact that "all methodologies have [...] boundaries" (Ibid, 29-44). In the case of biomedicine and complementary medicine, both have their limits, both come to a point when treatment is no longer possible. Thus the only correct method is the confrontation of orthodox position with a large number of relevant facts. Feyerabend argues that the usage of a variety of methods must sometimes be forced by non-scientific instances which have enough power, i.e. the Church, the State, a political party, public discontent or money. The examples of Copernicus, atomic theory, Voodoo, Chinese medicine and others show/prove that even the most advanced and seemingly most reliable theories are not protected from a transformation or from a total reject by the concepts that the vanity of ignorance has already thrown to the garbage of history, changed or completely discarded, and that any arbitrary view, whatever strange and »out of date« it appears, becomes the starting point for convincing clarifications and fruitful discoveries (Ibid., 53).

Invention, development and theories that are not only opposed to other theories, but even to experiment facts are neccessary. Oakley (2000: 291-306) further points out the fact that researchers imply their own ideologies, each having different interests, aspirations and values, accompanied by the production of a certain behaviour. According to Kuhn, there is no rational criterium that would allow a unique choice of better or more advanced paradigm, and Oakley (2000) stresses that we need to take a more critical and ethical approach to all types of methodologies.

Although biomedicine still plays the leading role in the world and dominates over other medical systems, from the sixties and seventies on health care policies in Europe (Germany, Austria, Great Britain, etc.), Australia, New Zealand and both Americas have slowly established more tolerant attitudes towards complementary and alternative medical systems. With the implementation of CAM into health care some governments, such as the Australian, have rationalised the state budget, which are burdened with the ever-increasing and rapidly growing costs of conventional medical services. The research (Grocott, 2010) conducted by Economics for the National Institute of Complementary Medicine (NICM) at the University of Western Sydney examined the cost effectiveness of selected complementary medicine (CM) treatments for some of Australia's most common and costly chronic health problems including low back pain, heart disease, depression and arthritis. This rationalization not only shifted health services to the private sector, it has also contributed to the expansion of health insurance offers covering also complementary and alternative activities. According to Thompson

and Nichter (2011) the United States established that kind of medical insurance is less expensive, but not for all diseases.

In Slovenia, health politics is convinced in the exact opposite. Negative attitude of medical profession toward the implementation of complementary medicine is mainly due to the financial flows, in other words, less money for psychiatric programs. There are examples of NGOs and some forms of community services, which are already included in the current action plan in the field of mental health as equivalent acters in the treatment of mental health problems. Some NGOs receive some funding from the health fund and that consequently deprives psychiatry of extra means. In this regard the psychiatrists' revolt (defending community care and less out-patient treatment) against the adoption of such a law can be understandable.

In addition, Modic (2014) ironically draws attentions to the discourse of investigative journalist promoting discussions of magic healers, alternative quacks, interpreters of future, warriors of good, readers of angels, shamans, prophets of therapeutic paranormal phenomena, promoters of positive forces, the Druids, herbalists, pseudoastronomers, mechanics of closed chakras and guiders of energy flows, which are all supposedly to be found in various parts of Slovenia; you only need to look for them. In short, this creates the impression that the pocket country of Slovenia is bursting with diversified alternative therapeutic solutions to such an extent that they could be exported in the manner of the American democracy.

Further Modic (2014) asks where all these oracles were hiding until 2008 (when the financial crisis struck Slovenia) and why despite their catharsic omnipresence and unsurpassable associations depression and anxiety remain among the most common mental health problems in Slovenia. Suicide rate is the most prominent public mental health indicator of the independent Slovenian state, signalling a persistent number of 30 suicides per hundred thousand people a year.

The problem lies in the fact that the field of complementary medicine in Slovenia is not regulated despite the adopted law – there is neither a registry of complementary "healers" nor verification of their practices. Everyone registered with the administration office can practice CAM. Slovenia adopted the so-called »Healing« law six years ago, but has not been implemented. Firstly, until now experts (among them also experts from the field of medical anthropology) have failed to agree on the appropriate name which would define the complementary and alternative medicine more precisely and assure it an equal position. Secondly, complementary and alternative medical system in Slovenia is still missing a professional basis, interconnection and an organized leading institution.

Thirdly, in 2011 the National Medical Ethics Commission strongly opposed to the inclusion of particular complementary health care services in the system of national health insurance. Jože Trontelj, the president of the Committee, is convinced that the

union of classical homeopathy and biomedicine would shake the foundations of the medical profession, break professional standards and set medicine back to the pre-scientific period (Teran, Košir and Ovsenik, 2011).

The part on theoretical consideration on concepts and treatment approaches to depression came to the end. Now the focus moves to empirical part where the findings of practitioners and their clients / patients were studied.

V CHAPTER

DEPRESSION BETWEEN THEORY, PRACTICE AND PATIENT EXPERIENCE

With this part book moves to the empirical part, where the theoretical framework for understanding depression in terms of psychiatry and Ayurveda presented in the first chapters is supplemented and compared with the results obtained from the practitioners and their clients/patients. In this chapter I was interested in: Is depression a common disease and why? How is it understood by psychiatrists, Ayurvedic doctors / therapists and how are patients experiencing it? Why are people depressed and are they responsible for their depression? How can diagnostic methods act as a bridge between the objective medicine and the subjective patient experience?

THE PREVALENCE OF DEPRESSION

All informants – psychiatrists, Ayurvedic doctors and therapists, psychiatric and Ayurvedic patients agreed with the WHO report that depression is the fourth leading cause of disability and disease around the world, and problematized the reasons for its increasing presence. Most psychiatrists felt that depression is more common today than in the past because it can be recognized better. The Ayurvedic doctor (A#2) pointed out that when something is defined as an "issue", it can be found in the general population. For example, the results of a recent study on mental health in Slovenia (2009) conducted by the National Institute of Public Health suggest that depression ranks high among the prevalent diseases (P#3: "*Depression is an illness that rises to the list of the most common diseases and partly also a stress-related disease.*").

Considering all age groups and both sexes, depression is among the most common reasons for the first primary care institution visit in Slovenia; 5.5 men per 1,000 and 13.6 women per 1,000 (Tomšič et al, 2009: 27). Although the study showed that depression is more common in women, the majority of psychiatrists believed that depression in Slovenia is as frequent in women (P#1: "*Very often the victims are women. During the second half of the 20th century, a woman was identified by having a job. However, this didn't bring relief at home. Extensive depression is noted in women who are overburdened.*") as in men. Psychiatrists warned also about the frequency of the covert depression, especially in men (P#9: "*Depression in men can reflect in alcohol abuse, speeding, cheating, aggression, increased workload (to be away from home), but in fact they suffer from depression. In men depression is masked, we say.*"), since women seek help more easily (P#9: "*Women seek help. Women cry, women accept that they are powerless.*").

Serious doubts about the numbers reported by the WHO were raised by the Ayurvedic practicioners. They associated this problem rather with the Western self that refuses to take responsibility for its own actions and is always looking for the source of its problems outside itself. Here the problem of lack of individualization arises, as an individual does not act autonomously and is not responsible for his action; the blame lies with the partner, the job, the politics etc. (A#1: "*And when we lie, when we are lazy and so on. These numbers do not always show the real picture.*). For example, at a roundtable one of the psychiatrists pointed out that in Slovenia only one out of ten patients seeking help actually need it, the other nine usually approach a psychiatrist for other reasons. In contrast, as the Ayurvedic practicioners noted, all people seeking help in India actually need it. (A#1: "*This is the difference between Slovenia and India. The numbers can be deceiving.*"). However, this is merely their individual perception. In addition, life in India is also becoming very stressful: I personally noticed a number of stressed informants in India.

Both psychiatrists and Ayurvedic practicioners saw the reasons for the growth of depression mainly in the changing lifestyle and listed broader socio-cultural factors contributing to the rise of depression:

- growing loneliness (P#1: "*A hundred years ago, people were much more integrated into the extended family network. Now the networks and relationships have become much looser.*"),

- work environment (P#8: "*If you look in terms of work, there is a lot more instability, there are fewer professions offering permanent jobs. Decades ago, people lived to reach retirement. Nowadays, the modern man can work all day long, the idiot. This way of life is really testing the boundaries of human capabilities. Maybe being overburdened once is enough to trigger a depression. This lifestyle, this pace, sucks you in and leads you on, you become a cog in an enormous machine.*"),

- uncertainty (P#1: "*The exposure to uncertainty in the developed world is certainly the base for developing depression. People have to make much more effort to carry all these burdens arising from the fast way of life.*"),

- technological developments (P#1: "*The technological developments of the previous half of the century gave us wings, as far as the pace of life and the changes that have occurred are concerned. During the 20th century more changes had taken place than in all the previous millennia together.*"),

- political and economic conditions (P#5: "*The economic crisis has made people anxious, frightened, with no sense of security, desperate or angry. Depression contains a lot of anger and aggression.*"),

- de-stigmatization (P#9: "*Now people seek help sooner and apparently there is more depression. People speak more easily and openly about it.*"),

- the transition from a traditional society to the modern society (P#9: "*Traditional society is a factor of stability for those who like a predictable and cohesive society; on the other hand, it is the unfavourable factor for those who do not want predictability and cohesion. Nevertheless, the possibilities offered by postmodernity – the fact that a person has many options – are on the one hand protective, because a person can apparently realize his ambitions and desires more easily. But, on the other hand, this also brings a great deal of uncertainty and much more frustration, because the increased number of wishes in this scenario goes hand in hand with the increased frustration as many of these desires are not realized or are very temporary, if we consider only the divorce rates. Postmodernity offers many options creating a large number of factors leading to depression.*"),

- living environment (P#4: "*Depression is more common in urban areas and easier to handle in rural areas."),*

- longer life expectancy (P#9: "*Women in the past did not live to experience menopause; similarly the elderly population, which is particularly susceptible to depression.*") and

- poverty (P#9: "*Poverty lessens the possibility of human adaptation to changes. First, people should be provided with basic security; they need food.*").

Similarly, Ayurvedic practitioners argued about the causes of depression. Considering the effects of the so-called civilized world people opt for individuality (although depression often arises due to a lack of individualization), and loose contact with the community that gives them a feeling of belonging i.e. that they are part of the community. According to Ayurveda, depression is also a sign of weakness of the nervous system, which supposedly is the characteristic of Western societies, where individuals are constantly exposed to mass media stimulants in their daily lives. This, according to Ayurvedic philosophy, leads to a long-term depletion of the nervous system (*A#2*: "*This is something that is happening in this society, the civilized society; it only gets stronger and not weaker, and I can only agree with the consequential rising depression.*").

Similarly to Europe, mental health problems are becoming more common in India as well. According to the Indian informants, the reasons for this can be found mainly in the approximation to the Western way of life. Or, as summarized by AI#1: "*Fast food, disintegration of traditional families in which fewer conversations take place, excessive ambition and propensity to moneymaking, alcohol abuse, divorce, less physical activity, which has been superseded by the widespread use of mobile phones, television and the internet, can be seen in the occurrence of the so-called "Western diseases" (diabetes, cardiovascular disease, obesity, cancer, and the aforementioned mental health problems.)*".

For this reason for example, Guru Ramdev's fitness programme gained popularity in India (Chakraborty, 2006). The programme is broadcast daily on the spiritual Aastha television channel and is a demonstration of how Hindu »ascetics« are dipping into a new era of the fitness consumer in the contemporary India. They are trying to carve a niche for themselves in the fitness industry by packaging yoga for the educated, professional classes and promoting it as a means of empowerment through which people can take control of their bodies and their health. Guru Ramdev's defence of his fitness/health programme on moral, anti-western and anti-capitalist grounds, while reminiscent of Gandhian discourse, now appears in consonance with his claims to legitimacy based on the degree of penetration of such »tradition« into the global market.

Having become common in Kerala, Indian informants discussed family suicide and identified it as a major problem. They associated family suicide with a predominance of Western materialistic values. The most common cause of such family tragedies is the husband's loss of employment, who is driven to extreme actions because of perceived (hopeless) situation of no longer being able to support his family. First, he takes the lives of his wife and his children, and then his own. Such painful family stories appear in the newspapers on a daily basis.

The social and cultural aspects are highly intertwined when considering the prevalence of depression and the vast majority of psychiatrists and Ayurvedic practicioners in Slovenia and India associated the frequency of depression with the modern way of life that is outpacing our adaptive abilities. They believe people are not able to adapt genetically, thus the number of stress disorders is on the rise. In short, psychiatrists and

Ayurvedic practicioners in both countries are well aware of the social determinants that contribute to depression, and are not focused only on a biological model of depression.

All the informants were of the opinion that depression is on the rise and felt that it is a common disorder. They all believe depression is headed to become the most salient disease if the situation in society does not settle. However, differences of opinion arose when discussing whether depression is being discussed enough or too little among the general public. Psychiatrist and psychiatric patients believed depression is being discussed enough, while the Ayurvedic practicioners and Ayurvedic patients pointed out that it is still not being discussed enough.

Although psychiatrists believed depression is being increasingly discussed in public, they raised great concerns about pharmaceutical companies encouraging depression diagnoses and the pharmacological treatment of depression with the profit motive. The objectification of depression in this context might lead people into thinking it is something separate from them, i.e. only an unwanted guest in their lives. The greater visibility of depression today goes hand in hand with the development of pharmaceutical products of the 20th century *(P#1: "The pharmaceutical industry has become one of the most profitable sectors, alongside arms industry. Medicines generate the greatest profit. The money they have invested in the development of antidepressants in the last ten years is enormous; billions of dollars for a new medicine. The medicine research machine is working at full speed and antidepressants are growing like mushrooms. There is already the fourth generation of antidepressants on the market.").*

The pharmaceutical industry justifies their products with great success on the premise that depression is a disease for which a medicine exists. Partly, the pharmaceuticals are right, as there is a biological component of depression. In addition to that, people need to be diagnosed with depression in order the prescriptions to be covered by insurance companies – diagnosis is a product in this economic system.

The psychiatric patients linked the cause of the increased depression to the increasing visibility and awareness of depression in public. They stressed that there is enough public discussion about depression and were critical towards the professions and individuals who overgeneralize the disease. In their opinion, today almost everyone has already claimed to be depressed and started taking antidepressants after three days of restless sleep. Psychiatric patients believed that depression had become "fashionable".

In contrast, the Ayurvedic practitioners stressed that people suffering from depression do not open up, they suffer in silence, they do not seek help or they do not recognize the problem. However, all problems are reflected in the physical (back pain, skin disorders, headaches and migraines, constipation, etc.) and psychological symptoms (insomnia, lack of energy, lethargy etc.), which drive people to seek help within Ayurvedic medicine. The Ayurvedic practicioners stressed that people are not conscious of their problems.

The Ayurvedic patients addressed also the burning issue of depression unawareness,

suppression or ignorance. The psychiatric patients supported their statements and both groups related the reasons for a high rate of latent depression to:

- stigma (Marija: "*People hide it because they are uncomfortable speaking about it.")*,

- lack of knowledge about the disease (Miha: "*I didn't know what was happening to me."),*

- lack of social and professional support as well as from their family and friends (Martina: "*They do not have anyone to trust to or think no one would believe them.")* and

- inability to articulate the distress (Martina: "*People do not know how to express themselves and suffer in the inside.*").

The Ayurvedic patients justified their arguments on the grounds that their social surrounding was poor at recognizing depression and contended that the public discussion should be increased in order to detect depression early. The Ayurvedic patients opposed the opinion that depression was "fashionable". In my opinion these findings reflect the fact that the rural areas are less exposed to public discussions on depression in comparison to the urban areas. Or, as 61-year-old Martina highlighted: "*They know certain things, but they hide them, especially in the village. This disease. They were looking at me differently, more scornfully*."

Indeed, the psychiatric patients were mostly coming from the Slovenia's capital city (except two) and Ayurvedic patients mainly from the countryside, and this probably reflects the fact that Ayurveda has no such stigma as psychiatry. As a result of their experience, the Ayurvedic patients believed they were understood neither in their social context (family, friends) nor by professional health care providers (family doctor).

WHY ARE WE DEPRESSED?

As presented in the theoretical part, today depression is understood within the bio-psychosocial model and, as we have seen above, the socio-cultural factors are very important in the formation and development of depression. The general public still holds the belief that depression is a disorder of the brain and in this respect I was interested in how depression is understood by psychiatrists and Ayurvedic practicioners as well as by Ayurvedic and psychiatric patients.

Psychiatrists initially defined depression as a disease, a condition, a syndrome, a disease of the brain, a mood disorder or a general reduction of human activity. Two psychiatrists, P#1 and P#2 explicitly pointed out that depression is a syndrome, not a disease *(*P#2: *"Depression is not a disease condition because every medical diagnosis is defined as a state which is not a desirable state, or as a state that disrupts the person or the surrounding environment. If a state displays certain signs and accompanying symptoms we can call it a syndrome. If the pathological path for a syndrome can be explained, the third degree is reached – a disease.").*

Most psychiatrists stressed their inability to explain psychopathological mechanisms of depression and pointed out the fact that this is not specific only for psychiatry but for the entire field of biomedicine. However, as explained in the theoretical part, Ayurveda describes the pathological process of depression, and for this reason most Ayurvedic doctors and therapists, both in Slovenia and India, defined depression as a disease.

As assumed, most psychiatrists understood the aetiology of depression within the bio-psychosocial model, although they rarely mentioned this precise term. In most cases, the aetiological descriptions of depression were presented as a "complex of multicausal factors", or a "combination of biological and environmental factors". However, one of the psychiatrists (P#1) showed a more holistic understanding of depression: "*In the last twenty years we discovered that genes are not enough, that depression is not something written in the genes, and unaffected by the environmental components. Now it is widely accepted that depression is an interaction of several factors.*"

At the same time, they stressed the crucial importance of the psychological developments beginning in the uterus *(*P#1*: "The importance of these early experiences is greater than the later learning."),* while P#6 pointed out the evidence (for example, Cziko, 1997: 49-71) of the brain showing that a human being is able to create new synapses and nerve cells and thus learn his entire life. This, however, reduces the determinism of early experiences.

Psychiatric understanding of depression is very similar to the Ayurvedic conceptualization of depression, yet the latter understanding is broader as it includes also the spiritual and astrological factors. The notion referred to in biomedicine as "genetic determinism" is actually the approximate equivalent of the traditionally Indian and Ayurvedic "karma". Karma is the expression for a disease appearing due to the (negative) actions taken by one of our ancestors. In this respect, karma is quite similar to the concept of genetic disease.

A#2: "*Every disease, including depression, is always a consequence of energy flow disorder - the energy of jivatma* [individual soul*] cannot stream freely through the nadis* [channels] *of the body. This means that jivatma cannot even stream through the basic channels, such as brain chambers, nerves, blood circulation, lymph, sweat channels. There is always a conflict between the energy of jivatma and the energy of a person with a bandage. This eventually wears out the body and the soul of the man, and there is no doubt which energy will prevail in the end. The frequency, which is finer, will not prevail. This is the main cause of any illness, including depression. This is also the reason why week people, people of weak mind, succumb to diseases so soon. In Ayurveda the material element is always the result of a subtle level.*"

In addition to *doshas* and *gunas*, the Ayurvedic practicioners discussed also the astrological pillar of Ayurveda, *djotish*, which represents a synergy of planets. *Djotish* is a preventive approach that helps clarify certain strengths and weaknesses of an individual.

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*. Interestingly, a correlation exists between biomedicine and all three doshas, i.e. they have physiological equivalents. Ayurvedic practicioners argued on the basis of science how *Vata* is always responsible for the transmission of electrical impulses and their movements, thus in the long run an excess, lack or balance of this quality determines the brain activity. *Pitta* is associated with enzymes and neurotransmitters. Their levels may be too high or too low, meaning this quality is not in balance. *Kapha dosha* is associated with the cerebrospinal fluid which is responsible for the quality of the brain. Eastern traditions emphasize connectedness and holism, meaning everything people think, experience and feel have affects on the mind and the body.

Or, as A#2 said: "*The psyche and the body are highly intertwined, they influence one another. A person with a weak mind cannot hold a strong body and vice versa, unless a spiritual component, the satvic quality, is involved, which is the source of harmony and in a way also the protector of our nervous activity.*"

The fact that the psychosocial environment determines the biology and the chemical structure of an individual is partly recognized also by psychiatry and neuroscience studies (Doidge, 2007; Bergley, 2007), nonetheless, there is still no clear consensus on this issue today, as it is still not clear whether psychosocial environment or biology is responsible for chemical imbalances.

In Ayurveda, the balance of fluids or *doshas* can be upset virtually by anything – from distress caused by *karma* to the physical or mental distress due to a lack of *agni*. A person lacking the fire element in his body for example cannot "digest" certain experiences. In this case, a permanently present mental *ama* forms, which clogs the channels and creates permanent disorders. This person leads an improper lifestyle developing unhealthy eating habits and daily practices, whereby, not only the type and the quality of food are not adequate, but also the rhythm of eating, his attitude and his state of mind during meals. This can eventually lead to a particular disorder. Although one of the psychiatrists highlighted the importance of diet in the development of depression, his understanding was not as in-depth as that of the Ayurvedic doctors and therapists. In Ayurveda nutrition is the key element.

However, psychiatrists and Ayurvedic practicioners agreed that depression should be understood as a multi-faceted condition. A chemical imbalance in the brain is only one aspect of the entire phenomenon of depression. In this context, one psychiatrist noted that if depression is conceptualized as an object, if people do not want to take responsibility, it is most convenient to allocate a part of the brain to depression. Here he pointed out the gap between the holistic and the linear way of thinking (P#1: "*The linear way, the way we are familiar with, suits perfectly the pharmaceutical industry, which is claiming that the brain is the source of depression. The problem is that the pharmaceuticals present depression to the public as a malfunctioning of the brain and greatly emphasize*

this aspect; despite the fact that we are accepting and are becoming accustomed to the bio-psychosocial model of interpretation, which is a combination of several various factors.").

It is reasonably to note here doctors and patients believing that pills are a good and a fast way to solve their problems are more likely to follow this way of understanding. However, due to diverse causes triggering depression, it is impossible to successfully treat it solely with medications. The findings leading to this conclusion are shown below. In short, in psychiatry and Ayurveda (or at least as understood by informants) depression is conceptualized very similar, but Ayurveda is choosed by those who express their problems harder and are more afraid of the stigma that psychiatry carrys with it.

The fact that considering only one factor in understanding of depression is not the optimum way, was also supported by the prehistories of psychiatric and Ayurvedic patients which offered rich insights into the detection of potential factors making a person vulnerable to developing depression. The analysis of informants' life stories revealed four types of depression. The first type is associated with traumatic experiences in childhood and adolescence; the second reflected long-standing, unresolved and inappropriate relationships; the third is related to the working environment; and the fourth type of depression is a reflection of negative life events to which an individual has been exposed. All types of depression are closely intertwined, thus it is impossible to regard depression as within one type only. Consequently, it is not surprising that the majority of informants reported several types or at least two types of depression.

Traumatic experiences in childhood and adolescence

The first type of depression is associated with a very important period in the life of every individual, the childhood. Childhood plays a key role in the psychological structure of a person. Thirteen informants reported growing up in a very chaotic environment, which prevented them from developing a stable and positive self-image. This type included five subtypes or factors influencing the later development of depression: physical and psychological violence, father's alcoholism, parents' divorce, over-protectiveness or a lack thereof and depression in the family. Among those, informants identified moderate to severe lack of love and support as an important factor in the development of depression.

Lea, 43 years old, described her childhood as difficult, mainly due to the constant exposure to physical and psychological violence. "*My parents didn't like me. I was beaten from as early on as I can remember. Everything was my fault. Once, on the train, I cried and my father beat me so hard that I slept for 13 hours. When I became a teenager my mother didn't think of me as a human anymore; only as a source of humiliation. These are difficult things. Now, being a mother, I cannot understand how people can allow such an attitude towards a child*." Lea reported not receiving enough support and love from her parents. "*I escaped into the world of books. You have to escape from this aggression, you have no other choice. They didn't allow me to go out. I was always grounded, allowed only to go to the shop and back, to take the garbage out and back, to school and back. They allowed me to*

attend catechism class though. That was my only socializing with peers. I was always blamed for something. I did not even celebrate birthdays." At the age of 17, she visited the child psychologist, *"because I was so desperate. But, I received no help, no support. She only said: "When you grow up, you will be able to talk, and then you will be able to let go. Until then you have to be patient."* In short, it was a bad psychological support.

The second factor is alcoholism in the family, which was present in the lives of five Ayurvedic patients, reflecting a general and widespread problem in the Slovenian society. In Slovenia, alcohol abuse remains one of the key public health problems – our country does not deviate from the European Union average in the consumption of alcohol, but rather in the damages caused by alcohol abuse (Ministry of Health, 2013).

Beti (47 years old) described her growing up with an alcoholic father: "*He was an alcoholic and that was it. It was terrible for me*." This experience resulted in Beti not trusting men. "*I never believed that not all men drink. I always asked them first if they drink alcohol. That was a major problem. Can you imagine how does it come out when you ask somebody that? I was never relaxed, I was always scared. What if this, and what if that's going to happen? He beat us a lot. There were such escapades. Our mother tried to protect us, but that only led to arguments and wars of words. There was only yelling and shouting*". Beti had almost no opportunity to socialize with peers because of the work on the farm. "*And even when I had a boyfriend (now he is my husband) I was not allowed to go anywhere alone – my brother was always accompanying me. It's funny, but it was like that*." At the age of 18 she took a permanent job, because she wanted to leave home as soon as possible. "*I just wanted to go away, anywhere; and then I ended up 200 meters away from home, where my husband was staying*." She said that home control still occurs and described this situation as problematic.

The third case is a 25-year-old Alma, who grew up with her parents' divorce lasting several years, full of quarrels and psychological pressure: "*I was quite a shy child. It seems to me that it was all great until I was five years old. We were a beautiful little family. Then my parents began having troubles which lasted for 10 years. It was a lot of arguing and disagreements. At the beginning they were talking a lot, and dismissed me when I showed up with "Alma not now, we are talking". Soon, the conversations became louder and louder. In the early stage I and my siblings were not allowed to be there, but at the end we heard everything. It was pretty bad. Later on my father became involved in vegetarianism, in alternative medicine, which provoked a growing conflict between them. Partly, I understood that my father was never at home, that he meditated and that my mother was always crying. I was very quiet and scared, not self-confident, a quiet child. As a result I developed low self-esteem and indirectly everything they say about children of separated parents. They both loved me, but as a child you interpret things in your own way. I never talked about the situation at home with anyone. We were very isolated as a family. To the outside world, we were the perfect family and almost no one knew what was going on behind closed doors. At that time, my peers did not know what was going on, so I started retreating into myself and tried to understand these things. It seemed to me that I should not be sad, so I started suppressing my*

feelings. Besides that, I also started negatively interpreting my surroundings, thinking I was a terrible person and always wondering if people were laughing at me."

The fourth factor is on the one hand lack of love and support, on the other hand, its excess, which might also prove to be problematic. Tomi (31 years old) described the lack of love and warmth as over-indulgence: "*I got everything I wanted. Every now and then I got love too, but not in general. I missed that and I still miss it. I miss it in general, from other people too. I would like to share feelings with other people very much. A person develops self-confidence if he is praised a little, if he is told something nice. I was not praised at home, no matter what I did or achieved. I did not get that feedback, when I expected it. They were always shouting at me*."

Nana (44 years old) also suffered from lack of love from her parents: "*I was raised on a farm in a working-class family, where everything was based on work; this was the motto of our lives. My parents got along well, but they didn't give me enough love; I remember almost no cuddling*[52]*, no hugs. It makes me want to cry. When I was older my grandmother cuddled me from time to time. I also missed warm words and praise*."

In contrast, parents' possessive, protective and conditional love could also be problematic because a child develops into a dependent and frightened individual. 45-year-old Marija highlighted the problem of excessive parental support and love: "*My parents were slightly older and overprotective. I was not allowed to ride my bicycle, except in the garden, so that I wouldn't be hit by a car. Later, I started to pretend I was a good girl. I often spent the night at my grandma's, at least my parents thought that, but in fact I was out all night. I was not allowed to go anywhere and this was the only way for me to go out. The first time I went to a club with my parents' permission was at the age of seventeen. Each time I went to a club I had to eat a piece of bread soaked in tuna oil, because my parents believed it inhibits intoxication. They gave me too much love, especially my mother. 'We gave you everything to be good' she says. They were worried about me constantly, because I'd always done something wrong. Even in college – if I was coming home late, the lights turned on in the house when they heard me in the garden. My mother was waiting for me to come home. And when I arrived home with my husband, the lights turned off. "You know, I was so* afraid", *she said*."

These examples indicate the second problem (the first is alcohol abuse) of the Slovenian society, i.e. the difficulty demonstrating and controlling emotions and expressing warmth and support which are an indispensable part of a healthy childhood development. Family relationships affect the child's self-esteem, which is of crucial importance in the development of depression. In this period of life a child urgently needs love, and if he does not receive it from the primary caregivers, i.e. the parents, he looks for it

52 An interesting example is the use of the word cuddling in the Dictionary of the Standard Slovenian Language - she will raise a child badly by cuddling. This indicates the fact that cuddling is something negative and it is in stark contrast to the current studies, advocating the need for cuddling, since a child can sooner die from a lack of cuddling than hunger. Otherwise, many societies believed that children can be spoiled with love, both with a hug, cuddling and the praise.

elsewhere. Most often, informants seeked security with their grandparents. The reason for this probably lies in the fact that mothers usually hold a permanent job and do not have much time for their children, but grandmothers do (a specific feature of post-socialist societies). Some informants saw a way to escape from the difficult family relationships by finding a partner (a saviour) as soon as possible. In these informants, depression appeared when the source of love and support disappeared. It is a social form of depression, which cannot be treated with medical therapy, as there is no medication that would replace the lack of love experienced by an individual.

The fifth factor is depression in the family. Adam (25 years old) grew up in with cognitive style depression from which his family members suffered: "*My problems began approximately at the age of 15 and slowly evolved into symptoms of depression. First I felt dizzy. Then I got a feeling as if something was going to happen, a feeling as if I got lost. My hearing was different. I was aware of everything, but as I was clinging to myself, I draw into myself. I panicked a little bit and started thinking what was wrong with me. These thoughts became more frequent and more intense with each day until I clung onto them. I confided my mom my problems which she understood in a way, since my brother and she had already gone through this kind of problems*."

With regards to this the question arises whether depression is genetically determined or is it triggered by some inappropriate behaviour patterns in the family that are being transferred to the afflicted person. However, more than one factor needs to be considered, in fact a triangle of biology, the environment and own activity, and within those the imbalance and the possible causes for the development of depression. As presented in the theoretical part, there are no genes for depression, but there are biological markers (Tamatam, Khanum, Bawa, 2012) which are genetically conditioned. In this connection, a special protein synthesized by cells appears in various cellular processes, which can result for example in a reduced synthesis of serotonin receptors, an impaired vascular wall in the brain, changes in neuronal morphology, etc. All these impacts could be reflected in the behavioural, emotional and mental patterns, which appear also in depressed people.

Highly relevant in this respect is also epigenetics, which is studying the ways the environment affects the functions and activities of genes in cells (human, animal or plant), and in particular the ways these environmental impacts are passed on to the offsprings. It has been long recognized that the events in our ancestors' lives cannot influence ours; however, according to the latest findings of Dalton, Kolshus and McLoughlin (2014), this traditional view is not entirely correct. They discovered "that there is an association between adverse environmental stimuli, such as early life stress, and epigenetic modification of gene expression". Epigenetic changes have been reported in humans with major depression and may serve as biomarkers to improve diagnosis. Antidepressant treatments appear to reverse or initiate compensatory epigenetic alterations that may be relevant to their mechanism of action. The team concluded that "epigenetic modification of gene expression provides a mechanism for understanding the

link between long-term effects of adverse life events and the changes in gene expression that are associated with depression".

Long-standing, unresolved and inappropriate relationships

The second type of depression, reported by fourteen informants, is related to long-standing, unresolved or abusive relationships. Informants reported conflicts negatively impacting on their self-esteem with their partners or former partners, parents, grandparents or children. Interpersonal relationships are a very common source of mental declinations which often go hand in hand with difficulties in the primary socialization and the individual's early experiences.

The 34-year-old Milena reported having a difficult mother, who after her husband's death was continuously complaining about her myriad health problems, was strongly reliant on her and was closely controlling her every move: "*There was something wrong every day, she demanded my full attention all the time, and it was never enough. She is the kind of person who always criticizes everything, so you always feel guilty, you're always doing something wrong. And then, of course, with two children and a partner you are torn between them and her. I was always on the go, always in a hurry. Then I crashed, I couldn't take it anymore. There upon also problems in the partnership followed. Last year we didn't speak to each other for a month; we practically walked one past another the whole month. This was the hardest. Then I sought help*."

The 64-year-old Teja had similar problems with her mother who did not let her live an independent and free life: "*Where am I going? When will I come back? Who is at our place? Where was I? Always as if I was a six-year-old girl. Now I am retired and still not free. That's awful. She is jealous of me. She wants the things I've achieved in live, but she hasn't. It's slowly killing me. I suffer greatly because of that, although I feel bad about her. It's a vicious circle. When too many negative events accumulated I* crashed."

Tanja (51 years old) lives in a three-generation household marked with interpersonal conflict: *"My husband is a bit too conservative. When our children grew up I started going out more often which proved to be a major change of our lives. My husband objected and disapproved of this. He prefers to be at home, whereas I prefer to socialise. It's difficult to reconcile various interests. You always have to maintain a balance. We live on the top floor, my parents below us and our son on the ground floor. I have to balance kids, my parents and my husband. It's chaos. If you're alone, you're free, if you're not alone you're not free. When I was too loud I irritated my son and my husband, and when I went out and came late I irritated my father. Life is very interesting. It is great, but sometimes it drives you mad and you do not know what to do."*

Beti (47 years old) moved in with her husband and his parents when she was eighteen. She moved away from one controlling family and moved in with another one: "*When I complained or had a problem with something, my husband didn't say 'I will talk to mother' or 'We will sit and talk', he always sighed 'Ah'. He could never talk and deal with*

these issues, not even now." Beti's in-laws avoided getting involved in arguments, but she said "*I needed to fight; just to let some things out. Sometimes I walked behind him and begged him to yell back, but no response. He just walked on. You know, you don't talk about these things to people you just met. I didn't have any friends and colleagues at work were mostly just co-workers. You don't explain this stuff to them either. I had the feeling nobody understood me. When I did get the opportunity to share my feelings, they replied: 'You are going insane'. The things that were troubling me or the things I wanted to clear simply didn't matter. Basically, you get the feeling that you are not wanted*."

All cases highlighted above as well as most other represent the problem of individualization, which can be seen as the third problem of the Slovenian society. This problem, addressed also by one of the psychiatrists, shows a marked ambivalence of the concept of individualization. On the one hand, the ethnographies of informants indicate the problem of individualization in the sense that a family does not act as one single unit – family members do not support each other, they are not interested in the feelings of one another. On the other hand, evident control and meddling in other people's lives (i.e. the informant) are very common. The results indicate that the informants' individualization levels are not too high but actually too low – they live and often work with parents and follow the expectations of their surrounding area even in relatively advanced years. For them it seems like they never grew up, but they remain children who are afraid of parents and they obey them.

As a result, the informants submitted themselves to their environment, ignoring their own goals, desires, aspirations as well as their own nature. They did not follow their minds or stand up for themselves, consequently, at some point in their lives, they succumbed. Unsettled relations can restrict the individual's freedom which consequently affects also his relationships with other people. 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: who they really are and how they relate to others and the world around them.

All described stories reveal some basic deviations of behaviour, thinking and feeling, thus in order to eliminate the source and the cause of depression the entire treatment and therapy should be family oriented. In these cases, the negative way of thinking was provoked by the psychological pattern of the family and the vulnerability. The aforementioned stories confirm the outcomes of the studies (Moran, Bailey and DeOliveira, 2008; Scher et al. 2005) on the importance of early experiences in the development of subsequent pathologies in the field of mental health, which have been a central premise since Freud. Negative cognitive styles have strongly marked the self-image of the informants and their subsequent ability to cope with life events.

Working environment

The third type of depression is work related. In this regard, eight informants reported transfer to another job, dissatisfaction with working environment, overload and burnout, poor conditions and unpleasant incidents.

Tanja (51 years old) reported having continuous problems with stressful work environment. She changed jobs nine times, as she believed she could find a job with a better work environment. "*I have to say that I'm a positive person and I don't like conflicts. I'm a shock absorber, calming things down. When I get to the limits when it's just not worth of worry anymore, I pack up and say 'I'll try to find an easier way out'*." This attitude is not surprising considering the fact that she lives in chaos with her husband, parents and children. Tanja does not consider changing jobs as stressful, "*because I find it challenging to meet and to get to know new people. I always start a new job with optimism, desire and expectation that things will surely be better, and at the beginning they actually really are. But, soon you see the internal relations and old resentments among people, and you are always on the line of attack. It's very stressful. Things in the office started to pile up when I was dealing with one specific case. I started work before seven and finished work at six. I started losing my mind and couldn't concentrate anymore. I was collapsing on the inside. I cried about everything, I laughed at everything, I was hysterical, and I was coming home all burnt out. Before I started working till six I, usually had gone to the gym after work and came home starving, ate something and went to bed. When working long hours, however, I could not sleep, I had headaches and I could no longer perform the basic tasks that I had been able to perform until then*."

Bor (34 years old) coped with pressures at work and was extremely unhappy with the working environment and the boss: "*The environment in these large factories is awful. You can't tell whether it is day or night. The salary was a disgrace; I lived from hand to mouth. When I paid all the costs of bills and food I had a hundred euros left. I was living like this for two years, but the situation slowly started to suppress me. I didn't see the point in this anymore. This happened when I was 25 years old. I should be progressing, but I stagnated, vegetated […] Dad says: 'You have to earn your living somehow'. I had problems with the boss. I held out too long. If I had changed my job, I wouldn't have come this far. I persisted only because my father advised me to persist. It was a mistake, but it happens. They say we make no mistakes, it's all part of the process. A man must be able to adapt; those who cannot adapt, fail. Each person probably has a strong and a weak spot. In some aspects you are strong, in others vulnerable*."

After many years Zoja (64 years old) was transferred to another post to a different company, which heavily affected her: "*After 25 years, I lost my job because they closed down that working place. They moved me elsewhere, which hit me very hard, because we had very good working relationships. I collapsed because of the transfer. I developed high blood pressure, for which I started taking medication, and headaches. I've been having headaches for the last 10 years now*."

Negative life events

The fourth type of depression is associated with unexpected events later in life. If there is no adequate support at the time of these events, the following events can be interpreted and understood in the context of cognitive style that has been internalized in the process of primary socialization. The more negatively oriented cognitive style, the more significant problems arise when coping with various life challenges (Alloy et al., 2008; Wisco and Nolen-Hoeksema, 2008). Family environment greatly affects the development of an individual. Still, warm and genuine relationships in the family are not the only prerequisite for the development of an independent individual equipped with all the means for a successful problem solving.

Seven informants reported the following unexpected events greatly influencing their lives: death of a close friend or relative, separation from a partner, moving to another social and cultural environment, moving for study purposes and disease. Informants gave central importance to these events because they were unexpected, they stand out of the regular rhythm of everyday life, and are thus highly informative. Unexpected events bring stress and interrupt stable life cycles. People construct their own reality, meaning everything depends on our own perception of the importance of particular events – the social construction of reality, if considering the theoretical framework of Berger and Luckman (1988).

Neli's (28 years old) problems began at the age of 18 when she lost her grandmother (mother substitute): "*That super grandma with whom I went to the concerts. I was shocked. I don't know how I passed the final examination so well. Then I collapsed, because I had no support. If your parents are divorced, you have to ride slalom between them your whole life. Children should not have to deal with these things. My grandma was actually my mom, she played the role of my mother. And when she died, a big hole open up, which started to be very destructive*."

Silvester (47 years old) lost a son in an accident at work. "*That affects me greatly*." Since then he has problems with his memory and is suffering from nervous tension. Four years later, Sylvester and his wife were involved in a serious car accident in which he suffered a head injury. "*I was unconscious and all the things that had been piling up exploded. Memory is the worst – I still have problems with my memory. For example, I never know how much money I have in my wallet or for some business. Money, the most basic thing, I easily forget about it. I already had an attack, two actually. My nerves triggered such an agonizing pain in my chest that an ambulance was sent for. Psychological attacks. Such a severe anxiety grasped me that I thought I was going to die. At least the first time, when I had no idea what was going on. And when I'm nervous, my forgetfulness further increases. I was not in the mood for anything, I had no enthusiasm for work. I was apathetic, nervous. I get mad fairly quickly, I do not let anyone to mess with me, not even my clients. I get mad too many times and too quickly*."

Tomi (32 years old) fell into depression due to breaking up with his partner (twice): "*My love life has always been a disaster; from my first love until now. I have no luck in love. My first relationship lasted for two years. When we were together everything was fine, but then we broke up I had no friends or colleagues. I did not go anywhere, I was at home all the time. Nothing excited me, I was lost, without a will to work and I could not sleep at night. I had no appetite, everything irritated me and I didn't want to talk to anyone*."

Metod (43 years old) lived abroad for several years. There he completed primary school and learned a different way of functioning, working and communication, which marked him for life: "*I think that my return to Slovenia was one of the crucial turning points in my life. The school system here was as different as day and night, and it was one of the most unpleasant periods in my life. Then my first psychological problems appeared. I had troubles breathing, I could not breathe. Somehow I never felt good, I felt foreign and I had no freedom, no freedom of thought. Everything was artificial here, and the tense atmosphere was more and more depressing me. For example, I had a problem approaching girls, I was getting increasingly frustrated, so I shut myself out. Before, I was more confident, but in Slovenia I did not feel well and I had problems*."

After high school Karmen (29 years old) moved to Ljubljana to study at the university. There she lived with her former classmate, but knew no one at the new faculty. This isolation in turn negatively affected her: "*I knew no one attending the same faculty, I did not meet anyone there, I was all alone. In that environment you feel so alone. I had friends, just not enrolled in the same college. A later events were stressful too, the work alone and all these life changes. Marriage, moving in with your husband. I was not happy, not at all. Nothing made me happy. I think that everything was wrong, nothing was right. And my job was very, very stressful*."

While working there, Karmen started suffering from multiple sclerosis (MS) which she attributed to her stressful job. Her doctors explained that depression is a consequence of the disease. Karmen experienced MS in this way. "*I did not sleep at night. I took the half past six train; I came home at five or six. I didn't relax in any way, I did not have the will. I just ate something and went to sleep. I asked at work what would happen if I leave as if I knew this* [a disease] *will happen. I badly wanted this and I got it*." This is an illustrative example of how different types of depression are related to one another, as already mentioned at the beginning of this part.

Ethnographies of informants confirmed the findings of the latest studies proving that depression is a combination of bio-psychosocial factors, meaning not only one individual factor influences the onset and the development of depression. A person is defined by his biological constitution, human psychology and social environment in the form of interpersonal relationships and all structural elements that are present in a society.

As already indicated above, ethnographies reveal some "cultural" features of depression in Slovenia, especially:

(1) burnt-out people falling into depression because they are exhausted and over-worked;

(2) lack of individualization in people (especially women) living and working with a narrow range of family members with frequent conflicts and constant interference in their lives even in adulthood;

(3) great fear of failure that paralyzes many people, especially men;

(4) structural components, such as the threat of or actual long-term unemployment;

(5) alcohol abuse and;

(6) lack of warm and supportive family relations.

DESCRIPTIONS OF DEPRESSION

Informants understood depression within the bio-psychosocial model of depression, however, different components of model have been reported and emphasized. A similar picture is also reflected by Ayurvedic and psychiatric patients. Both have considered depression within their own experience. Psychiatric patients have significantly attributed it to their upbringing, lifestyle, environment and genetic predisposition.

Alma (26 years old) understands depression as a combination of biological and psychological factors: "*I would say that it is a disease. If I were just lazy, I would also not be interested in things. But, I liked doing some things, I just didn't have the will to do them. I have this theory of synapses and neurotransmitters, which you can partly regulate with drugs, partly with your mindset. Every organ in the body can be sick, even the brain. I'm constantly thinking 'What if I do not sit right?', 'What will they say?', 'I'm ugly', 'I'm terrible', 'How do I look like?', 'I'm not wearing any make-up', 'I do not want to live', 'What to do?', 'I hate myself', constantly something. This is quite a big stress*."

Marija (42 years old) associated depression with genetics, as she believed this was clearly evident in her family environment: "*I am convinced that there is a disorder in the brain and that it is genetic. I made sure of that when my child developed the same disorder. My mother had it, my half-sister had it, so the whole line*."

Adam was also convinced that his depression developed due to depression present in his family. This demonstrates also a lack of individualization as a person refuses to take responsibility and often blames others – in this case, the family bears the blame for everything. Similar consideration was stressed by the Ayurvedic practicioners. In short, even the understanding of the cause of the depression between psychiatric and Ayurvedic patients are not different.

Metod (43 years old) believed depression is "[…] *a set of moments, events that accumulate*

over a period of time and affect our well-being. Let's say my well-being purely on a personal level, for example emotions, self-esteem, self-confidence, but also career and relationship to the surroundings."

For Nela (28 years old) depression "[…] *is basically a continuing dissatisfaction with life. Sometimes you have too many things to deal with – the oral exam, the written exam, the payment order... I was not receiving scholarship and it can be a shock moving every year.* "

Ayurvedic patients understood depression determined by the psychological and social factors. Martina (61 years old) explained depression: "*It is about your life, different stages of life you experience. And then other events that happen in your life, traumas. All this piles up over time, as you do not release them. And also complaisance, pleasing other people*."

Sandra (40 years old) pointed out that: "*a person suffering from depression is not able to cope with the situation on his own, he desperately needs help. Depression is a serious illness, a person has to realize this and needs to want to get better. My depression is the result of unresolved relationships within my family, my environment."*

Both groups emphasized that depression is a serious disease, needing expert help, and that it cannot be regarded only as a disorder of the brain. The biological component is merely one facet of depression. Hence, their understanding of depression conforms to the bio-psychosocial model. In contrast, when regarding depression as a disease Ayurvedic patients never referred to it as "a chemical imbalance" or "a disturbance in the functioning of the brain". Instead, they tended to explain depression in close connection to them, in a deeper psychosocial context. These variations in understanding between both groups of patients might be a reflection of their psychiatrist's or Ayurvedic doctor's / therapist's discourse when interpreting depression or their condition.

Almost all informants considered depression as a disease. Psychiatry and Ayurveda similarly conceptualized it within a bio-psychosocial model, whereas Ayurveda regarded it even broader. The reason for this probably lies in the fact that this medical tradition considers spiritual aspect as an important factor in the causality of depression. The psychiatric patients put slightly more emphasis on the biological aspects of depression compared with the Ayurvedic patients, who demonstrated a broader understanding of depression.

SYMPTOMATOLOGY

Depression is a multifaceted disease, in each individual manifested in a very unique way. In general, three symptom clusters of depression were identified from informant narratives, corresponding to Ayurvedic depression classification according to the doshas. The first symptom cluster includes obsessive thinking, restlessness, insomnia and anxiety. The second cluster comprises burnout, work-related exhaustion, aggression

and nervousness and the third cluster asocial behaviour, passivity reflecting in excessive sleeping, reduced eating, work absence and inactivity and general lack of interest. Ayurveda has a more sophisticated system for depression diagnosis, as it is primarily focused on the individual and offers a more personal and individualized approach to depression treatment. Although psychiatry recognizes different types of depression, it does not attribute particular symptoms to each type of depression. Compared to Ayurveda, psychiatry merely lists the symptoms. Ayurveda focuses on the emotions entirely, while psychiatry solely on the intensity of emotions.

All informants experienced lack of energy and will and problems with memory and concentration, however, the symptom development and symptoms varied depending on individual's experiences. Informants reported both psychological and somatic symptoms, meaning that depression affects the individual as a whole, although psychological aspects predominated in informant reports (feelings of sadness, crying spells, loss of self-confidence, etc.). As already demonstrated by some studies, (Waza, Graham, Zyzanskia, Inoue, 1999; Bhugra and Mastrogianni, 2004), this suggests a tendency for Western cultures to emphasize the psychological symptoms of depression (psychologization), rather than adopting the orientation of East-Asian cultures which tend to express depression via physical symptoms (somatisation).

Seven informants (Marija, Metod, Sandra, Beti, Tomi, Martina and Bor) revealed having suicidal tendencies at some point in their lives. Only one of them (Beti) has actually attempted suicide as a cry for help, the other six informants abandoned the idea of suicide due to being a parent or knowing that suicide is not the solution to their problems. Some of them have had suicidal thoughts in the past. Furthermore, none of the informants reported suicide in the family, which is highly important, as people often "learn" the patterns of handling distress by imitating their family members.

Women informants often cried, six of them cried during the interview. The interview might have also had a therapy effect, as it included the description of the patient history, the description of their disorders and their reflection. Morecroft, Cantrill and Tully (2010) argued that this reaction (i.e. crying) may encompass not only changes in the interviewee's perceptions and behaviour, but also the possible development of a more meaningful appreciation and understanding of their condition. This reaction depends also on their treatment phase and their level of coping with the disorder. However, informant relief is often the only advantage of this type of research – it could be said that when people talk about burdensome things, the more likely they will be relieved.

In an attempt to solve their mental problems, all men turned to work, one to alcohol. Similarly, four women informants sought the solution in work. The explanation lies in the nature of (post) socialist societies where work defines a person, both men and women. But often they are depressed because they work too hard – this is a vicious cycle, or self defeating behaviour.

INDIVIDUAL RESPONSIBILITY

Responsibility can be a difficult topic to discuss. The only guiding premise was that a person cannot be fully responsible or completely irresponsible. More than half of the interviewed psychiatrists stressed that an individual is always co-responsible for the development of his depression. According to psychiatrists a major factor with this regard is the individual's upbringing. For example, psychiatrists mentioned studies indicating how children of depressed and pessimistic parents develop negative thinking, negative self-esteem, and self-pity feelings (P#3: "*Those parents who are less satisfied with their children continuously encourage them to try harder, to do better. As result a child becomes highly critical of himself. He thinks he is not good enough, he wants more. He nourishes this negative energy to confirm his poor self-esteem. He does achieve success to some extent, but soon he runs out of energy that is driving him to be better; he breaks down and falls into depression."*).

These children often take on responsible jobs because their depressive personality drives them to prove themselves they are important. Therefore, a positive self-image is a key instrument, as also stressed by psychiatrists (P#10: "*There are very few things threatening you, if you're happy with yourself. But, if you're not satisfied with yourself, you always keep an eye on the idea that you are not good and wait when it will hit you.*").

Ayurveda representatives also attributed the greatest role in developing depression to upbringing and relations within the family and similarly explained the drive of taking on responsible job positions as a possible carrier of a pathology deriving from a family environment (A#3: "*Many successful people are successful precisely because they possess a strong personal motivation to succeed. This fills their psychological void. This is still only a crutch, but a crutch that allows this man to walk. However, if you resort to addiction, your crutch breaks, because it cannot carry the weight in the long run - it does not solve the situation.*").

The individual's co-responsibility for the development of depression was identified as positive by one psychiatrist (P#1). If a person activates his own forces and makes an effort, he can affect the course and outcome of depression. In this regard he presented the Augustinian prayer ("*O God, give me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference*") that he suggests to his patients. This prayer emphasizes the individual's responsibility for the segment of life that can be influenced and points out that there are always things in life which cannot be changed.

However, depression can prove to be problematic if people assume too much responsibility; because guilt is one of the fundamental signs of depression (P#1: "*It is not the problem that there is too little, but too much responsibility. A depressed person is inclined to feel guilty.*"). In the therapeutic process, it is therefore required to work on identifying areas that the patient can change (P#1: *Some things simply do not rest with your responsibility and you need to accept that.*") and to identify depression and admit that the person is suffering from depression (P#1: "*Depression is not an object that hits you, but a pattern which you've became overly accustomed to, a pattern you've learned.*").

Ayurveda similarly understands the individual's co-responsibility for the development of depression as psychiatry. Co-responsibility in terms of Indian tradition is understood in the context of the continuity of consciousness, depending on the level of understanding of life a person has reached. Ayurveda practitioners are convinced that a person is absolutely co-responsible for the development of depression in some way. However, a person carries the responsibility only to a certain extent, as the circumstances are sometimes beyond his power to respond to them responsibly. A person is co-responsible for the things happening here and now. However, in Ayurveda the dimension of time is understood much broader, as it is committed to the concept of rebirth, i.e. reincarnation.

Also psychiatrists and Ayurvedic practitioners pointed out that a person is frequently not aware of his condition. If a person lacks awareness, he also lacks the sense of co-responsibility (A#3: "*If he is aware, he might also be responsible*."). Many people do not realize that their lifestyles, behaviours, thoughts, feelings and habits affect their mood, meaning they are always co-responsible, since each person, to some extent, has a freedom of choice (at least in adult life). If we are aware of something, we have a choice, if we are not, we do not have it (P#1: "*The difference is dramatic if someone is passive, goes with the flow feeling sorry for himself, lamenting, blaming others and not doing anything about it, simply put – depressing*.").

The same psychiatrist highlighted an interesting fact connected to our culture, that there is an evident tendency to use objectifying nouns in the Slovenian language (P#1: "*I have depression, I have a bike, I have a cell phone* etc."). One of the psychotherapeutic directions argues that it is more suitable to use the verb "to depress", as it denotes an action, something a person does, and not an object that an individual possesses. On the contrary, the other fraction (i.e. disability activists) argued that the objectifying structure, i.e. "I have depression", is more appropriate than the verbal form, i.e. "I'm depressed." which indicates that depression is the entire identity of an individual (Longmore, 2000). However, this provides a different basis for co-responsibility argumentation, since a person can take more responsibility using the more appropriate linguistic formulation.

Some psychiatrists pointed out that depression is not just a problem but often also a solution to certain issues. Subconsciously some people have a secondary benefit from depression. For example, a person is relieved of certain activities (e.g. of work) or has a privileged position, for example, in marital, family and friendship relations (e.g. more attention). (P#1: "*This is very important, because depression is often based on some relational systems, that's why it is necessary to determine the positive effects of depression. We cannot assume the world would be better off without depression, because many people benefit from their depression.*").

In contrast, four psychiatrists strongly denied individual's responsibility for the development of depression. Firstly, depression is a set of different factors, and for this reason it is impossible to discuss responsibility in this relation. Secondly, the susceptibility to a particular disease each person is supposed to possess in himself, was

pointed out (P#7: "*Let's say one is more susceptible to cancer, another to heart diseases, the third to stomach ulcer and the fourth to depression. A person is not responsible for catching pneumonia as he is not responsible for breaking his leg or getting cancer, so in no case can he be responsible for suffering from depression*"). Thirdly, depression causes such severe suffering that no one would ever choose to develop it.

All these arguments are justified, however, referring to the last argument put forward by the psychiatrists denying any patient responsibility, it can be asserted that a person consciously does not choose depression, but he might be not aware of his contribution. This issue has been highlighted by psychiatrists as well as the Ayurvedic practicioners. All in all, it needs to be discussed in terms of responsibility and guilt. Some psychiatrists equate responsibility with guilt, meaning if a person is responsible for something, he is also guilty. In short, the main point of psychiatrists was that a person is not guilty, but may be responsible for his depression.

Aside from psychiatrists and the Ayurvedic practicioners, also most of the patient informants agreed that a person is co-responsible for the development of depression and were able to determine their co-responsibility for their depression. Three ways of taking responsibility were detected from the informant narratives: responsible, partially responsible or not responsible. Two informants had problems with defining responsibility (Adam, Zoja) and were not sure about their co-responsibility for the development of their depression.

Six Ayurvedic patients (Beti, Sandra, Bor, Silvester, Bobi, Martina) admitted being co-responsible for their problems. Beti left the hospital thinking: "*Mainly you carry your guilt by yourself and I finally realized that. I should have talked more, regularly confronted and discussed my problems, but it was not possible. My husband doesn't want to talk about such things. I don't have any friends, I have nowhere to go, so I had to get used to live in this way, but it takes many years to get used to.*"

Sandra replied that "*you cannot blame others for everything. Perhaps you are to be blamed the most, because you do not know how to lead a different way of life. Others absolutely cannot be solely responsible for your incapability of having the life you should have*."

Silvester believed that the answer is quite simple, "*I don't appreciate myself enough. I could also work from 7 am to 4 pm, but I'm in the workshop till seven, eight pm*."

Bobi said, "*I can only blame myself."*

Bor stressed his responsibility too. *"I am sensitive to what people say to me, especially in a group and lasting all day long. I am very weak in this area, I let things affect me. This is my contribution*."

Martina agreed, "*yeah, I'm sure I contribute to some extent*."

Two aspects are demonstrated here: responsibility and guilt. As discussed above, both psychiatrists and the Ayurvedic practicioners strongly emphasize the co-responsibility of an individual for his own problems, but only if an individual is actively involved in the problem. If this holds true, he can solve it by himself to a great extent which ultimately is very emancipatory. Many critics (Zollman, Vickers, 1999; Hill, 2003) contending complementary medicine argue that these practices "blame" people for their problems. If considering the presented cases, this would mean that an individual is "blamed" also for something that he actually cannot influence.

For example, Silvester did not injure his head by himself and Bobi cannot be blamed that his employer violated the law (working 11 years without benefits on student wage[53]), which greatly contributed to the development of his depression. As already noted, the Ayurvedic practicioners did not attribute "blame" to individuals for problems of social-structural nature; it seemed that informants blamed themselves for all these problems (a probable symptom of depression i.e. an exaggerated sense of guilt). However, the Ayurvedic practicioners and the psychiatrists pointed out that a person can change some things while others are beyond his power to be changed. Moreover, a person must also find a way to accept them. In short, change what can be changed (responsibility) and accept what cannot be changed (neither guilt nor responsibility).

Among psychiatric patients only three (Metod, Milena, Tanja) considered themselves co-responsible for the development of their depression. Metod: "*I do not know why or which part exactly, but something had to be in me that triggered this. I never succeeded to analyse this well enough to make a conclusion. I'm sure that this disease did not just appear from nowhere. I had to do something to contribute to this state. Sometimes, I think that the turning point was when I dropped out of college that terribly affected me. I remember dreaming about this, I had nightmares. Now, I have no problems with this, but at that time I considered this as a big failure in my life. I am sure that I greatly contributed to* my disease."

Milena pointed out that depression developed "*because I did not take actions. The last five or six years when I was still living at home my mother heavily burdened me. I did not know how to stand up for myself anymore, because it was never my way, I was always following someone else's wishes. And I've always been manipulated with, a marionette. 'Go here, go there'. And if I did something differently: 'Why is this so? You cannot do so.' I always had to do what others thought it should be done. Of course, I functioned in this way also in the beginning of my relationship. I forgot about what I wanted, about what I liked. I forgot about my friends; I used to hang out with them, but suddenly it was all over. I let this happen and it was my fault. And then I was basically gone, everything was just about others. Other people have been managing my life. When I realized this, it was too late. This was the main problem*."

53 Student work / wage is cultural specifics. This concept (way of work) is not recognized in other countries (cultures).

Tanja stated that "*I should not worry so much and be upset about things which I don't have any impact on. If you can influence things and you do not is one thing, but if you can't, you should not get upset. But, I always want to be involved and change things. I cannot ignore things. At work for example, some people sit at the computer all day and do nothing. They like it, they do not get mad with themselves, they do not think 'I'm unsuccessful', 'What are they going to say if I am ineffective?' or 'What will the boss think?'. A lot depends on what you are like and what boundaries you set. It is difficult to change yourself. There is no time. But this means that you have to break some ties. But which ones? What will make me better and won't hurt others? My eldest daughter is great, but very resentful, and I do not like to fight with her. She has a boyfriend, but he's a horrible human being. But I never meddled in these things. She is old enough; it's her life and her decision. Indeed he sensed that I wasn't very fond of him. Their visits became less and less frequent until they almost completely disconnected from the family. She stopped visiting our family; it was horrible. I wouldn't like to experience this again*."

With regards to partial co-responsibility for the development of depression, the psychiatric and Ayurvedic patients gave similar answers. The latter, however, associated co-responsibility with temperament (Karmen: "*Maybe because I'm so sensitive, because too many things bother me, because I am the way I am.*" Angela: "Maybe, yes, because I'm more sensitive and worry too much." Tomi: "Maybe my upbringing and probably, because I'm stubborn and headstrong in nature.").

Psychiatric patients associated their co-responsibility with:

- unawareness (Marija: "*I was surely doing something wrong, but without knowing it. I had been blaming myself for everything up until I went to treatment. Even my husband's drinking; I thought it was entirely my fault. Now, I do not think so anymore*."),

- late help-seeking (Lea: "*Maybe I should have acted as soon as it all started, but it all happened so quickly, without some transition. I suddenly wound up in depression. And it takes long to admit it. Today, I think that you can help yourself, but I think it's very hard to gather the energy to do this. Not that I feel guilty, because then I probably didn't think this way. I cried, did not sleep, didn't eat, had anxiety attacks, was restless, vomited. I immediately knew that I had to do something, I didn't let it progress. But, I needed a couple of years to realize that. If you want to face this by yourself, you need a lot of energy at that moment, because if you succeed going for a walk, it is a great success.*") and

- lack of experience and knowledge (Nela: "*If I knew at eighteen what I know today, I would of course use all my wisdom and knowledge. If you don't have the appropriate knowledge, you cannot do anything. I remember one movie: 'If I were young again, I would act differently' and the other replies, 'you would have done exactly the same'. I am partly responsible because I could not make changes, that I didn't learn to do things differently, as my professor advised me. The most difficult thing is to change the way we function, to learn how to do things better. This is the hardest thing to achieve.*").

With the exception of one informant, no one denied his contribution to and at least partial co-responsibility for the emergence of their problems. Individuals are often unaware that they are generators of their depressed states, as demonstrated by psychiatrists and the Ayurvedic practicioners as well as by a number of authors (Alloy, Abramson, Keyser, Gerstein, Sylvia, 2008).

The informants, who took the position that they were co-responsible for depression, also knew and explained the cause of their problems, meaning that they became fully aware of their problems and their co-responsibility. At this point it should be noted that informants discussed their co-responsibility from today's perspective, when the causes and factors of their problems have already been analysed and determined during their treatments. Before the treatment process none of them felt co-responsible for their disease.

In a way, socialism "salvaged" people from a certain responsibility by devolving it to institutions, authorities, etc. Now we can closely observe how this paradigm is breaking when the responsibility is being shifted to an individual in a number of areas (health, education, work). Meanwhile the proactive tendency emerged expecting that people take actions in raising the quality of their health, education and work by themselves. But, how does a person handle a situation in which responsibility is required, but the power of co-decision or influence is absent?

BETWEEN OBJECTIVITY AND SUBJECTIVITY

When a psychiatrist is dealing with a depressed patient, it is crucial to identify the distribution and involvement of bio-psychosocial factors. This normally requires an in-depth interview (similar to Ayurvedic) with the patient based on five axes, as psychiatrist noted. The first axis enables psychiatrists to define to what extent depression is associated with the genetics or the biological structure of the individual.

The second axis help define how depression is related to the psychological structure of the individual and to what extent the individual's historical developments (from childhood on) contributed to and influenced the development of his depressive personality structure (P#1: "*In some people it is clearly evident that they have a certain way of thinking, behaviour, feeling which is prone to develop something like this*."). The first and the second axes are connected with some basic susceptibility to depression partly associated with the individual's temperament and personality as well as with the effects of his growing up process. These factors can strongly influence, reduce or increase, the susceptibility to depression.

The third axis includes diseases that might be associated with depressive disorders. According to Kores Plesničar and Plesničar (2007), depressive symptoms are common in patients with coronary heart disease. Williams (2012) stresses that mechanisms linking depression and increased cardiovascular risk remain poorly understood,

however, the most current literature proposes several mechanisms. One of the recent studies (Kovačič, 2010) showed that 15 to 20% of patients admitted to hospital for heart attack meet the criteria for a major episode of depression diagnosis and people not diagnosed with coronary artery disease are at up to three times greater risk for developing coronary events. There is an important connection between depression and coronary heart disease, however, the majority of patients with chronic diseases face a much higher risk for developing depression.

Moreover, Ayurveda also emphasizes the connection between depression and the heart, the latter being considered as the seat of intellect in this tradition. As Charaka notes, affliction of the intellect is a result of damage to its substrate, the heart (Sharma and Dash, 2009: 410).

The fourth axis defines the triggers of the existing situation (P#1: "*We don't talk about the causes, but about the triggers.*"). Here, the stressors are being assessed, i.e. stressful events of the previous six to twelve months creating depression; for example death of a close person, divorce, accident, serious illness and the like.

The fifth axis is associated with the social aspect, as it enables the psychiatrist to determine the individual's involvement in his social network (P#1: "*The lonelier the person is, the higher the possibility for developing a depressive disorder and vice versa.*"). Today the frequency of anxiety depressive disorder is also associated with increased loneliness, as already noted in the first part of this chapter. One can be lonely even within a family, if the warm relations are missing. Several informants said that outside the family (or partner) they do not have friends.

At first glance, the diagnostic approach of psychiatrists seems fairly comprehensive since a multi-level approach within the framework of bio-psychosocial model is applied, and as such it could be compatible with the Ayurvedic approach. However, after a close observation and in-depth examination of the Ayurvedic approach the differences between the two approaches became very clear. Ayurveda tries to obtain a deep insight into the biological / physiological functioning of the body with regards to the Ayurvedic conceptualization of disease, i.e. disease occurs due to *dosha* imbalance. Ayurveda is very interested in the biological functioning of the body. Usually Ayurveda first examines the physiological factors and then the psychosocial, whereas in psychiatry this is not always the case. Occasionally, psychiatry makes additional clinical tests, mostly blood/urine test or thyroid test, but the interviewed psychiatrists stressed that this is more often the exception rather than the rule.

The field note results showed that the first visit to an Ayurvedic doctor is devoted to examination and diagnosis, following a standard procedure:

(*Darshan*) physical appearance (skin, eyes, teeth and tongue): upon entering the Ayurvedic consulting room the patient is asked to undress to his underwear, sit on the massage table and do a ten-breath *pranayamas* according to the doctor's instructions.

Meanwhile, the doctor has already started to examine the visible signs: the depth of breathing, the expansion of the lungs and spinal posture. During the *darshan* examination the Ayurvedic doctor observes the visible aspects of the patient's illness in order to construct a narrative that includes the less visible aspects. Moreover, as A#1 said: "*I accept what the patient says regarding the results of the modern tests*." In his practice Foucault's interior gaze[54] is not used for corroborative purposes only. When observing three Ayurveda practitioners in India Langford (1995) noticed that Ayurvedic doctor asked the patient about his complaints, he did not emphasize *darshan* more than the interview. Thereupon the patient is asked to lie down on his back. At the same time, the Ayurvedic doctor examines the lymph flow (both sides of the neck, armpits, side abdominal area and the groin), bloodstream (thigh muscle) and the glands, which are regarded as "the disease clogs".

(*Prasana*) questionnaire (an insight into the mental state and the clinical history of the patient): The questioning is always carried out, as it is an indispensable part of the diagnosis. The purpose is to go deep into the patient's life which is similar to the psychiatrist approach. The patient's behaviour reveals his mental state and his understanding of himself. While the Ayurvedic doctor is examining the patient's skin, eyes, teeth and tongue, he is being thoroughly questioned about his eating habits (favourite food, quantity of water intake, etc.), leisure activities (hobbies, sports, nature), relationship with parents, partners, children and other family members, friends, co-workers (features and way of communication), and career satisfaction. The questioning starts with the patient's childhood in order to obtain the continuity of an individual's life and to reach the deepest parts of the patient as possible. At the end, the patient is asked to fill out a questionnaire on his clinical history: previous diseases, prescribed medicines, areas of the pain (if present) and description of current problems.

(*Sparsana*) pulse measurement (insight into the vital organs of the body): while talking to the patient, the Ayurvedic doctor measures his pulse on both hands with three fingers. Pulse motion and tongue colour are not so much symptoms of a disease entity as glimpses of a disease process unfolding between the patient and the world (Langford, 1995: 337). An Ayurvedic doctor is not completely opposed to using modern diagnostic technology, particularly not to those that measure the efficacy of his treatments. However, it is noteworthy that modern diagnostic tools do not always give an accurate account of the patient's health state, for example, the haemoglobin level in the blood. In biomedicine, blood must reach a certain threshold to be considered as "healthy blood". A#1 recalls that "*blood changes throughout the day, in the short-term and in the long-term. There are differences in the blood of each nation, its pace and attitude to the*

54 Foucault's interior gaze refers to his term "clinical gaze". In the 19th century a physician has been given the power (with the help of technical inventions) to rely on his "clinical gaze" to see the "hidden truth" in the patient. A doctor could diagnose a disease, formulate solutions and talk wisely about medical problems; he could construct a particular disease on the basis of his anatomic-pathological perception. See: Foucault, 1994:107-124.

surroundings. In any case, everything goes too fast in Europe anyway. Everything depends on the DNA, on each individual, on the perception on the lifestyle of course and finally on the diet which regulates the entire process and also produces haemoglobin in the blood."

The diagnosis (of the disease) is determined by the biological structure of the body (*prakriti*), the state of *doshas* (*vata-pitta-kapha*) and the current condition (*vikriti*). The purpose of the detailed examination is to determine which *doshas* are present, which *dhatus* (tissue) and organs are affected and what is the *prakriti* of the patient. The observed Ayurvedic doctor did not perform the urine check as suggested in the Ayurvedic literature.

The difference between the two approaches is clear: Psychiatry considering psychological / physiological components of depression as important, but it is more oriented toward seeing both components as a separate and not as significantly linked like in Ayurveda. Ayurvedic doctors rely on both, the »biomedical« anamnesis and the psychological factors. This difference could be regarded as division into "spirit" and "biology".

In one study (Lafrance, 2007) the interviewees demonstrated an uncomfortable fit between objective biomedicine and their subjective experience of depression. They claimed to be without tangible evidence to confirm the "reality" of their condition. However, according to Parsons (1951), without objective evidence that a person's condition is beyond his control, sufferers' pain and identities remain suspected. To be exempted from everyday obligations, the sufferer requires legitimation which only a medical expert can provide.

Most of the informants sought biomedical help first from their family doctors. Only two informants turned directly to a psychiatrist for help, however, both had a friendly or a working relationship with the psychiatrist (working at the same hospital). Five Ayurvedic patients stressed or experienced doctor's doubts about the reality of their problems, which raised serious doubts about the reliability and credibility of the doctors' judgements, as some of the informants were repeatedly asking for help (up to three times).

However, this finding is not surprising at all, as Slovenian doctors in the primary health care were only recently trained to recognize depression, i.e. two years ago. All informants experienced doctor's doubts about the reality of their depression before that. Furthermore, there were aslo two examples of a patient's refusal to consult a psychiatrist (as advised by their family doctor), as both believed psychiatrist's help is not needed.

On the other hand psychiatric patients generally did not experience doubts from their doctors/psychiatrists. They stressed that biomedicine does not require laboratory tests, as a doctor needs to be qualified and trained to effectively recognize the symptoms and understand people. They highlighted the problem of patient insincerity, as they should be openly revealing their problems. At the same time they admit that people often do not know how to articulate their problems as Ayurvedic patients noted.

Additionally, they stressed the importance of trust between the doctor and the patient. If trust exists, it is easier for the patient to open up, to describe his problems and to trust the doctor. Both Ayurvedic and psychiatric patients highlighted the importance of doctor-patient relationship, which should be confidential, deep and sincere. However, both groups stated that the way patients verbally express their problems should not be an obstacle in identifying problems, as psychiatrists and family doctors are professionals trained to overcome such obstacles.

Ayurvedic practicioners also emphasized this attitude, while the psychiatrists placed great hopes in the discovery of practical diagnostic approach. Psychiatrists believed that modern neuroscience has considerably progressed in understanding the functions and the activities in the brain structures. This process of biomarkers is currently still in the research stage, but a method allowing to precisely determine imbalances in the functioning of the brain is believed to be available very soon. In addition to that, the first articles on biomarkers were published a few months ago presenting indicators that could record serious and deeper forms of depression with high accuracy and good sensitivity. Nonetheless, psychiatrist identified the financial problem as the most prominent issue in this field at the moment, but remained fairly optimistic.

However, the Ayurvedic practicioners and both groups of patients expressed concerns about all these different scientific methods arguing that they are all oriented towards objectification. The human experiential world is impossible to be precisely defined, as there is always someone experiencing something in a different way. Ergo, it is impossible to reach the very depths of the human psyche or mind - be it emotional, mental or physical nature.

Despite a large number of permutations, Ayurveda considers that medical professionals should depend on their own wisdom and instincts (A#2: "*A doctor must be a person leading a pure life, as only in this way can he determine what is wrong with a person. His finely developed consciousness perceives a person and his problem.")*, in addition to all the Ayurveda instruments at their disposal (examination of the eyes, tongue, pulse, etc.). Depression is not just a state of mind, but the state of a person as a whole (A#2: "[…] *because both the psyche and the body are very closely connected; depression is always a reflection of a person, which includes both*.").

Although the development of new diagnostic tools for the identification of depression represents a step forward even for those patients experiencing doctor's doubts, the development of these tools might cause an even greater deviation from a personal and profound relationship between the patient and the doctor. If the new technique is not used just as a screening method and the usual therapeutic relationship is discarded as invalid, an even higher degree of mechanization of the relationship might be reached.

VI CHAPTER

QUALITY OF PROFESSIONAL HELP AVAILABLE TO A PERSON FIRST FACED WITH DEPRESSION

The quality of professional help was evaluated upon a close observation and examination of the informants' search for help and of the experts' diagnosis method, where I mainly focused on the doctor / psychiatrist psycho education (i.e. diagnosis presentation and interpretation). In addition to that, the quality of professional help was assessed also on the basis of other factors, namely the choice of the treatment model, the role of non-governmental organizations and the reasons for seeking help in complementary medicine and Ayurvedic medicine.

HELP-SEEKING BEHAVIOUR

The epidemiological data of the National Institute of Public Health show that the incidence of mental disorders does not coincide with the rates of help-seeking in health care (see Table 6 below). The data indicate that less than 10% of people suffering from a variety of mental disorders seek help. Most of them seek help for psychosis, which is an exceptionally difficult disorder and professional help is urgently needed. People suffering from a milder form of psychosis (about 50%), however, can function quite well; in more severe cases people are searching for help. But mood disorders significantly less interfere with daily functioning, so people even less serch for help. A visit to the doctor does not necessarily result in a proper diagnosis and an adequate treatment. Often patients are not even referred to a specialist, and if they are, specialist treatment does not always mean a proper diagnosis and appropriate therapy.

TABLE 1: The prevalence of major mental disorders in the population and the actual number of patients who sought psychiatric help in 2009. Data include both sexes.

Mental disorder	Prevalence in population (Wittchen HU et al., 2011: 21, 655–79)	Expected number of patients in population	The actual number of patients who visited a doctor in 2009 for this disorder	Percentage of patients who visited a doctors compared to the expected number of patients with this diagnosis
Psychotic disorders	1.2%	24,000	10,420	43.42
Major depression	6.9%	138,000	13,628	9.88
Bipolar affective disorder	0.9%	18,000	1,736	9.64
Panic disorder	1.8%	36,000	1,300	3.61
Agoraphobia	2.0%	40,000	214	0.54
Social phobia	2.3%	46,000	287	0.62
Generalized anxiety disorder	1.7 – 3.4%	40,000	871	2.18
Specific phobias	6.4%	128,000	49	0.04
Obsessive compulsive disorder	0.7 %	14,000	434	3.10
PTSM	1.1 – 2.9%	40,000	5,785	14.46
Somatoform disorders	4.9%	98,000	1,047	1.07
Hyperkinetic disorders	0.6%	12,000	1,104	9.20

SOURCE: Šprah, Lilijana, Tatjana Novak and Mojca Z. Dernovšek (2011). Ocena tveganj za razvoj težav v duševnem zdravju prebivalcev Republike Slovenije. Analiza tveganj za razvoj težav v duševnem zdravju prebivalcev Republike Slovenije v posameznih statističnih regijah s pomočjo prilagojene metodologije Indeksa boljšega življenja. Elaborat..

This issue, however, is not present only in Slovenia, but also in other parts of the world. A recent survey conducted in six European countries (Belgium, France, Germany, Italy, the Netherlands, Spain) indicates that about half of people needing treatment for mental disorders do not receive any medical help (Schomerus, Matschinger, Angermeyer, 2009). There is a large number of people with mental health problems resorting to different forms of help and many studies investigate the reasons why people do not seek help for their problems. Sometimes, up to 10 years go by before a patient is given the correct diagnosis.

There is a number of reasons explaining why people suffering from depression do not seek help. According to Bernstein (2010) one of the most common reasons is denial or lack of awareness, which has already been indicated by all four groups of informants and described above.

Anosognosia (an impairment of the frontal lobe of the brain, which governs self-awareness) leaves a person with an inability to understand that he is sick. Dr Amador, who pioneered research into this syndrome 20 years ago, claims it appears in about 50% of people with schizophrenia and bipolar disorder. Experts believe that a similar problem sometimes occurs in people with clinical depression, although this is still in the research phase (ibid.).

A study conducted by Barney, Griffiths, Jorm and Christensen (2006) demonstrates that many people feel embarrassed about seeking help from professionals, and fear being stigmatised by their social environment. Moreover, some informants in this study expected professionals to respond negatively to them. The research team concludes that self- and perceived-stigmatizing responses to seeking help for depression are prevalent in the community and associated with reluctance to seek professional help. Interventions should focus on minimizing expectations of negative responses from others and negative self-responses to help-seeking, and should target younger people. Schomerus, Matschinger and Angermeyer (2009) established three factors regarding the negative attitude to help-seeking: “anticipated discrimination”, “anticipated job problems” and “anticipated shame”.

But, what people do when they fall sick? As demonstrated by some anthropologists (Lin, Tardiff, Donetz, Goresky, 1978; Chrisman, 1978), the healing process begins with home care (including the wider social care) which leads to specific therapeutic procedures in all cultures and social backgrounds. The healing process begins with the identification of symptoms. Recognition of the symptoms depends on the cultural

definition of "normal", i.e. a healthy situation and the understanding of the causes and the broader context of disease. Each society runs health systems, as defined by Kleinman (1980: 24), which consist of a single medical system (either formal or informal). Health systems cover all forms of social responses to disease (from therapeutic practice of formal and informal medicine to the so-called "home treatment").

Informants alleviated their symptoms with herbal antidepressants, herbal sedatives, environment changes (study or work), work, complementary methods (bio-energy, homeopathy, chiropractic and acupuncture) and philosophical practices (Buddhism, vegetarianism, yoga). One of the informants resorted also to alcohol, which is not surprising, since depression is an important factor contributing to alcohol abuse in Slovenia. There is a high percentage of alcoholics among depressed people in Slovenia, whose excessive alcohol consumption started as a form of self-medication. According to some studies (Agosti, Levin, 2006; Fergusson, Boden, Horwood, 2009) alcohol can inhibit depressive symptoms in the early stages of alcohol abuse, but it can greatly aggravate the symptoms in the later stages (when a person develops an addiction).

Experts are split on the issue which occurs first, alcohol addiction or depression, and provide different interpretations. Furthermore, also certain socio-demographic, health and individual factors can affect the drinking patterns of behaviour. Brown and Stewart (2008) argue that the use of alcohol is an attempt to escape difficult emotions or alternatively to produce positive emotional experiences.

Informants were more or less successful in the use of informal mechanisms to cope with their problems. Their depressive symptoms have or have not temporarily improved, but they did not disappear completely. Although these strategies temporarily improved their depression, they only prolonged and deepened their depressive problems in the long run. Some patients, who did not seek professional help, developed such a severe depression that made them incapable of functioning. There is a high possibility that they develop a deep depression that will have to be treated institutionally.

The vast majority of the informants tended to delay medical help-seeking within the formal system, which also coincides with the above-mentioned data on help-seeking by individuals suffering from mental disorders. However, a lack of supportive therapies and often unsatisfied professional services are also important factors heavily contributing to this issue.

FIRST VISIT - OFFERED HELP

In the previous part it was argued that the majority of informants first sought biomedical help by visiting their family doctor. Only two informants turned for help directly to a psychiatrist. It needs to be noted here that there is a long waiting period for a psychiatric examination in Slovenia. Most informants received only pharmacological treatment

and no psychotherapy or any other supportive method. Psychotherapy was offered only to three informants, but they all enjoyed a special relationship with the psychiatrist, i.e. they paid for psychiatric services or were in a friendly relationship with the psychiatrist, although it is inappropriate that a doctor treats his friends.

The results show that combined treatment is not always possible. Firstly, these are isolated examples of such combined treatment and professional help, which suggest that quality often depends on connections and friendships, and on the financial situation of the help seeker. In these three cases, the waiting period for their first examination was extremely short, which in turn significantly shortened their treatment process. This reflects the state of the health care system in the period of transition from socialist into capitalist society, which negatively affected people's socio-economic status. Capitalism has greatly exacerbated social state and many people are encountering poverty, exploitation and unemployment.

Secondly, it is necessary to bear in mind that medication therapy might be the most appropriate method for some patients, for example for those not stable or strong enough to undergo a less medicalized form of treatment.

Thirdly, a patient receives some psychotherapy from the psychiatrist, but it is integrated and concealed in the interview and other activities (psychiatrist homework, interviews with relatives etc.). Most patients do not register that this is a part of the therapeutic activity, because it is not explicitly determined as such, but also because they are not sent to any special groups and similar activities perceived as therapeutic. Counselling is also part of psychiatrist's work description. According to Vec (2002), a psychiatrist can employ a variety of communication techniques in his advisory interview to: (1) gain a clearer picture and a better understanding of the patient (better and more adequate decoding of patient's messages) and (2) (therapeutically) help the patient to realize, understand, change, etc. his functioning (communication, emotions, relationships, behaviour, etc.).

Fourthly, the way psychiatrists present counselling therapy to their patients poses another issue. Often a patient does not perceive a conversation with the psychiatrist as therapy or counselling, because it does not appear as a classic therapeutic session, but only contains specific psychotherapeutic interventions. The patient presumes the doctor dismissed him only with a prescription for medication, but the psychiatrist might have introduced him to a new cognitive, relaxation or some other technique while writing the prescription. My research revealed that only a few of the psychiatric patients were introduced to breathing exercises, autogenic training, relaxation techniques and self-help groups.

Fifthly, partly due to systemic barriers in terms of funding the health insurance covers a particular number of psychotherapies, so there is a long waiting list; similar applies hip surgery. This is the reason some people seek help via private psychotherapists and in

non-governmental organizations or in Ayurveda.

Sixthly, in Slovenia the access to psychiatrists is not evenly distributed across all regions, as shown in the Table 7 below. All four groups of informants (psychiatrists, Ayurvedic practicioners, Ayurvedic and psychiatric patients) believed that there is a lack of psychiatrists, psychotherapists and concessionaires,[55] in Slovenia, and official statistics confirm their observations. There are 190 psychiatrists in Slovenia altogether; 102 of them work in the Ljubljana region and a further 36 in the Maribor region. Regions without a psychiatric hospital (Primorska, Dolenjska with Bela Krajina, Koroška) are covered by one to seven psychiatric specialists (Ministry of Health, 2008).

TABLE 2: Access to psychiatric care in Slovenia

Psychiatry	*1*	*2*	*3*	*4*
Regional Unit of the Health Insurance Institution of Slovenia	*Number of inhabitants*	*Number of specialists*	*Number of specialist per 1000 inhabitants*	*Number of concessionaires/ teams*
Celje	*195,946*	*13*	*0.066*	*2*
Nova Gorica	*102,565*	*5*	*0.049*	*1*
Koper	*140,178*	*7*	*0.050*	*4.5*
Kranj	*198,713*	*17*	*0.086*	*1.5*
Ljubljana	*608,429*	*102*	*0.168*	*17.09*
Maribor	*319,282*	*36*	*0.113*	*6*
Murska Sobota	*122,483*	*2*	*0.016*	*2*
Novo mesto	*108,094*	*5*	*0.046*	*2.5*
Ravne	*135,484*	*1*	*0.007*	
Krško	*69,940*	*2*	*0.029*	
Slovenia	*2,001,114*	*190*	*0.095*	
Without LJ	*1,392,685*	*88*	*0.063*	

SOURCE: Ministry of Health, 2008: 1-2.

Despite the fact that every fifth Slovenian faces mood and anxiety disorders, there are only five active psychiatrists per 100.000 inhabitants. Zdenka Čebašek Travnik (2012), a psychiatrist and former human rights ombudsman, notes that the less developed regions encounter the greatest problems of doctor availability: "Poor accessibility to these services affects poor people, people with lower incomes and fewer resources, ergo people with several problems" (in Brežan, 2012). In addition to that, poor and less

55 Concessionaires are part of the public health care and are treated as such – they need to clearly define which provided services are not covered by health insurance.

educated people do not know where to seek help and what kind of help they actually need. In time they realize that their »strange feeling« is actually a health disorder that can be treated like any other disease. Much of this is still strongly present in the society, especially because a large part of Slovenia is rural and stigma has a considerable impact on people with mental health problems.

In the case of moderate depression without suicidal tendencies accessibility to psychiatric care is limited. Informants waited three months for their first psychiatric examination, and the psychiatrists stressed that this is a common practice. Only cases of acute depression or attempted suicides are treated urgently. The president of the Association of Psychiatrists, Blanka Kores Plesničar, highlights that in Slovenia psychiatric treatment is possible without a doctor's referral (ibid.). In my opinion only a person suffering from an extremely severe or acute condition directly approaches the psychiatric hospital.

In contrast, the majority of Ayurvedic patients already received psychotherapeutic interventions during their Ayurvedic treatment. Furthermore, patients who underwent manual Ayurvedic therapies (oil therapy, marma therapy, shirodhara, swedana, clay therapy, therapy on a heated table) have reported improvements in their well-being after the first treatment. Contrary to that, psychiatric patients experience improvements only after approximately three weeks when antidepressant start to take effect.

Both psychiatric and Ayurvedic patients were especially critical regarding excessive medicalization (Marija: "*Patients get a medication and nothing else.*") and expressed the need to largely replace it with psychotherapy. They understand the trend in the USA where it is common to regularly visit a psychotherapist. Sometimes a person finds himself in a difficult situation; he needs a conversation, an opinion, an advice, but might have no one to consult and confide to. Marija pointed out that "*you need a psychologist, psychotherapist to help you work on yourself, to help you think and to show you that you're thinking wrong. Things might not be like you see them.*"

The patients strongly emphasized that doctors should have a list of psychotherapists at hand (not psychiatrists or psychologists), although psychiatrists already have an overview of private psychotherapists and concessionaires. Obviously the informants were not aware of that. Both groups of patients do not regard psychiatrists as trustees, but only as a person treating them and having not much time to spare for them.

The problem of excessive medicalization of depression was highlighted also by psychiatrists and the Ayurvedic practicioners. Psychiatrists believed that in the second half of the 20th century people began "worshipping the pill", which they consider to be the result of the desacralisation of our society (P#1: *"Fewer and fewer people believe in God, on the other hand, we got an alternative deity - the pill.*"). In addition, psychiatrist highlighted the importance of health education and stressed that actions should be taken to educate and inform people about medicines.

The Ayurvedic practicioners did not answer the question about the quality of professional

help per se, but they did mention two issues: cultural differences and the unequal and discriminatory legal status of complementary medicine. A#1: "*If an individual wants to be treated with Ayurveda, he needs to take sick leave. To do that he needs to lie to his doctors and hide Ayurvedic therapies from them, because doctors might lose their licenses if they work with other methods*."

ROLE OF NGOS

The network providing programs and services in the field of mental health includes also non-governmental organizations. NGOs started operating in the 1990s and have become one of the most important institutions working in the field of mental health in the community. NGOs have established various counselling programs, day care centres, residential communities, legal support and other activities (Zorko, Jeriček Klanšček, 2009: 92). The most recognizable non-governmental organizations active in the field of mental health in Slovenia are ŠENT, Ozara and DAM.

As the NGOs cover the gaps in the mental health services all four groups of informants noted that NGOs contribute greatly to issues regarding mental health in Slovenia. Psychiatric and Ayurvedic patients placed great stress on the benefits of their psychotherapeutic support - listening to the patients, talking to them, creating a feeling of acceptance and showing them they are not an isolated case. Psychiatrists saw a great potential in NGOs, both in terms of prevention and complementarity. They, however, pointed out that much depends on the organization's professional expertise and on the reasons for patient participation.

According to the Mental Health Act, the activities and services provided by NGOs are mostly performed by volunteers, but there is a need for quality expertise and for professionalization of their activities, because now they are impaired in providing mental health care due to the staffing, organizational and financial factors (Ministry of Health, 2008: 2).

Psychiatrists highlighted also the increasing problem of children and adolescents suffering from depression. Studies (Tančič, Poštuvan and Roškar, 2009; Šešerko Viličnjak, 2013) have shown that most of them do not receive expert help although they urgently need it. In this regard, psychiatrists strongly stressed the valuable role of NGOs, especially their community programs designed to approach the patients, i.e. "outreach" in their living environment. (P#1: "*The most successful projects are street projects where therapists and professionals interact with children and young people*."). Similarly, the Ayurvedic practicioners described NGOs as a major contribution to the mental health field, but criticized them as being too passive and referred to the alarming state of the society. Hence, NGOs' projects designed to approach people enjoy great support also from the Ayurvedic practicioners.

WHY AYURVEDA?

The results of field notes and interviews with patients have shown that most of the informants did not seek help due to certain beliefs and personal views on treatment. The decision to use Ayurvedic medicine was based on experiences of their friends, acquaintances or family members.

When discussing the reasons for utilising Ayurveda the informants stressed the following: depression itself, dissatisfaction with psychiatric care, fear of the side effects of the medicines, somatic and psychological complaints, failed biomedical treatment, fear of drug dependence, search for natural, safer methods, search for a different view, different interpretations, explanations for their problems and curiosity.

Informants did not turn to Ayurvedic medicine due to their disagreement with the diagnosis, but because of the method of treatment, the impersonal relationship between the doctor and patient, long waiting period on first psychiatric examination, excessive medicalization and because of the lack of psychotherapeutic support. Most of them were receiving Ayurvedic treatment exclusively, and only one used Ayurveda merely as a supplement to psychiatric practice. Informants turned to Ayurveda because they believed it is body-friendly and more "natural", and because the psychiatric treatment might be stigmatizing. In general, informants did not resort to Ayurveda due to inadequate or lack of medical care but because they only received medical and not also psychotherapeutic treatment. In addition to that, informants searched for new explanations for their depressed states in Ayurveda.

Most informants (except Martina) had no prior knowledge of Ayurveda. The argument of Potrata (2002) and Luhrmann (1989) claiming that those who practice complementary and alternative medicine, New Age ideas (Potrata, 2002) or contemporary witchcraft (Luhrmann, 1989) learn the set of new beliefs and premises primarily through practice, is valid also for Ayurveda. Ayurvedic patients learned about Ayurvedic beliefs and premises in the course of their Ayurvedic therapies and did not opt for this treatment model because it corresponded to their views, opinions or beliefs. However, unlike contemporary New Age spiritual practices and witchcraft, Ayurveda has a long tradition, a substantial body of literature and a comprehensive system of beliefs.

The informants' life stories demonstrated that patients in the West increasingly receive prescriptions for medications. These in turn cause side effects and further deepen their medical problems. In addition to that, treatments are also likely characterised by impersonal approach and poor communication with patients. These are the main reasons for resorting to complementary therapy and are in proportional relationship with the gaps in the formal mental health system.

VII CHAPTER

THE COURSE AND OUTCOME OF TREATMENT

The course and outcome of treatment depend on the doctor-patient relationship, the role of the patient in the treatment process, social support and the quality and comprehensiveness of therapeutic support that can be full of obstacles and difficulties. In this regard, a comparison between psychiatric and Ayurvedic treatment and patient experience has been drawn in all four segments, the effects of Ayurvedic and psychiatric care have been recorded and an evaluation of psychiatric and Ayurvedic treatment has been carried out.

DOCTOR-PATIENT RELATIONSHIP

In the late 18th and 19th centuries, the doctor-patient relationship started transforming as a consequence of the transition from a rural-agrarian society into an urban-industrial society. In the 1930s, for example, the relationship was presumably better due to personal relationships between doctors and patients outside the medical context. Shortly, as a result of industrialization, biomedical revolution and urban planning (Callahan and Berrios, 2005: 50); and probably also due to the health care organization and the increased doctor workload, the doctor and the patient became mere strangers enjoying an "artificial relationship". Nevertheless, today, medical treatment of friends is not acceptable and is considered unprofessional.

Today, the doctor is no longer a mediator in the widely accepted cultural system of values. The bond between a patient and a physician is fashioned by the physician's specialist knowledge as a delegated interpreter of a commonly held set of doctrine about health and illness based on the dominant cultural model of the West. Frequently, the doctor is not a member of the same community, he knows little about the life of the patient and his family, and vice versa. Indeed, in a pluralistic society, the possibility of such a commonly held set of beliefs is increasingly remote (Callahan, Berrios, 2005). If you don't have a concrete link with the community beliefs, then maybe the transmission of scientific ideas as »cultural« ideas put scientific ideas in a very abstract, »objectively«, almost »sacred« position.

In contrast Singer (2004) claims that doctor-patient interactions also constitute an arena of hegemonic interactions. Studies of these interactions show that they commonly reinforce non-egalitarian hierarchical structures in the larger society by (1) stressing the need for the patient to comply with a social superior's or expert's judgment, and (2) directing patient's attention to the immediate causes of illness (e.g. pathogens, diet, exercise, smoking) and away from structural factors (over which the doctors feel having little control). For example, although a patient may be experiencing job-related stress caused by an onerous work environment, the physician may prescribe a sedative to calm the patient rather than challenging the power of an employer or supervisor over employees. In the past, according to Callahan and Berrios (2005: 50), doctors were more experienced in identifying disturbances in their patients' lives and used their position of influence as a placebo effect.

According to DelVecchio Good and Good (2000: 243), "clinical narratives", i.e. stories of therapeutic activities created by physicians for and with patients over time, lie at the heart of doctor-patient communication, and the analysis of clinical narratives provides a means of exploring key dimensions of therapeutic relationship.

Eight of the twenty informants (mostly Ayurvedic patients) pointed out that they discussed only their current states with their psychiatrists and stressed that there was no in-depth discussion of their issues. Psychiatrists did not focus on their histories and childhood events as being the sources of their subsequent negative, inaccurate cognitive

adaptations. This provides important evidence about the non-holistic patient treatment that is not oriented towards the identification of the broader patient life, which would give a deeper understanding of the individual and his needs.

Psychiatric patients were generally satisfied with their psychiatrists. Though three of them changed psychiatrists one to three times, their relationship with the present one was evaluated as positive. In other words, the psychiatrist took the time to carry out a comprehensive interview about the patient's current situation and his historical development and also explained the diagnosis and the causes of his condition.

As the negative side of the relationship, psychiatric patients highlighted insufficient discussion in later control visits, which they associated with the absence of psychotherapy. In addition, the secondary role of the patient and the lack of individual instructions or guidelines (presented in the next part) as well the absence of check tests designed to monitor patient progress were also considered as problematic by some psychiatric patients.

Compared to psychiatric patients, Ayurvedic patients were much less satisfied with the doctor-patient relationship. This was at the same time one of the reasons they opted for Ayurvedic treatment and also the reason for their unsuccessful biomedical treatment. Ayurvedic patients reported having a comprehensive interview with their Ayurvedic doctor / therapist, which was oriented toward the understanding of their current and historical conditions. This interview is typical for the Ayurvedic approach and is very similar to the psychiatrist evaluation. Two informants (Silvester, Tomi) reported having no discussion about their childhood with their Ayurvedic doctors, and both noted that there was no in-depth discussion of their issues.

During my several-month Ayurvedic practice observation a special phenomenon was noticed that could be in some way connected to this anomaly. Three months after the Ayurvedic consulting room opened at a new location, the interest has increased to such an extent that the initial in-depth and holistic care became impossible. The massive influx of clients forced the Ayurvedic consulting room to make compromises due to the lack of time. This did not reflect in the therapeutic work considerably, but it did in the psychotherapeutic treatment, which was also a subject of great criticism by Silvester and Tomi. In short, lack of time primarily affects the psychotherapeutic treatment quality in both practices. In short, very comparable with the psychiatrists – they do not have the time; time is only for therapy (in the case of biomedicine medical therapy, in the case of Ayurveda massage).

When evaluating and comparing the relationship of psychiatrists / physicians and Ayurvedic doctors / therapists most informants highlighted the following key differences:

- Less formal relationship (Tea: "*More relaxed. For example, if you* do not address someone formally *it seems to me that you cannot bluff, lie or hide things. And I liked that in an Ayurvedic doctor best. 'We will be on a first name basis,' he said, and only when you are on a first name basis, you can truly open up. I liked this very much. You don't have*

to worry about: 'Hmmm, I'll tell the doctor this and keep that for myself.". You're closer and the atmosphere is more relaxed. You get more information from someone, if you're on a first name basis, if you're close to someone. I think his approach is great. He listened to me more attentively and he gave a more accurate answer. But, he did not use many words. His explanations were simpler, not so rigid, not so strict, not stuck to one thing. Simpl, and easy to understand.")

- Greater willingness to listen and understand (Sandra: "*Yes, this is the difference. An Ayurvedic doctor understands you better, he accepts you and your words. The general practitioner just listens to what you have to say, but you don't know what does he think. Maybe he thinks that she already has what she needs. You are just a number. When you show up for an appointment, he has to give you something. You show up, get that and leave. Here in Ayurveda, the doctor-patient relationship is different. You leave the Ayurvedic doctor with a feeling of relief. You don't get that from a general practitioner. An Ayurvedic doctor is different. When explaining your troubles, you see that he is listening to you, that he understands you, that he is helping you in a way. Already this gives you a feeling of relief. You have to reveal everything to the doctor so that he knows what is going on with you, but I could never open up to a general practitioner in such a way as I opened up to the Ayurvedic doctor*.")

- Mindfulness (Karmen: *"The difference is huge. In Ayurveda, everything is more on the personal level, the Ayurvedic doctor feels you intensely on the energetic level. But he never says anything straightforwardly. My Ayurvedic doctor did this only once – he told me that I was not down to earth, that I was floating and that I needed to get a grip of myself. On my first Ayurveda therapy I brought my medical reports. He looked at them and said: "You suffer, you suffer like a dog and yet you laugh". And I said "yes". It was the first time someone has said this to me and I found it very funny. I thought: "Oh, finally someone who sees right through me, someone who can tell my problems!". In general, it seems that Ayurveda therapists really focus on you in that hour and a half. And this really makes a difference.")*

- More personal and active dialog, conversation (Beti: "*The two approaches are totally different. At the psychiatrist's – you get there, he sits, reads and receives a few phone calls, "How are things at home?" he asks, he briefly scans you, "You seem well today. Do you need some drugs? Has something special happened?" then he writes a prescription and you leave. In contrast, I had long conversations with the Ayurvedic doctor and discussed things in depth. In these conversations he was able to point me in the right direction, he showed me that I'm wrong about some things, that I'm not doing some things right, he suggested to take a different position or approach and argued that not everybody is always right. He never ever said: "Do this and don' do that." We had spontaneous conversations, which I missed from the very beginning of my treatment. In fact we usually had a long walk, we walked a while, we sat a while, and the conversation about my feelings grew intense and deep. I had the feeling that he was really talking to me. And even if he did not understand, although I know that my Ayurvedic doctor understands me, this kind of conversation is completely*

different from the conversation where the other person is quiet, does not respond, react or direct you.")

- Support and hope for control over and solution of the problems (Tomi: "*When I first visited the Ayurveda consulting room, I told them how I felt and talked to them for a while. Then the girls started to massage me. They said that everything is going to be all right, that I should not worry. Other than that, I honestly don't even remember. Compared to the general practitioner, the conversation was much more open, I could talk to them easily. When you visit your family doctor, they do not even have the time for you, as they have many other problems and they just want to dismiss you as quickly as possible. I remember having a relaxed conversation at the Ayurveda consulting room. It's great to have someone to talk to, to tell them what's on your mind. Because the problems you have, you need to solve* by yourself anyway.")

- The time component was emphasized by the majority of informants (it is necessary to bear in mind that the informants have paid for their therapies).

- Pragmatic guidance (advice) on how to control a certain situation (Bor: "*I'd been telling my story. When a problem occurred, when he felt that I became restless, he explained how to solve the problem or suggested to continue talking about this issue. He calmed me down. There were quite a few of such moments. He taught me a few tricks about handling problems, which are simply fantastic. For example, I spoke about the existential threat, which probably derives from the Buddhist theory. In this regard he really helped me with this theory. A human being doesn't need a lot to reach happiness, only food and water. As I understood him, happiness is given by God, it doesn't depend on the money or material goods. I have been a vegetarian for three years, so this concept suits me perfectly and I totally agree with him. He's good and I highly respect him which is good, as you need to respect the man who is trying to help you if you want the help to be successful*.").

When evaluating the relationship between psychiatrists and Ayurvedic therapists, one informant did not identify any difference. He regarded both relationships as identical (Bobi: "*I equally opened up and shared.*"). However, the Ayurveda expert provided guidelines to overcome his problems, whereas the psychiatrist did not provide any helpful advice - this is one of the main differences in the directness or indirectness of the therapy.

Most psychiatric and Ayurvedic patients were familiar with the diagnosis, although most of the informants had already received the diagnosis before they turned to Ayurvedic medicine. While six psychiatric patients were explained what depression was, none of the Ayurvedic patients received such an explanation. The reason for this lies in different approach to treatment and disease understanding in Ayurveda. Ayurvedic doctors/ therapists indirectly revealed the core of the patients' problems, but they did not employ biomedical explanations.

Medical psychiatric researches show that certain elements of the doctor-patient

relationship are closely linked to communication (Anderson, 1976: 1). It is possible that psychiatrists or Ayurvedic doctors / therapists explained to their patients about the disorder and its features, but the patients simply forgot because they were preoccupied with their symptoms at that time. Furthermore, it is a known fact that cognitive functions are severely curtailed in the acute phases of depression, i.e. poor attention and greatly hindered working memory, which is closely connected with the processing of new information and stimuli (Pelosi, Slade, Blumhardt, Sharma, 2000; Rose, Ebmeier, 2006).

The majority of the informants received psychiatrists' interpretations of the causes of their problems or of the factors influencing the development of their depressive states. Two informants (Nana and Zoja) felt that they did not receive an adequate explanation for their condition, yet Zoja was explained that her psychiatrist could not determine the cause of her problems. Half of the informants' stories (Metod, Marija, Leja, Milena, Tanja) explicitly reflected the application of the bio-psychosocial model in psychiatrists' interpretations of the causes. These explanations described depression as a combination of several factors and life events that have accumulated over a certain period of life. Since these situations were not processed or were inadequately processed, they affected the patients' mood. Two informants (Nela and Alma) had established on their own (through online research) that the cause of their problems is their parents' divorce or the fact that they are children of divorced parents. Adam was ambivalent about the cause of his depression – in one way he considered his problems as normal, but in another way he attributed the cause to family genetics and his personality structure.

Other stories do not reflect the application of the bio-psychosocial model in depression interpretations. The reasons for this can be considered from different aspects. Firstly, the members of the same profession, i.e. psychiatry, are not unanimous. Every psychiatrist is a member and a supporter of a certain psychiatric school. Secondly, perhaps not all psychiatrists have completely adopted the bio-psychosocial model yet, although the psychiatric literature has been exhaustively discussing this subject over the past ten years. Thirdly, the application of the bio-psychosocial model in the interpretation of depression has not been conveyed effectively to the patient due to time constraints, limited patient participation or memory impairment. Fourthly, the psychiatrists are well aware of the shortcomings of the bio-psychosocial model and prefer to the work within a broader socio-cultural model.

Most interviews with the Ayurvedic patients explicitly reflected the psychosocial model of explanations of the causes rather than the bio-psychosocial model. The interviews with two informants, Silvester and Tomi, reflected neither model of explanation because an in-depth questioning or conversation with an Ayurvedic doctor was not conducted. The fieldwork results show that they were quite reserved in speaking about themselves.

In general, the individual approach in Ayurveda and the collective approach in biomedicine are distinctively noticed. Moreover, Ayurveda uses similar tools as

biomedicine when approaching an individual. However, the analyses of informants' narratives revealed that Ayurveda strongly and primarily focuses on the individual rather than on the disease.

THE ROLE OF THE PATIENT

The role of the patient in the treatment process is extremely important, which was confirmed by both, psychiatrists and Ayurvedic doctors / therapists. According to psychiatrists, the role of the patient is determined by the degree and the form of depression, therefore the greater the patient's progress in the treatment, the greater his role in this process (P#10: "*A patient plays an active role with regards to his capabilities. At the beginning his capabilities are very limited they are defective. We gradually activate them, we increasingly encourage him to actively participate in the treatment, he increasingly takes on the responsibility for his treatment*.").

The patient is provided with as much information as possible to increase his understanding of the condition, but psychiatrists emphasize that the patient's understanding depends also on his intelligence (P#8: "*If someone is mentally less developed, he is not able to participate as actively as an intellectual*."). Ayurveda also draws attention to the individual's intelligence, especially in terms of change initiation (A#2: "*For example, people of weak mind, the mentally limited, they need a loving yet strict mentor.").*

The patient's role in psychiatry is significantly different as his role within other medical branches, as patient cooperation in psychiatry is of crucial importance (P#9: "*You need to understand that we do not have any objective ways of determining psychiatric diseases. In addition to what can be observed in a patient, it is very important that he describes his symptoms and reveals how he feels and how he is*.").

Cooperation heavily depends on the relationship between the patient and the psychiatrist. Both needs to cooperate – the psychiatrist has to recognize the core of the patient's problems and the patient has to discuss them (P#10: "*Some people talk a lot and expect a lot. They focus on the problems or memories in the past. But some don't say much. Often you don't really know what their problem is*."). Some people refuse accepting psychotherapy because they are simply not prepared to work on solving their problems (P#10: *"Fifty percent of the patients refuse psychotherapy after the completed medication therapy.")*. This has been highlighted also by the Ayurveda practitioners.

Patient cooperation is crucial in any case, as the patient needs to be actively involved already during the medication therapy. A psychiatrist sees the patient once a month for fifteen minutes. In the meantime, the patient is responsible for himself, meaning that the role of the psychiatrist is to actively prepare him to take a proactive role (P#3: "*I like to tell my patients that, when the treatment of the first depressive episode is finished, they need to know about their problems more than I do*.").

In this regard a significant difference between psychiatry and Ayurvedic medicine has been found. Ayurveda provides significantly greater support to the patient in generating motivation for change (A#2: "*I always give them an option to call or send an e-mail. I remember being in regular contact with one lady at the time when she was struggling with those states. This is also a way to support people in these crisis situations, so that they can successfully go through them*.").

Also the fieldwork results obtained in the Ayurvedic consulting room suggest that a friendly and confidential patient-doctor relationship supported by continuing telephone conversations and communication via social networks has beneficial effects. Daily support provided to the patient appears to be much greater in Ayurveda than in psychiatry. However, it should be noted that such relationship is not completely possible in psychiatry, as psychiatrists need to strictly respect the boundaries of their professional code. Despite that, some psychiatrists enable patients to contact them via e-mail or text messages. In short, there are two related reasons - weaker professional boundaries between Ayurvedic therapist compared to psychiatric therapists, and weaker boundaries between directness and indirectness of the therapy.

Only a few psychiatrists emphasized that patient guidelines should always be individually determined. People are different, therefore interventions should also be different (P#3: "*For example, people suffering from depression are often very passive by nature, meaning that already their temperament forces them to bury their heads in the sand when problems occur. These people prefer that someone else solves their problems for them. But, people suffering from depression can also be extremely active in their nature, even hyperactive these people are used to have command of all the things in their life.*").

Psychiatric interventions for active patients are directed towards re-establishing control over their lives. A psychiatrist needs to inform the patient about his disease, provide relevant information and engage him in minor therapeutic tasks to help him gain control over his life. Interventions for passive patients on the other hand are oriented towards maximizing and enhancing their activities.

Psychiatrists placed the greatest emphasis on physical activity, which should always be adapted to each individual's abilities and past experience (P#3: "*I wrote 'physical activity' on the prescription as a joke quite a few times.*"), group therapy (e.g. autogenic training) and relaxation techniques, which need to be selected according to the type of depression (P#3: "*A relaxation technique doesn't help a person suffering from a melancholic type of depression, a person completely apathetic, not feeling anything and not pleased by anything. This person has nothing to release, he needs to be activated. On the other hand, a person suffering from depression accompanied by anxiety needs both – activation to release the internal stress and relaxation to calm his mind and body.").*

Some also recommended keeping a mood diary, engaging in crossword puzzles for brain exercise, taking a short sick leave, reading popular psychology science literature, coping

with potential stressful events and using complementary methods. The most important guideline, however, is the development of a stress reduction plan which aims at reducing the stress factors and enhancing the beneficial factors, meaning engaging in activities in which an individual finds pleasure.

Ayurveda also considers physical activity very important (A#1: "*Doing regular exercise – jogging, cycling, walking; spending time in nature – taking a walk in the woods in the moonlight; recreational water activities*."), in addition to spiritual activity (A#1: " *Practicing pranayama and meditation, listening to relaxation music, engaging in various activities such as yoga, qigong, tai-chi ...")* where it does not distinguish between the different forms of depression and the adequacy of the release, following dietary instructions (A#2: "*Not skipping hot meals, eating slowly*, *having regular and small meals, not consuming greasy, reheated, un-rich or cold meals, reducing the amount of bitter and astringent foods, having the main meal at lunchtime and a light dinner at least three hours before bedtime*.") and following the daily and seasonal regime (A#1: "*Wearing appropriate clothing for each season, going to bed earlier, avoiding humidity and cold – especially not exposing nose and throat in winter time, following an orderly daily routine that enables some leisure time each day and does not create unnecessary pressure, laughing and having fun*.").

In order to recover from depression, the patient needs to change his lifestyle, and for this reason, his role is extremely important. Most likely, the patient relapses if he continues to follow the same lifestyle. However, when physically more active his prognosis significantly improves (P#4: "*An active patient being able to undertake activities that please him and bring him satisfaction will recover from depression much easily and much quicker*.").

The individual's ability to balance his life is of crucial importance – the ability to balance the five pillars of life: work, family, recreation, spirituality and hobbies, as one of the psychiatrists vividly illustrated (P#10: "*Our society pressures people to work harder – the more you work, the more you're worth*). *But, the more time you dedicate to your work, the more you neglect the other four pillars, and this creates an imbalance*.").

Therefore, each depressed patient is advised to consciously re-establish all the pillars, with the exception of the work pillar, by force (P#3: "*He needs to force himself in physical activity – every day at least half an hour of physical activity in a group in order not to think about his problems*."). As Ayurveda emphasizes, the patient should want to improve his well-being (A#1: "*The most important thing is that a patient wants to change his life. The Ayurvedic therapeutic program is designed in such a way that the patient raises his awareness by himself*.").

In general, the importance of the patient role was stressed in both psychiatric and Ayurvedic care. Informants most frequently reported two guidelines received from their psychiatrists, i.e. physical activity and social contacts. The third guideline, though rarely reported, was proper diet. One of the informants keept a diary. The main

difference between the two approaches was that Ayurvedic experts recommended all the guidelines and techniques mentioned above (meditation, yoga, physical activity, dietary guidelines, communication, etc.) to all informants, while they provided individual guidelines to each individual patient according to his type of problem in comparison to psychiatric patients who did not received individual guidelines (with the exception of three informants who received individual directions due to friendly relationship with the psychiatrist or they paid for psychiatric services).

Ayurvedic patients reported a variety of guidelines received from their Ayurvedic practitioners. To alleviate the stress of unemployment, Bor was advised to study the Buddhist theory explaining that materialistic success is not connected to happiness. In short, Ayurvedic practicioners used reframing (general method of changing the meaning of something and thereby changing minds and moods) and spirituality.

To overcome his fear, Bobi was instructed to return to the same spot in the woods where he experienced great fear and to lie there calmly to defeat it.

Martina was advised to become an independent person; a person of her own body not led by other people, and received a book *Self-Knowledge* as a gift.

Silvester was recommended to work less, to relax more, to take walks in nature and to find peace.

Sandra was encouraged to leave the house more often, to leave her family alone from time to time ("*I never went anywhere alone, because I felt that it is not well accepted if* a *woman is unaccompanied.*") and to stop constantly worrying about them. In addition to that she was urged to change her way of thinking.

Karmen was instructed to go out more frequently, to socialise more and to have fun. In addition, walks in nature were also suggested.

Tomi was advised not to worry too much, assured that all issues will resolve and instructed to be tolerant and patient with matters he has no power to change.

Teja was urged to directly express her disagreement, regardless who is she arguing with "*Speak out, talk to people*."

Angela was suggested to follow a diet and to engage in different activities as much as possible where she will have less time to think about her problems. In addition, she was instructed to start thinking positively.

Beti was advised to listen to herself and to be present in everything she does ("*Don't rush, do everything you do calmly and slowly, take time for yourself, go somewhere and just observe things and people*.")

However, the role of psychiatric patients was much less oriented toward individual

problem-solving. Despite the fact that four informants (Marija, Tanja, Metod, Milena) reported receiving comprehensive guidelines, it is necessary to bear in mind that they were all treated by the same psychiatrist.

Metod stressed that "*my psychiatrist always wrote down guidelines for me. When I expressed a problem, she tried to illustrate clearly and in detail how to address the matter. A typical example was my fear of the unknown, which represented a major problem for me for a long time. For example, the outcome of a project. I was terrified, afraid to death of the unknown."* The psychiatrist advised Metod to try autosuggestion (and autogenic training which is in fact complementary method), "*to learn to convince myself to get past a difficult situation, that I have to do a one step forward. I actually practiced a lot and got by the difficult phases quite successfully. Sometimes it wasn't helpful at all and sometimes only partially*."

Tanja said that "*I worked too much and I had to learn to work part time, only four hours. So I started working seven hours, then six, five and finally four hours. At that point I dropped what I was doing and simply left. If I'm not mistaken, I worked part time for four months*." Her psychiatrist advised her to change her job. "*And when you get a new job, you have to set things differently and establish relationships between colleagues in a different way, so you won't feel pressured again. But it is difficult to establish a relationship, if the other side is not willing to. If you work only with one or two people and if you get along, that's great. But, if you meet six, eight new people every three months, it's impossible to stay in touch with all of them.*"

Marija described how she started combating her problem: "*The first week, I went to the mailbox and back every day. The second week, I went to the shop, stood outside the shop, looked inside and went back home. These were my first steps toward independence. Then the psychiatrist put me in a relaxation group. That was good, because there were ten of us with similar problems. When you see that a professor and a doctor have similar problems as you do, you feel great.*" At the same time the psychiatrist advised Marija to consider her needs too and listen to herself. Marija awoke from her inert state with the help of computer games. "*They helped me to replace my worst-case scenarios with something else. When the children were in kindergarten, I played Tetris or Mahjong for four, five hours a day. When I played games I could not think about other things and that helped me a lot."*

"*I knew that all along*," responded Milena to the question about psychiatric guidance. "*I knew that no one will do anything instead of me. They can stand by my side, but they can't solve my problems instead of me. I knew what to do very well. I started getting my life together, taking care of my appearance and being physically active. The psychiatrist advised me all that – to be active, to do as much as possible for myself. This is my life. I have to make things happen. Everything is up to me. No one will do anything instead of me*."

In conclusion, the role of the patient in the treatment process is extremely important, as it is closely connected to the treatment outcome. The Ayurvedic healing system has many different means and methods available to treat mental distress, but all treatment

methods are oriented toward a comprehensive treatment of each individual's distress. Ayurveda aims to activate all senses of an individual and to this end an individual is being activated in all areas of his life. A part of psychiatry also places great stress on physical activity and proper diet, but unfortunately it lacks supportive methods. In this respect Ayurveda has a great advantage as it has much more to offer, but maybe that is not acceptable for all.

Ayurveda emphasizes the individual's active role in the treatment process and explicitly expresses the impact of the patient's lifestyle choices on the course and outcome of his treatment. In this respect, the individual needs to assume responsibility over those segments of his life which can be influenced and controlled. This approach was strongly advocated also by psychiatrists.

COOPERATION OF RELATIVES

Psychiatrists and Ayurvedic doctors/ therapists in Slovenia and India have stressed the importance of cooperation of relatives in the treatment process. Psychiatrists have pointed out that the involvement of relatives in the treatment process depends on the degree of depression. In the case of a deep depression the patient is usually hospitalized and relatives always actively participate in the treatment, as the treatment plan often heavily depends on them (P#3: "*Even if a suicidal person is in outpatient care, the anti-suicide pact is developed, which always includes family members.*"). Even in the case of moderate depression, the cooperation of relatives is generally highly desirable, particularly to support the individual in his activation (P#3*:"If we are planning patient activation, we usually include a family member or a close friend whose job is to encourage the patient and to say: 'Get up!' or 'Come on, let's go out for some fresh air, you've* had *enough of lying around.*").

At the same time, the cooperation of relatives provides the psychiatrist a deeper insight into the individual's living environment (P#9: "*You can see what is true and what is not true, because people with depression often have a distorted sense of reality.*"), as family relations and partnership can be one of the most important sources of mental distress, as pointed out by some psychiatrists.

One of them illustrated this issue with a meaningful example of the Moorehouse couple (Stritih, Možina, 2000). Mrs. Moorehouse was suffering from depression. Her husband perceived his wife's potential recovery as a threat and was subconsciously pushing her back in depression. Because he was suffering from low self-confidence it suited him well that his wife was depressive and always at home, not tempted to commit adultery. People living with a depressed spouse for example can enjoy certain psychological benefits which are deeply rooted in their subconsciousness. Consequently, family relationships can root and deepen the mental disorder of a particular family member (P#1: "*You have to pay special attention to this. I always bear in mind the duality of depression and include*

relatives to see what is really going on, to recognize the mechanisms contributing to the maintenance and the deepening of depression and to see if there are some patterns that can help the depressed person recover.").

Besides, psychiatrists and Ayurvedic practicioners have shown that this type of treatment is necessary in the treatment process, because it brings greater success and better outcome of the treatment (P#1: "*The activation of close family and friends is one of the most important factors influencing the success of the therapy and vice versa, which is also supported by literature*."), however, the problem lies in its realization. Even if the individual's health status is improving, there is a higher risk of relapse, if the family support is lacking. In this context, both psychiatrists and Ayurvedic practitioners referred to the Italian treatment practice, where the family approach is a common practice. The reason most likely lies in the nature of the Italian society which attaches greater value to family relations (A#2: "*This branch of medicine is very important, because the environment defines the person and the immediate environment, the family, so much more.*").

However, the treatment practice in Slovenia is quite different in this respect. The cooperation of relatives is less common, mainly because it is relatively difficult to motivate family members to make their contribution. If they really want to help their depressed relative, each family member needs to define what they can change about themselves and about their relations towards others (P#1: "*The family usually identify one person and declare him sick, point their fingers at him and expect him to change. Instead of that, each family member should point his finger at himself and admit: 'I also contribute to this problem.' This, however, presents a problem, because each member needs to admit co-responsibility for the problem of the depressed relative*."). People frequently find this interpretation shocking and unacceptable. Rather than admitting their co-responsibility, they change therapists and continue believing that only one family member has problems.

The involvement of relatives is extremely important in the treatment and care of children and adolescents, because mental health disorders among this population are most highly correlated with family relationships. As one of the psychiatrists critically presented, the problem lies in the focus shift from family therapy to individual therapy that has been taking place in the last twenty years (P#1: "*Psychiatrists decreasingly attend trainings in family therapy and increasingly treat children and adolescents on an entirely individual basis. And this is quite scary. If treating a young person solely individually and only with medications, without parents participation, you pave the way to chronic problems of adolescents and children*.").

Most psychiatrists considered the involvement of relatives as generally necessary, but highlighted two problems – they often do not have the time and their cooperation largely depends on the patient's wish and permission (P#8: "*A patient has the right to refuse the participation of relatives. According to the Patient Rights Act we cannot force him. However, this is rarely the case with depressed people, and we actually always work with*

families too."). Generally, in the treatment of children and adolescents their parents are involved, in the treatment of middle-aged people their partners and in the treatment of elderly people their children or grandchildren.

The importance of the involvement of relatives in the treatment process was strongly stressed also by Ayurvedic doctors and therapists both in Slovenia and in India. They mentioned also that depression often derives from the family environment and family relationships. According to one of the Ayurvedic doctors, AI#1, in India "*the treatment of depressed individuals should include also the treatment of family members, if not, the individual returns to the same environment and consequently the problems quickly reappear*."

Another important factor of the cooperation of relatives is their support for the patient and the impact that their family background might have on the individual (A#2: "*Family members can have an impact. In the more traditional societies relatives come with the patient to therapy, they are supporting him, they are doing mantras for him, they are keeping him strong, and they are performing rituals for him. The modern society doesn't know this kind of support. The patient is actually all alone*.").

This is the fundamental social and cultural difference between India and Slovenia. According to the narratives of Indian informants, patients never seek help alone. They are always accompanied by at least one family member. In Slovenia, the situation is quite the opposite and much more difficult (A#1: "*In my opinion, the reason for this situation in Slovenia is quite simple. Here, people consider depression shameful and not as a medical condition that can affect anyone, especially under present circumstances in the country. In Slovenia, it is better to have cancer than depression, because everyone visits the cancer patient and offers to help, but no one visits or offers to help a depressed one. It's as if they were lepers*.").

Given that both, psychiatrists and Ayurvedic doctors / therapists pointed out problems appearing in the process of cooperation of relatives that are mainly socio-cultural in nature (individualism vs. collectivism, traditional society vs. postmodern society), were quite expected. Family members were not involved neither in the psychiatric nor in the Ayurvedic treatment, however, in Ayurveda, they were involved separately, meaning that family members were not present with the informants in therapy, but joined the therapeutic process separately as individuals with their own health conditions.

One family member of almost half of the Ayurvedic patients also received therapy, either a partner or a parent. This makes the key distinction between Ayurveda and psychiatry, demonstrating a significant advantage of Ayurveda. Due to the positive experiences of Ayurvedic patients and the holistic approach of Ayurvedic medicine, which regards diseases as a consequence of the dosha imbalance (thus not as fragmented as biomedicine), every person with any kind of problem can contact the Ayurvedic doctor. Everything a person needs is in one place, in one person, meaning that it is not necessary to visit the family doctor first and then various specialists. The question,

however, is whether Ayurvedic doctors have adequate understanding and knowledge of all the diseases.

Psychiatric and Ayurvedic patients pointed out that relatives should be included in the treatment process at least to inform and educate them about depression - what depression is, how can they help etc. Quite often relatives deny the problems of the depressed family member, dismiss them and show no understanding, which was clearly evident in the cases of some informants (Martina: "*Family members need to accept the individual's problems, try to understand him and support him on his way to full recovery*.").

The cooperation of relatives in the treatment process especially comes to the fore when the patient recovers from depression. After the recovery he perceives and interprets his environment differently and responds to it in a different manner. Family members often find it difficult to adjust to these changes, due to inconveniency and also because it is easier to control and handle a depressed person. However, new problems arise when a recovered person starts reacting to the stimuli from the environment (Marija: "*When you stand up for yourself and object, a disaster hits*."). The patients would be very pleased, if the doctor approached their relatives and advised them help, but in their view, this would not achieve the desired result (Alma: "*Law of quantity – will you start changing the whole first or only a small part of it*?").

PROBLEMS OF TREATMENT

I have observed obstacles and difficulties in treatment that psychiatrists and Ayurvedic practicioners encountered at three different levels – at the level of an individual, at the level of the society and at the professional level. Some of these issues are already mentioned in the previous paragraphs, but in the following paragraphs they are presented more comprehensively, as they are described through the patient's experience and special attention is being paid to potential differences among the issues.

At the level of an individual

At the level of an individual, the psychiatrists have identified a number of problems. The first problem was seen in the hesitation to seek help (P#3: *As with any other disease, the longer you hesitate, the more the disease will advance*.").

The second problem is the refusal of medication therapy. Some patients are *a priori* against medications, because they feel that conversation works better for them. Over time patients find out for themselves whether they really need to take any medicine.

The third problem is taking advantage of depression diagnosis and its secondary benefits. Indeed, a psychiatrist is the expert whose opinion is taken into consideration by the commission, deciding on an the extension of sick leave or the disability commission (P#4: "*There are several such examples, where you realize that in the end that some did*

not even take the prescription (we have access to that information); that some came just to complain. We believed them, wrote them prescriptions, sick leaves, health reports. Some come just to avoid having to work full-time. This is a problem. You realize that some still take advantage of you.").

Some patients obstruct treatment because they want to have secondary benefits, and do not in fact want to get better (P#8: "*Imagine a typical Bosnian woman. I won't say they are all alike. A woman has had back pains and has been suffering from depression for eternity or the condition has been recurring. She says she wants to feel better, but in reality she has obtained secondary benefits due to her depression. If she is depressed she does not have to go to work or cook, her whole family takes care of her. If she was no longer depressed, her husband would start drinking and beating her again. She is not motivated to get cured from her depression - she will just treat it with medicines and do nothing more.").* This is not surprising, because people can adopt depression as their identity for various reasons.

The fourth problem or a challenge as some psychiatrist see it, can be identified in the specifics of each individual. Frequently, some people are depressed because of their personal characteristics and some even have personality disorders (P#8: "*People feer and interact with others in very difficult ways. That is sometimes actually an obstacle. Due to the characteristics of their personalities, patients are mistreating themselves in a masochistic manner or – should I say – they enjoy their depression*."). Such disorders are associated with their personal history.

The fifth problem is seen as the influence of family members, who are not being cooperative (P#8: "*Patients may be constructive, willing to work, but if they have difficult family members who obstruct them over and over again, that might cause them problems and distress*").

As the sixth problem, they indicated the premature abandonment of medication therapy. Some patients have a false impression that when they get better, they no longer need therapy (P#4: "*The biggest progress, compared to the beginning of treatment, is seen after the first three months of antidepressant treatment. But there is a great danger that the patient will arbitrarily terminate his therapy*"). However, seven informants stopped taking medicines on their own.

The seventh problem presents the abuse of medication and an increased use of several psychotropic substances like alcohol, caffeine and sometimes illicit drugs.

The eighth problem, which could be seen as a culmination of all the problems mentioned above, is the unpreparedness and lack of motivation of an individual to get a deeper insight of himself. Many of the patients took treatment in a very superficial way, e.g. "Just give me a pill" (P#1: "*The patient needs to be prepared to invest a lot of effort in small steps to learn how to cope with stress, how to manage his feelings... so that he as a person in a relationship does not exert himself too much*."). Sometimes it is impossible to convince the patient to change and consequently antidepressant medication is necessary.

Psychiatrists believed that psychotherapy is very important in the long run, if depression is associated with the lifestyle of an individual, which has been strengthening for years. Psychotherapy is monitoring and encouraging stabilization of changes in the patient's daily life (P#1: "*This is also one of the problems, since people really need support from the very beginning.*").

Ayurvedic doctors and therapists did not point out any key issues about problems at the level of an individual. One of them, A#2, has pointed out that "*sometimes I deem a problem to be associated with the pitta people or people, possessing some type of pitta aspect - since for pitta people it seems impossible to solve a problem in such an easy way - which is what I associate with suspicion or doubt*." To those people the price seems excessive, and the investment is too high. They are not willing to put so much effort into it as they are not sure about the outcome.

These are not actual problems, but merely characteristics of an individual person (A#2: "*Although pitta people are strong-minded, this does not guarantee them recovery because they tend to expect to resolve their issues far too quickly. If they have not experienced a serious turn or a fall, they simply consider that this will not work. I can give them guidelines and encourage them to continue treatment, to calm down their excessive rajas. If they do not contact me, treatment usually ends there. They do not consider having some faith in this matter. These are people who may present a problem. Not so much to me as to themselves*; *because they will get no benefit from any of their treatment.*").

In this case the psychiatry and Ayurveda are only similar in the point where they both discuss the problem of temper and characteristics of the individual. The two approaches appear in different roles: those who seek help in Ayurveda are actually looking for help and are willing to pay for it as well. I do not suggest however that people who seek help in psychiatry do not actually want it.

At the level of society

At the level of society, psychiatrists discussed the stigma that is still present as the most salient problem, even though society has become somewhat more tolerant to depression in recent years. People still have prejudices and feel ashamed (P#3: "*No one likes the asylum, or the psychiatrist.«I'm not crazy, why would I go there, what will people say, in a small town everyone knows everything, there is no medical confidentiality...*"). The biggest misunderstanding of depressed individuals is still most commonly encountered in the working environment (P#9: *Not all employers are informed about their depressed employees who go to the hospital and sometimes they are not understanding enough*."). Furthermore, people still find it difficult to tell their friends that they are depressed, that they are sick.

Indian informants also highlighted stigmatization as a major problem. People in India do not seek help within their own city; they almost always go to some other place. AI#1: "*If I meet a patient outside the hospital, he will not greet me because others will immediately know that he is being treated; otherwise, he wouldn't know a psychiatrist.*

Social stigmatization of the mentally ill is a major problem."

Another problem is the general climate in a society, which is creating precarious life situations, such as unemployment and mobbing (P#5: "*I think mobbing has increased significantly. In the time of economic crisis some very non-ethical personality traits of people (on positions of power) come out. It is awful to hear what is going on.*"), various pressures and frustrations and consequently the early symptoms of depression and anxiety are rising. Psychiatrists believe that there are not enough precaution measures established in the society to protect the mental health of the people.

Ayurvedic practitioners in Slovenia highlighted two other problems, which are mainly socio-cultural. The first problem is the active use of nutritional guidelines. People do not understand what it means to cook for *vata*, *pitta* or *kapha* because it is not a part of their culture (A#2: "*I dedicate about an hour for the diet, an hour for a diagnostic review and an hour to prepare and find out what needs to change. For example, there are no cookbooks translated into Slovene. To those who speak English, I can recommend or send a pdf of a cookbook. Those who do not speak English may choose cooking courses - but whether they attend them and find something for themselves, I do not know. This is an operational problem that could be easily solved if someone decided to write a book on how to cook according to Ayurveda with plants that grows here in Slovenia. Most of the ingredients should be local.").*

However, fieldwork findings have demonstrated that A#1 solved this problem by writing and publishing a detailed review of an individual *dosha's* diet, i.e. what is appropriate for each *dosha*, which combinations of foods are and which are not recommended, which spices and oils to use. A#1 educated his patients through printed publications with general directions for each *dosha*. He took the Slovenian food into consideration and organized culinary workshops to teach people how to cook according to Ayurveda principles; but not many people attended those workshops. A#2 pointed out: "*We need to equip people with the knowledge that enables them to switch easily if they decide for a change in their diet and to give them an idea of what can be cooked quickly to suit their pace of life, since some classic recipes are difficult and time consuming*."

The second disadvantage is that people who use manual and complementary methods refuse to inform their family doctors about their combined treatment (A#1: "*Slovenians need more information to help them understand that 70% of people in India practice the Hippocratic medicine combined with Ayurveda, as a preventative and curative method for maintaining their health and well-being*.").

Ayurvedic practicioners also discussed the cultural differences; among them are the lack of openness and awareness, the customary hiding of distress and the differences between living in the city and life on the periphery.

At the professional level

Psychiatrists highlighted the homogeneity of the profession and the heterogeneity of conceptual beliefs about the treatment as the first problem at the profession level. The field of treatment is confusing – there is an issue about whether to rely on a treatment based on medicines only, one that only involves psychotherapy, or a combination of both (P#1: "*In the past, mild forms of depression were considered not to be treated with medicines. Some still support this idea today. Each individual therapist has their own ideas.*").

As the second problem, psychiatrists stressed that combination therapy is impossible due to the lack of clinical psychologists and psychotherapists. Clinical psychologists and psychotherapists are not available for everyone and the insurance companies do not cover the costs of psychotherapy (P#5: "*There is still no rule book for a professional qualification of psychotherapy that could serve as a guideline for the insurance companies, although there have been several attempts in the past ten years.*").

The third problem at the professional level is seen in the pharmacy. On one side, antidepressants are effective for severe or moderate forms of depression, but on the other hand antidepressants can be very harmful, if they are prescribed to people with mild depression. Psychiatrists wonder whether psychiatry and psychotherapy contribute in maintaining this negative climate inside the society (P#1: "*Instead of emancipating the patient through various forms of treatment, antidepressants make people feel comfortable and able to adapt to the situation of contemporary world, which of course is not always a good thing*."). They underlined the need for in-depth methods of treatment and non-pharmacological techniques.

Furthermore, psychiatrists see this widespread prescribing of the antidepressants as a problem because although they are relatively safe, there is no sufficien awareness that these drugs alter patients' emotions (P#11: "*Not to a great extent but a certain change still happens*"). At the same time, they pointed out that people are often confused about which drugs are *de facto* addictive. Indeed, anxiolytics cause both psychological and physical dependence, which is why the authorities are now trying to completely ban them as treatment. While antidepressants do not cause any physical addiction, it is advisable to gradually stop using them. According to Jordanova and Dernovšek (2001) the reason why dosage should be gradually reduced before the complete withdrawal of the antidepressant is not because a dependency has ensued, but because withdrawal reactions depend on the nature of the antidepressant.

Antidepressants have a specific mode of action and do not become effective in twenty minutes like aspirin or sleeping pills. According to Resman (1997) antidepressants cause clinical effects not only by influencing the neurotransmitter systems (mechanism of inhibition of reuptake or direct effect on the receptors), but some of them also directly influence the cell membrane or enzyme systems. Anderluh (2010) stressed that Selective serotonin reuptake inhibitors (SSRIs) are the most frequently prescribed antidepressants

and currently present the golden standard for therapy of depressive disorders. New treatment guidelines for depression also recommend SSRIs as the starting treatment. SSRIs influence serotonin transporters in a selectively inhibitory manner, which allows a re-uptake of 90% of released serotonin from the synaptic crevices. Elevated level of serotonin activates not only postsynaptic but also presynaptic 5-HT receptors.

This is why the increased concentration of serotonin in the synapse does not immediately lead to a stronger transmission of the signal in the postsynaptic neuron. Neurons respond slowly by reducing the sensitivity of the presynaptic receptors (downregulation), which takes a couple of weeks and that explains why the effect occurs only weeks after the start of the therapy (Anderluh, 2010: 68). The problem of treating with antidepressants is that they work with a time lag, i.e. they need weeks to become effective (Harmer, Goodwin, Cowen, 2009). To an individual patient this period often seems too long, so psychiatrists believe that it is very important for the patient to not only get the prescribed antidepressants, but also to receive psychotherapeutic treatment every day of his crisis, if necessary. Therefore, combination therapy is of tremendous value, depending on the severity of depression.

The fourth major problem is seen in contemporary medicine, which does not research the placebo phenomenon sufficiently. In the case of antidepressants (and anxiolytics), the placebo effect can be substantial - up to 60 percent, according to psychiatrists. But the problem of medicine is that it does not know what triggers the placebo effect.

One of the psychiatrist relied on meditation, which he advised to his patients. He gave an interesting example of individuals for whom the condition usually worsened during the first two months of regular meditation, but that was actually a sign that the meditation had begun to work. For example, he indicated the importance of the "mindfulness" concept, which has become quite popular throughout America and Great Britain and also in psychotherapy in general. Mindfulness is a skill, while meditation is a tool that serves to develop mindfulness skills.

Ayurvedic doctors and therapists particularly warned about the problem of outpatient and institutional Ayurvedic treatment and about qualifications of Ayurvedic therapeutic staff. There are no possibilities for institutional Ayurvedic treatment in Slovenia, which is essential (A#2: "*Patients must be in an Ayurvedic institution, where they receive certain food, certain herbal preparations that help them clean the pranic channels in their heads and stabilize the neural pathways. Those preparations make a person more satvic, which means that the EEG waves get slower or stabilized and energized.*").

Ayurvedic doctors also see a problem in psychiatric outpatient treatment, especially due to the extended use of antidepressants and suggest that biomedicine should give more attention to prevention, working with patients and monitoring them and support people in improving their conditions and initiating a positive change in their lives (in agreement with psychiatrists).

Ayurveda has certain purification techniques, such as *panchakarma* and changes in nutrition, which enable the thickness of these substances to be reduced. Ayurveda can also suggest herbs that could be very effective in strengthening the nervous system. But the problem is that with outpatient treatment the therapist does not know if the patient is following guidelines regularly (A#2: "*I do not know what happens outside the consulting room.*").

The Ayurvedic doctors cited insufficient access to the Ayurvedic medicines as the biggest problem. Some of them are now registered, (for example *asvagandha)*, but still remain impossible to obtain in Slovenia. The practitioners must therefore look for alternatives (A#2: "*I have some contacts with people of Hare Krishna who go out there [to India] and I can obtain certain things through them. But this means it takes weeks before they come back. I also advocate that it is possible to replace as many Ayurvedic herbs as possible with local ones, which is actually better because local herbs are more suitable for us. But in some cases that is not possible, since you cannot find an equivalent*.").

At the level of European legislation, many Ayurvedic medicines have already been registered, but they cannot be bought in Slovenia. They can be found in the form of dietary supplements on the Slovenian market, which is not sufficient for a comprehensive and institutional Ayurvedic treatment. Some Ayurvedic medicines are sold as nutritional supplements (in both Slovenia and Europe) and as such are not of suitable concentration, required for Ayurvedic treatments. One of the Indian Ayurvedic professionals in Slovenia therefore remarked, A#4: "*Take for example Mind Care, a dietary supplement which is intended to prevent depression and to strengthen the brain and memory functions; the laboratory test has shown that the content of herbs in this product is extremely low.*"

Pole (2006: 215-226), an Ayurvedic doctor who started his practice in England, is upset that Ayurvedic medicine in the West is faced with so many challenges, especially in terms of legal regulations, education, environment, clinical operations and culture. One of the challenges when trying to make a system of knowledge global is to "translate" its epistemology and to make it acceptable for different cultures. The education and the recognition of healing skills among countries differ very much, which can result in halting the import of certain Ayurvedic herbs that may be prohibited by law. As Ayurvedic medicine never requires only one, but always a combination of different herbs, its practice in Europe is hindered. [56] Because of the new legislation in the European Union, all traditional medicines have to meet certain quality and safety requirements. In some cases, the consumption of certain medicinal plants has become so widespread that their use has become an environmental issue and some particular species in India have already been identified as being endangered.

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56 Ayurveda allows the use of medicinal plants from the individual's environment. It could be possible that with a good knowledge of European folk traditions, many medical Ayurvedic medicines could be prepared from local plants.

Problems of treatment from the perspective of the patient

Psychiatric and Ayurvedic patients between and within the groups experienced different levels of satisfaction with taking medicines and with their side effects. Psychiatric patients have reported side effects (in particular a decline of libido), which was the major cause for a replacement of medication. However, all psychiatric patients agreed that the positive impact of the antidepressants outweighs the disadvantages (Alma: "*A brain is a brain afterall.*"). They claimed that their will to live has been restored. Some started to enjoy life more after only a month, some after a year, yet others only after several years.

Due to the unsatisfactory effect of medication or because the help offered to them was not enough, three psychiatric patients also turned to complementary and alternative medicine (bioenergy, homeopathy, accopuncture).

In contrast, Ayurvedic patients turned to Ayurveda precisely because of the problems with taking antidepressants or unsatisfactory effects of traditional medicines. All Ayurvedic patients reported side effects (problems in sex life, increased body weight which further destroyed their self-esteem, loss of physical strength, drowsiness and general apathy), all of which occurred while taking prescribed medicines. None of the Ayurvedic patients treated within Ayurvedic medicine reported difficulties or discomfort during the treatment process.

Ayurvedic patients were much more critical towards the use of antidepressants compared to the psychiatric patients. Ayurvedic patients saw drug dependence as a major problem of psychiatric treatment (Sandra: "*A person gets used to pills and cannot function without them for long.*"), claiming it is ineffective (Sandra: "*I was very pleased with the results for about six months, but then it turned worse*.") and that it takes too long before any improvement is seen.

Psychiatric patients did not see treatment of depression with antidepressants as a problem, although they also indicated some concerns, which were not exclusively related to the drugs. Instead, they believed that family doctors presented the main problem, since they did not have adequate knowledge of psychopharmacology (Marija: "*When a psychiatrist talks to the patient, he knows what the patient needs."),* which prolongs the treatment process. At the same time, they were critical of the over-prescription of antidepressants. They felt that it is extremely irresponsible that a family doctor has the power to prescribe antidepressants because that could cause a lot of harm. However, they could also see a positive side to family doctors prescribing the anti-depressants since waiting times to see a psychiatrist are very long (Alma: "*I was supposed to wait for six months, so my family doctor decided to prescribe the medication for me*.").

Both psychiatric and Ayurvedic patients stressed the importance of complementing pharmacological therapy with psychotherapy. They believe antidepressants merely masque the real problems on the short run because they cannot solve the deeply seated

life problems (Marija: "*People should take appropriate psychotherapy after which they could stay drug free.*"). Psychiatric patients also believed that pharmacological treatment of depression with antidepressants alone is only successful in few cases, usually connected with the genetic form of depression. Ayurvedic patients explicitly pointed out that people need other forms of help, such as (confessional) conversation, yoga, meditation and breathing exercises. Both psychiatric and Ayurvedic patients stressed that patients themselves need to change; otherwise, with time, they will need increased doses of medication.

Ayurvedic patients were much more critical towards psychopharmacological products because they were much more focused on the natural approaches to treatment and ways of helping themselves. Psychiatric patients believed that taking antidepressants had more positive benefits than disadvantages and were very critical to (family doctors) who do not have enough knowledge about the basics of psychopharmacology; how to avoid taking less appropriate medicines and over-medication. A moment comes when patients must show their trust in either nature or in science, technology and the effects of the pill.

On the contrary, Ayurvedic practicioners drew attention to the safe and relatively rapid efficiency of Ayurvedic methods. They considered them to be much friendlier, both for the people and the planet. Scientific studies of Ayurvedic treatment methods mainly suggest the same. Ayurvedic patients, similar to the psychiatric ones, pointed out the problem of very late effectiveness of antidepressants and reminded that sometimes a person needs immediate intervention.

A common problem for all four groups of informants is the lack of combined treatment and medicalization.

CHANGES UNDER PSYCHIATRIC AND AYURVEDIC TREATMENT

Most of the psychiatric patients (seven of them) reported changes in their personal lives, a few less (four informants) reported changes in the way they interact; mainly the improvements in the relationships with their partners.

Changes in the lives of Ayurvedic patients who were monitored during and after receiving the treatment, the follow-up period and the implementation of the guidelines, have been significant in many areas. All informants reported changes in their personal lives and improvement in their well-being or their mood. They gained new strength and energy; the somatic and psychological complaints disappeared almost entirely. More than half of the informants (six of them) reported changes in the interpersonal area.

Ayurvedic informants also reported many other changes, such as those related to their jobs, cognitive style (how they see themselves, the others and the environment, they

gained new perception of themselves and learned how to think positively), changes in emotions and in coping with problems and also changes in their eating habits. But it should be noted that both groups of patients stressed they have to work daily on changing different patterns (for example, thinking patterns), otherwise some problems could reoccur.

All Ayurvedic patients observed changes in their well-being after the first treatment. Today, they still notice changes but at the same time they admit that they still need to work in this area if they want to avoid repeating the old situation. They also highlighted their own experiences as a source of help for others in similar distress (Martina: "*This gives you a feeling of satisfaction because you have passed the test, and you can talk about it and share things with others and understand them.*").

In addition, this part focuses on the informants' relationships with themselves. In psychiatry, this is often referred to as the return of control over one's life. In Ayurveda it can be defined as re-establishing contact with oneself (one's inner knowledge), which can frequently be experienced as fragmented in a constantly changing psycho-social environment.

However, Ayurvedic and psychiatric patients believed that the inner contact with themselves had been strengthened. Psychiatric patients stressed that it was necessary to first get to know oneself in order to start changing the behavioural and thinking patterns (Metod: "*Drugs are just a tool, but you really need to put a mirror in front of you and ask yourself whether you are happy with the face you see or not. When you face this and admit to yourself that this is not what you want, that you want more, this can only be positive because you're looking for something better yet you didn't even realize that before.*").

Ayurvedic patients felt that they were slowly beginning to realize the importance of knowing themselves and their needs. They began to intensively think about what was happening to them and why their depression had occurred. After the experience with Ayurvedic medicine they believed that they understood depression much better (Martina: "*Ayurveda rebuilds you as a person.*"). At the same time, they pointed out that Ayurveda was more committed to the person and his soul than psychiatry.

Meanwhile, psychiatric patients stressed that every patient should have spent a period of time in an environment, for example an Ayurvedic institution, where a person could re-establish the relation with himself again. This means that each individual should spend some time alone in isolation. They stressed that every individual should disconnect from the outside world in order to become closer with his inner self from time to time for at least a week (Metod: "*In order to calm down for a period of time, get yourself in shape, literally. This is why holidays are for.*").

Further care for the patients proved to be either positive or negative. Ayurvedic patients raised the problem of the diversity of views, thoughts and approaches of individual psychiatrists (Angela: "*Some seem very different.*") as well as the constantly repeated questions during control visits, in which they did not see the point (Martina: "*She kept asking me the same questions*.").

The results of the psychiatric help evaluation or satisfaction with psychiatric care were difficult to interpret because some informants were constantly switching psychiatrists, which may be seen as resisting therapy. According to Newman (1994) such behaviour is not simply an impediment to treatment, but also a potentially rich source of information about each client. This information can be assessed and utilized to strengthen the therapeutic relationship, help the therapist to better understand the ideographic obstacles in the attempts to change and devise interventions that may motivate the client towards therapeutic activity and growth.

Moreover, more than half (six psychiatric informants) positively evaluated psychiatric help, but it is necessary to keep in mind that four of them were in a different (personal) relationship with the psychiatrist. Those patients either paid for psychiatric services or were in a friendly relationship with the psychiatrist, which is inappropriate. Psychiatrists should not be in a "personal relationship" with the patient, which means that a friend should not treat a friend.

With the remaining four informants, their judgements varied from very negative to positive, because patients had very different experiences with several psychiatrists. I detected a huge problem, because not every psychiatrist provides a quality professional help (and not all psychiatrists are very good) to a patient who is facing depression. As it has been shown, patient's negative experience with a psychiatrist could negatively affect the outcome of a treatment. The views of psychiatrists are very different from one another. Therefore, one patient could have been diagnosed with a disease by one psychiatrist, while the other one might see that same patient's situation as a normal condition (similar can happen with Ayurvedic practitioners). This proved to be an even bigger problem, because the patient himself cannot decide whether something is wrong with him or not, so he might be completely confused. This situation can also affect the treatment, the course and the outcome of depression.

From the testimonies of informants it is obvious that the patients' experiences with doctors and therapists differ. Paid services could be of better quality and more comprehensive (but often the private health care is specialized for something that is not complicated and more profit-oriented), which proves there are inequalities in access to health services.

However, both groups of patients believe that identifying the underlying causes of depression is very important. Psychiatric patients stated that medicine should be more

holistic and take more time for every individual patient (Alma: "*The medical care today relies on subspecialisations, and family doctors don't spend enough time with the patient – only 3 minutes per each.*").

Psychiatric patients have deliberately sought psychotherapeutic help because they believed it is necessary and has different approach (Marija: "*We were looking for a psychotherapist because they have a more human approach. Without psychotherapeutic help it would not have worked out for me.*"). They were convinced that combining medication and psychotherapy is the most optimal approach.

Ayurvedic patients were convinced that conventional and alternative medicine should be integrated (Bor: "*I support the idea of integration. It seems to me that one can't work without the other.").* For example, both groups of patients referred to the neighbouring Austria and the US and pointed out that in the US the insurance companies cover the cost of Ayurvedic treatment, and also place much more emphasis on preventative medical care.

Ayurvedic patients stated that Ayurveda presents a different way, which addresses people with a different approach, different questions (Beti: "*If the question is raised differently, it is better for patients, because they relax differently.*"), more peaceful and more humane compared to the traditional doctors (Martina: "*For example, when you go to see a doctor, he may be in a good mood, but he still asks certain things sort of gruffly.*") although we know that even the Ayurvedic practitioners cannot always be in a good mood.

They believed it is very important that a person knows how to listen, so that an individual can speak honestly about the problems. Because family doctors do not have enough time, they ask very superficial and short questions, which prevents them from getting a deeper knowledge of the individual. Ayurvedic patients attributed Ayurveda with a deeper and more comprehensive insight into individual's problems (Karmen: "*He really saw me while my doctor did not see the real condition I was in*"). They believed it also provided a greater support for the individual in terms of practitioners' availability in critical moments.

THE ABILITY TO CONTROL AND MAINTAIN A STABLE MOOD

Similar to psychiatrists and Ayurvedic practitioners, both groups of patients supported the individual's ability to control and maintain a stable mood. Both groups of patients have cited a number of approaches and methods which help maintain harmony in their lives.

Psychiatrists answered this question differently. One of them relied on positive psychology, which is again gaining prominence with concepts such as: optimism, enthusiasm, psychological well-being, personal growth, personal power and creativity. It is about exploring positive emotions and positive moods, because psychology has

long been focused on exploring negative emotions. One of the psychiatrists (P#1) cited a study conducted among the adolescents in Israel who maintain a positive and stable mood (Hexel and Nathanson, 2010). The study compared a large group of young people, who were involved in one of the altruistic activities (helping others) with a group of adolescents who were not participating in them. The result has shown a highly significant statistical difference for adolescents, who were being active in the community by helping others; they were in a notably better mood and had a more positive attitude.

The psychiatrist also pointed out another interesting example from the novel *San Michele* (1929) by a Swedish doctor Axel Munthe, which tells a story of a well-situated female patient. Her doctor tried every method possible with no success. One day he took her with him to a very poor community, where she helped him with treating wounds. The woman was instantly healed and began helping the community. (P#1: "*Even Freud said, if you want to have a stable life, express your love and do what makes sense to you.*").

Another psychiatrist pointed out that patient with mild and moderate depression present a bigger responsibility. Nevertheless, it could be argued that depression is a process in which time plays an important part, so the deeper or more difficult form of depression could actually present the culmination of mild and moderate depression. Therefore, a person needs to transit through the mild and moderate levels of depression to become deeply depressed, because the maintainer of such condition could be the individual alone. Psychiatrists emphasized different approaches, e.g. Ayurvedic medicine, meditation or physical activity (P#12: "*Anything that helps.*"). One of them pointed out that many tend to forget that even patients with depression have the right to exhibit labile mood and sadness sometimes (P#11: "*Sometimes we expect them to be too stable.").*

In contrast, Ayurvedic practicioners pointed out that the selection of a particular approach depends on the cause. The cause may be linked to the exhaustion of the system or its slowness, its excessive vehemence or sophistication, exhaustion due to one's own character or the cause is linked to the presence or the absence of hereditary conditionality (A#2: "*The method of supporting someone trying to maintain a stable change depends on what kind of person that individual is.*"). It could be said that Ayurveda has a more sophisticated system of detecting and treating different types of depression. Ayurvedic practitioners stated the US as an example of a country with a lot of *kapha* type of depression. This requires purification techniques to evacuate the excessiveness from the body, particular dietary changes and especially *pranayamic* techniques for raising the nervous system and the fire inside the body and also greater physically activity.

They also pointed out the importance of associating with positive people, which instils hope in liberation from depression. This means that the patient follows a path to regain hope or vision, a belief that the problem can be solved and that there is a way out. When the patient gains hope and vision, he develops good resources or motivation, which is very helpful.

Ayurvedic practicioners stressed that for patients, included in an outpatient treatment, maintaining a stable mood is very difficult or even impossible for some, because there are some limitations (A#1: "*It is about the number of people and the colourful diversity of these experiences; not all cases are simple.*"). Family and social ties are very important, as finding an activity that makes them happy.

In addition to antidepressants, psychiatric patients also cited a positive attitude and thinking, auto-suggestion and relaxation before bedtime among methods which help them to disconnect from everyday worries, to reset themselves (Metod: "*I could not sleep because I believed I was supposed to save the world.*"). The informants also believed in an extremely positive impact of breathing exercises and physical activity (jogging, brisk walking), but they pointed out problems with discipline. They were certain that they needed the most was to find ways to divert attention from negative thoughts.

They were, in some way, grateful for having suffered from depression because otherwise they would not have learned all these lifestyle changes and positive thinking. They reported that they had become stronger, more stable and able to stand up for themselves when needed. "Illness-related benefit" has proved to be enormous. Interestingly, some patient informants reported that because they became more determined, now partner can rely on them (Metod: "*Before, if I panicked, my wife used to calm me down, but now it's the other way around.*").

Ayurvedic patients reported that with their own activity and influence they could affect the course of depression. Maintaining a stable mood has helped their concentration and they started to understand that they need to take care of themselves first. Everyone needs to get to know their problems and find a way to overcome them and then they need to follow the doctor's instructions. In such situations, one can take a meditation course and learn how to resolve the issue in a few short moments (Martina: "*To surrender yourself, switch off and relax, to gain new strength. Meditation is really a good thing.*"). They also attributed great value to walking or any other physical activity (such as yoga) and to the change of the environment. Ayurvedic patients believed that the use of such tools affected the ability of a person to control their own mood. Regular use of these tools (such as relaxation) can almost be regarded as protective behaviour; a person can benefit from that in the long run. However, turning this into a habit takes time and determination.

With active participation in the treatment process, informants have realized that they are the owners of their bodies, minds and emotions, which meant that a lot depended upon themselves. They achieved this by putting a greater emphasis to the role of the individual in the Ayurvedic therapeutic process, changing their own lifestyle habits and cognitive patterns and utilising Ayurvedic strategies to maintain a stable mood. Ayurvedic medicine strengthened the awareness of their co-responsibility for their problems, and increased their resilience and ability to cope with stressful events and challenges in their lives.

On the contrary a recent study of Vilhelmsson, Svensson, and Meeuwisse (2013) has shown how biochemical understanding of the mental illness may be embraced because it relieves the person of his own responsibility for the situation he is in; but relieving a person of responsibility can also result in a sense of powerlessness. The magic bullet approach may have its merits but can also jeopardize treatment by preventing the patient to see 'the big picture'.

All four groups of informants' listed a wide variety of methods that can help maintain a balanced mood: altruistic activities, different approaches (Ayurvedic medicine, meditation, pranayamic techniques, auto-suggestions), physical activity, purification techniques, dietary changes, associating with positive people and good social support, positive attitude and thinking, relaxation before bedtime, change of the environment.

VIII CHAPTER

PERSPECTIVES OF AYURVEDIC MEDICINE IN SLOVENIA

In the last chapter the following questions were observed: What is the Ayurvedic practice in Slovenia compared to India? What is the attitude of psychiatrists towards the use of complementary methods and Ayurveda? Is the spiritual aspect an important part of depression treatment? It is possible to treat depression in a natural way?

AYURVEDIC MEDICINE FROM INDIA TO SLOVENIA

As it is already mentioned in the theoretical part, mixing the elements of Ayurvedic practice with elements of biomedicine is not uncommon. According to Ernst (2011) from the later period of British colonial engagement in south Asia, a person's right and entitlement to medical care and the colonial state's obligation to provide institutional treatment facilities received increased attention. As the early twentieth-century case of an Indian hospital superintendent shows, this practitioner's professional ambitions went beyond the confines of 'colonial psychiatry'. In his institution he practiced science-based psychiatry, drawing on models and treatment paradigms that were then prevalent in a variety of countries around the globe.

In India, medical integration (Ayurveda and biomedicine) as a social and political phenomenon is seen in different areas:

(1) In public health care, Ayurveda and other methods play an important role (Sharma 2001: 1524 Bodeker 2001: 165-166). Thus, for example, Cherian Ashram combined Holistic Centre for Ayurveda and biomedicine under its own name. In some cases, the Ayurvedic practice was carried out independently, in others it was complementing the biomedicine and in some cases only biomedical approach was used.

(2) In medical education, the integration of Ayurveda and biomedicine is promoted through teaching the basics of biomedicine and vice versa (Sharma 2001: 1,524; Mudur 2001: 1090). Notwithstanding the criticism, many Ayurvedic colleges also included some elements of biomedicine into their programs, while the Indian informants (AI#1, AI#2, AI#3, AI#4) claimed that the reverse process has not taken place. For example, at the Ayurveda College in Kottakkal students have to pass examinations in anatomy and chemistry, yet on biomedical faculties in India it is not obligatory to learn the Ayurvedic approaches. In India the exclusivism of biomedicine and the ambition of its supporters to ensure its dominant role in the health system can also be noticed. This is also reflected in the significantly lower salaries of Ayurvedic medical staff.

(3) Ayurvedic preparations can only appear on the European market if they comply with exact biomedical clinical standards and employ marketing strategies that follow the model of large pharmaceutical companies (Banerjee 2002: 435-467).

(4) In therapeutic practice, integration denotes the use of biomedical instruments and diagnostic technologies and concepts, both in teaching and practice of Ayurveda (Leslie 1992: 177–208). Ethnographers (Lang and Jansen, 2013) have shown how the biomedicalizing Ayurvedic psychiatry in Kerala occurred because the current conceptualization of depression as a neurochemical imbalance is easier to correlate with the Ayurvedic concepts of doshic imbalances.

The technological advance of the West and the transfer of Western ideas and values have notably changed the trend of social and cultural life in India (as well as in Europe)

with the globalization process. People in India have begun to trust the technologically advanced biomedicine. The results of field work in a psychiatric hospital and ashram confirmed that the vast majority of clients now first seek help in biomedicine. Ayurveda acts as a secondary treatment, only after biomedicine proves to be unsuccessful. Clients of the Cherian Ashram services have primarily inquired after biomedical treatment, or at least a combination of both approaches, while the main Ayurvedic doctor (AI#2) in a psychiatric hospital pointed out that "*about 90 percent of patients come for help after several years of failed attempts of allopathic treatment. Cases in which they would immediately turn to Ayurveda are rare*."

Some studies (Pillai et al. 2003: 785-786; Nisula 2006: 214; Varma, 2006: 3610-3611) confirmed this observation. The choice of biomedicine as the primary solution is closely related to the infatuation with technological effectiveness that enables immediate effects of treatment. Those studies from India are in contrast with my research findings, which show that the effects of Ayurvedic treatment are often seen faster than in biomedicine. Ayurveda is probably not an immediate solution for each problem. Some studies suggested that many patients expect the use of biomedical instruments in Ayurvedic clinic (Alexander and Shivaswamy 1971: 599; Leslie 1992: 185; Nisula 2006: 218).

The ashram that was observed here was equipped with instruments such as stethoscope, injections, blood pressure measurement devices, transfusion equipment, etc. The staff members were dressed differently. Some wore white uniforms, not unlike those in Europe (pants, jacket, shoes) while others wore classic Indian garments – women wore saris and men wore classic shirts and pants. In the psychiatric hospital, fewer elements indicated the presence of the biomedical "culture". All medical staff and patients were dressed in traditional clothing (saris, shirts, trousers), medicinal powders were kept in large glasses and plastic containers, the laboratory and the pharmacy contained only the most basic equipment (containers, scales). Patients were able to receive visits without any time constraints. The library was also open to the staff and the patients. In general, the relationship between staff and patients was less formal than the one we are used to in the West.

The impact of biomedicine was most obvious in the diagnosis, where ancient Ayurvedic nosology and physiology is often supplemented with biomedical approaches. One of the doctors AI#1, said the following during his interview:

"*For the diagnosis we use ICMD [International Classification of Mental Disorders] and then the Ayurvedic diagnostic – we consider both. While working on my PhD, I dealt with sexual disorders and the classification has been completely in terms of ICMD. Then we checked Ayurvedic books to see if anything is mentioned there. We use both approaches for clinical purposes, but the treatment is Ayurvedic only. If we need any support from modern medicine, we send the patient to the hospital. Treating difficult cases of depression with high suicidal inclinations with Ayurveda is not easy. In some cases, there is a need for immediate action. The well-being of the patient is always our top priority. Sometimes we need the*

support of modern treatment. But we try to keep biomedical treatment at a minimum and decrease the side effects that may affect the person's quality of life."

The Ayurvedic treatment of depressive disorder in this regard has changed compared to the psychiatric one. This quote indicates that Ayurveda is also faced with powerlessness in cases when Ayurvedic techniques are not effective enough. Ayurvedic doctors from the psychiatric hospital admitted that in the acute conditions biomedical interventions are needed. One often come across a critical attitude of medicine, which emphasizes what it cannot treat, and that complementary practitioners prefer to emphasize more on what they can and less on what they cannot treat.

In this respect I observed that some Ayurvedic informants from the psychiatric hospital and from Slovenia both stressed on both what they can and what they cannot treat, while Ayurvedic doctor from ashram was convinced that Ayurveda successfully treats depression and that there is no need for outside help. This is where a clash between the modern and the traditional Ayurveda ensues. Some informants from Slovenia also talked about what they can treat and less about what they cannot. In this regard the characteristics of Ayurveda in India and Slovenia are comparable, because obviously the Ayurvedic practicioners in Slovenia are also divided - some support the old school while others support the modern approach.

An interesting paradox is that while in India people more or less strive to use biomedicine, the Ayurvedic treatment in Europe is gaining interest and becoming successful. Although Indian philosophies have been used in Europe ever since the ancient times and there are two main reasons for that: the fact that the Ayurvedic approach offers a more complex (holistic) treatment of the disease and that changes in the perception of the doctor-patient relationship have occurred.

In many European countries, such as Italy, England, Austria and Germany,[57] doctors study Ayurvedic medicine at a postgraduate level (Rosenberg 2010: 292). All of these countries have opened Ayurvedic clinics, equipped with some biomedical technology that offers internal and external hospital practices. Some private insurance companies, for example in Germany, also cover the costs of Ayurvedic treatment. Today Ayurveda is recognized in many countries as a versatile traditional system of holistic medicine, based on science. [58]

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57 In the last fifteen years, Germany has created studying programs of Ayurvedic massage, nutrition and medicine; more than 3,000 students have been educated in longer training programs; approximately 13,000 adult students, including 500 doctors and 2,000 members of the medical profession have attended the follow-up courses in various fields of Ayurveda and yoga (Rosenberg 2010: 292).

58 In much of the world, scientific research is carried out on particular medicinal herbs from Ayurvedic Pharmacopoeia and individual therapies. The first large-scale European research project in the field of Ayurvedic medicine in 2009 was launched by the Institute for Social Medicine and Epidemiology and health economics at the Charite Medical School in Berlin, together with the Central Council for Research in Ayurveda (part of the Indian Ministry of Health). The study is focused on the effectiveness of Ayurvedic treatment of osteoarthritis of the knee (Rosenberg 2010: 294).

The situation of Ayurveda in Slovenia is not the same as in the abovementioned countries or in India. In the context of current health policy in Slovenia, there is certain scepticism and reluctance towards the use of complementary methods. In Slovenia, Ayurveda is widely known only as a type of massage, a beauty therapy which is offered at wellness centres. Four Ayurvedic therapists work independently and three Ayurvedic doctors have a consulting room. One of them is working in the "House of Ayurveda" (located in the capital city of Ljubljana) that also offers treatment with accommodation, but the owner did not want to cooperate in my research (same as two of the therapists). »House of Ayurveda« and two other hotels offer the most comprehensive Ayurvedic treatment but these options are quite expensive. Formally speaking, education for Ayurvedic medicine at the university level in Slovenia does not exist.

In the Ayurvedic consulting room where the ethnographic fieldwork was conducted, a number of Ayurvedic therapies are carried out, with an exception of the more complex and time-consuming *panchakarma* (deep detoxification of the body), which is the cornerstone of treatment in India. For the whole *panchakarma* process one need proper accommodation. That does not mean that they do not perform some particular stages of *panchakarma*. They perform the whole-body massage with medicinal oils (*abhyanga*), streaming of medicinal oils on the forehead (*shirodara*), herbalized steam treatment (*swedana*), nasal administration of medicinal oils (*nasya*), but without the emesis (*vamana*), purgation (*virechana*) or enemas (*basti*).

At the Ayurvedic psychiatric hospital in India, the biological treatment method was primarily used. In the hospital I noticed that a patient gradually started to give up biomedicine medication and turned to *panchakarma*; a deep detoxification of the body, after being admitted to the Ayurvedic psychiatric hospital. Informants in India were united in the belief that before the patient starts taking Ayurvedic medicines, it is necessary to deeply clean the body (AI#1: "*If you remove the antidepressant and begin with an Ayurvedic treatment, you will only heal superficially, because deep down toxins are still present. Consequently, it is necessary to clean all the roots or channels of the body first.*"). In short, this means that biomedical medicines should be abandoned before starting with Ayurvedic treatment. There was less emphasis on the spiritual part of Ayurveda (chakras, yoga and meditation) at the hospital, compared to the ashram.

In ashram patients have practiced yoga and *pranayama* every morning and *agnihotra*[59] every morning and evening. According to Koch (2007) *agnihotra* should reduce depression. Meditation and shirodara are particularly recommended for patients with depression.

In Slovenia, as elsewhere in Europe and the US, many people practice yoga, *pranayama*

59 Agnihotra or homa therapy is the technical term from the Vedic science of bioenergy denoting the process of removing the toxic conditions of the atmosphere through the agency of fire. This means healing and purifying of the atmosphere with fire as the medium. You heal the atmosphere and the healed atmosphere heals you (Koch, 2007).

and meditation. However, individuals often practice it without spirituality which, according to the tradition, underpins Ayurveda. Or, as one Ayurvedic doctor, working in a hospital, opined (AI#1): "*Meditation, yoga and pranayama are intended for spiritual development, but the Western world wants it all too quickly, because of their pace of life. However, someone who wants to implement this method first needs a good understanding of the theory to be able to advance slowly and with the help of a guru. In fact, if you want to implement it, you need to adhere to certain rules in regard to what you're thinking, what you're saying. There are certain rules. Only highly developed spiritual men (who have devoted their life to spirituality and live in the Himalayas) have such power, such energy that can impact the chakras directly. Otherwise, you cannot do it*." Even though it is still beneficial to practice yoga even without adhering to the spiritual principles, according to Indian informants, a person will not achieve real results without understanding its spiritual basis.

Due to the "conservative"[60] legislation in Slovenia, the treatment with Ayurvedic medicines is also limited, regardless of the fact that all the other Ayurvedic methods (manual therapies with the use of medicinal oils and other preparations (which are part of panchakarma process), nutrition, lifestyle changes, psychotherapy, meditation, pranayama) have proven to be effective. The positive experiences of their clients, which were communicated by the word of mouth, have resulted in the full occupancy of the consulting room. Clients did not decide for Ayurvedic treatment on the basis of their own knowledge, and even less on the basis of their personal convictions and beliefs, but rather on the experience of others. None of them knew what Ayurveda was before their first therapy.

I found out that Ayurveda practice in Slovenia and India differ. Ayurveda in Slovenia cannot be seen as a prominent medical system, mostly because of the lack of institutional practice and genuine Ayurvedic medicines. It is impossible to treat someone with Ayurveda in an institutional manner. A mere outpatient treatment is insufficient for those who are severely affected by depression or are going through an acute phase of depression. There is also a lack of Slovene-speaking Ayurvedic doctors.

PSYCHIATRISTS' ATTITUDE TOWARD CAM AND AYURVEDIC MEDICINE

Complementary medicine was very well supported by all psychiatrists as it was perceived as a logical addition to psychiatric practice *(P#6: "Especially for someone who is in remission, to reduce the risk of recurrence.").*

60 In Slovenia, complementary medicine is still not lawfully regulated since the Act of 2007 and the amended act of 2011 do not adequately regulate this field, for example, providers of complementary methods (who still do not keep documentation of an individual client). I contacted all the providers of Ayurveda in Slovenia in order to obtain the greatest possible number of people with depression which are treated with Ayurveda, but with the exception of my informants, no one kept records of any medical condition, and some also have no personal data of their clients.

Through the interviews with psychiatrists, three major problems were identified. Firstly, CAM is not legally regulated and there is no verifiable registry of those who practice CAM. This is why psychiatrists are facing difficult situations because they are not able to advise the patient. More precisely, it is not possible to select appropriate complementary methods because the field is so poorly organized. Practitioners do not know where to direct their patients (P#5: "*I do not know where to send my patients, who is qualified, there is no registry on the internet, and you cannot trust someone blindly. Therefore, official medicine can also reject complementary methods because there is no organized system. If there was a system and control to track the results, it would make everything more formal, and some doctors might see these methods differently. It seems to me that if you asked doctors about their own personal view on this matter, many doctors would have a positive opinion about complementary methods. But health system is like that – it all starts and ends with the money, the pharmaceutical industry and medicines*.").

Despite this obstacle, half of the psychiatrists have already advised some form of complementary techniques to their patients (yoga, meditation, homeopathy, acupuncture, Bowen therapy). Today, some complementary methods have already become a part of the legitimate repertoire (for example, autogenic training, meditation, breathing exercises etc.) in Slovenia.

Secondly (in connection to the first point), psychiatrists pointed out that they would be ignorant if they had not noticed the current sad and harmful situation in the Slovenian society. They pointed out that a lot of people, dealing with complementary medicine, see it as a chance to make a good amount of money after only taking some basic and short-term courses, and are very confident with making all sorts of promises to their patients. This book indicates that those opinions are merely personal perceptions and do not necessarily represent the actual situation. Ayurvedic practitioners of this book have acquired education on colleges and they gained many years of Ayurveda practice.

Some psychiatrists relied on cases of accidental deaths, known to us from the news and the examples from their own practices (P#4): "*There are certain people who abuse CAM in order to make huge earnings and therefore cause a lot of damage. These practitioners directly advise people to abandon the prescribed therapy and rely on their methods only. We usually do not know what kind of therapy they offer, so these cases are very problematic.*"), which shows CAM in a bad light. But those examples are exceptions, not the norm. According to my patient informants it is known what those therapies included.

Although the biomedical sector had more "comparable" cases of accidental deaths, the consequences for both, biomedical and complementary practitioners, are significantly different. In Slovenia, a doctor may lose a license, be charged with malpractice or similar professional misconduct. In terms of responsibility for the consequences of their treatment, it is more difficult to take legal actions against practitioners of complementary methods. Patient visits complementary practice at their own risk and practitioners are not formally responsible for the negative outcome or damage that might occur. The

reasons are different, also because some patients are hiding the fact that they are using such practices.

There are some methods with a long tradition (P#9: "*As far as Indian or Chinese medicine are concerned, I believe that thousands of years of tradition prove that there's something about it, but I do not advise anyone to be treated that way because I do not know enough about it.*"), in which highly educated people (including doctors) are included. Some methods are unfairly thrown into the same bin, therefore a legislative framework in the field of CAM is needed (P#8: "*Some alternative forms have already been recognized abroad… I see no reason why they could not get recognition in Slovenia too.*").

On the other hand, most psychiatrists have no problem with the fact that patients seek support within the complementary medicine (P#9: "*I allow it as long as they take my medicine too, such is my philosophy.*"). However, this frequently happens because the psychiatrists consider complementary methods to be harmless - i.e. they let the patient go to an alternative health practice because they believe it is not harmful, but also that it has no benefits. Legal commitment is also in the forefront. The doctor is legally obliged to treat to the best of his ability and skills (the treatment guidelines prescribe exactly how to diagnose and treat patients). When a patient is taking medicines, the doctors are safe, legally speaking. If any unforeseen complications (such as suicide) occur, the investigators visit the psychiatrist. They also review the health records, treatment regimen, etc. If it turns out that everything is not in accordance with the guidelines, professional supervision follows and/or a review by the medical chamber. In the worst case scenario the doctor loses his licence or faces time in prison.

When patients asked psychiatrists for an opinion about a particular method, one psychiatrist decided to get a rough insight into the method in question, because not all methods are suitable for every type of mental disorder. In some cases, they may even be harmful (P#10: *"I sometimes do a little research about what the modality would be like, because, for example, meditation would not be preferable in cases of psychosis since it causes a different experience of consciousness and with meditation the patient's condition might worsen. We must be careful with psychotic people, but for anxiety or depression meditation can be beneficial*"). They believed patients must try to help themselves in as many ways they can because each person responds to something different (P#8: "*We are looking at all possible ways, just anything that would help make things better.*").

Thirdly, psychiatrists stressed the question of how to improve the collaboration between biomedicine and complementary medicine. They believed that Slovenia should establish a better dialogue and should follow the examples of Italy, Germany and Austria. The EU required certain changes, so we are now witnessing small progress. Psychiatrist pointed out that the work plan of the new President of the Medical Association is focused on improving the Slovenian attitudes towards CAM. Legalization of homeopathy is a priority (because it is demanded by the EU). This would be essential, because the current act does not promote cooperation and dialogue between the two medical systems.

The psychiatrists believe that the patronizing attitude of health politics and medical doctors towards CAM is not a reflection of an advanced society. Simply rejecting alternatives is not going to solve the problems of CAM. They pointed out that patients' needs should be the main concern of health politics. In this context, psychiatrists warned about the problem of pharmaceutical industry, which exerts pressure on the profession by offering sponsorships for medical meetings (conferences, symposia) (P#10: "*But this is a global problem with medical profession: in order to save money, the state system does not invest in such medical / psychiatrist trainings or meetings.*").

According to my own experience in both Slovenia and India, the sponsors of such conferences and meetings are not the manufacturers of teas, massage oils, etc. even though they do offer their products at such events. Indeed, the sponsors of the conference "Ayurveda: A new way for healthy life in Europe" which took place in Portorož, Slovenia (March 5-6, 2009) were the Indian Embassy in Slovenia, Ayush department of the Government of India and the Life Class Hotel in Portorož, where the conference was held. At the event, titled "Second International Conference on holistic medicine", which took place in Kerala, India (September 11-13, 2011) none of those manufacturers were present.

THE SPIRITUAL ASPECT OF TREATMENT

Some psychiatrists agreed that the spiritual aspect of treatment in psychiatry is missing. They stressed that the bio-psychosocial model in medicine is often taken into account only at the declarative level, because only the biological aspect is accepted while the spiritual one is excluded. Part of the problem is probably also the fact that the promotion of spirituality may be in conflict with the Constitution, which guarantees religious freedom.

Some of the psychiatrists argued that Western culture and medicine continue to suffer from Cartesian dualism between body and soul (P#1: "*There is a lot of research on social neuroscience or psychosocial genetics, so this shift is happening slowly but medicine today is still too materialistic, biologistic and fundamentalistic, as if the biology was the foundation on which everything is built on.*").

For example, the psychiatrists rely on psychotherapy. The first study to show how the psychotherapeutic process within five meetings changed the operation and structure of the brain (in case of arachnophobia) was published thirteen years ago. (P#1: "*The study presented a picture of the brain before and after the therapy.").* Biology is only one of many possible descriptions of reality, so in the epistemological sense, neither biological, neither psychological nor social explanations have any advantages (P#1: "*Those are methods of interpretation - metaphors. Speaking about the molecule is nothing more than a metaphor when we are talking about the will.*").

One of the psychiatrists even stated that between 2006 and 2010 he was a part of an expert group preparing a law on the psychotherapeutic activities where he proposed an annex for the inclusion of the spiritual aspect to bio-psychosocial complex, which was rejected *(P#1: "The Ministry of Health cannot accept the fact that the spiritual dimension is also important and inseparable. This is another example of an unfortunate divide.").* The rejection was also understandable, because for many the spiritual aspect is a part of religion and as such shoud be separated from the state. On the other hand, it is impossible to force someone into spirituality – it is a matter of personal choice.

Finally, most psychiatrists stressed that it would be necessary to consider the spiritual aspect, which can be an important influence in depression treatment. They were not talking about religion but the interconnections of all living and non-living things on this planet, which is also one of the premises of Ayurveda (P#1: "*What people believe in also represents the ecological knowledge. I believe that people are connected to each other that we, as living beings, are made like that, we are relational beings. We are also connected to both the animate and the inanimate world. All of this constantly affects us and if you look globally, we are all a part of a very large network, which is constantly in motion. Every symptom that occurs to an individual may be associated with the characteristics of ecology. If everything is connected, which it obviously is, then whatever we do in the environment has an effect on us; and what we do to ourselves can affect the environment in the form of climate changes. I believe that people can develop a greater or lesser sensitivity to this broader unit of survival, so to speak, that constantly regulates us. Regulation does not happen in my brain, but my brain is designed in a way that the control is always linked to the wider environment. Contemporary social neurobiology confirmed that.*").

Here the interpretation of spirituality is related to a larger wholeness: (P#1: "*I read anthropology studies from Africa, where they studied the behaviour of people from a certain village at the onset of some drastic events. For example, when they were in a serious conflict, if someone got killed, injured or committed suicide, the whole village came to a halt for a few days, they stopped working and started preparing for a cultural ritual. Through the rhythm of the drums the whole village turned to joint activities and, as a unified community, initiated a process of treatment and healing. They believe that anything that happens to an individual is linked to the entire community. This is something that we often forget*.").

A person needs to be humble and has to cultivate openness and sensitivity in broader terms which is why one of the psychiatrists regularly meditates and uses meditation when treating patients (P#1: "*I regularly meditate and when I work with patients I try to get into a wider state of consciousness, so I work in an altered state of mind. I am trying to silence my rational part as much as possible to be able to go with the flow. Modern psychology talks about the flow of experiences, something that flows, although this is a clear metaphor for something that heals. I have often had a feeling that it is not about me but rather a wisdom that has accumulated through what I inherited, what I learned as a child and through my professional life and experiences. I have faith in this sub-consciousness*.").

Psychiatrists have associated spirituality with the potential that lies within us; which is why it is necessary to activate our maximum potential, because people who achieve that often have great healing capabilities (P#1: "*Even before a single word is spoken, his* [healer] *presence can have a very beneficial effect.*"). Historically speaking, spirituality has always been associated with healing (P#1: "*In the traditional sense, medicine and spirituality have always been connected.*"). This is why some psychiatrists see the fact that modern medicine excludes the spiritual aspect as tragic.

However, spirituality is in fact also present in psychiatry, but it all depends on how the experts, state departments and institutions are defined. For example, one of the psychiatrists (P#1) told the story of Uganda, which has less than 20 psychiatrists although there are no fewer psychiatric disorders than elsewhere. But the majority of mental treatment there is performed by the traditional healers (however there is no control on proper diagnostics or qualification of healers). If someone has a problem, they stay with their healer for a day or longer. If they turn to psychiatric help, they get half an hour for the examination. I believe that in this case the traditional approach offers a better chance for recovery than the outpatient psychiatric approach – unless the patient is hospitalized, where they can receive a more comprehensive care.

Psychiatrists believed that there are a lot of supporters of complementary medicine, as well as those who practice complementary methods for their own personal growth. In practice, psychiatrists could demonstrate the causes or factors to an individual patient in different ways, which is also closely connected to the therapeutic relationship with the patient and his capacity of understanding (P#2: "*If you know the patient well, you can quickly come up with the healing method, by choosing the right way of presenting things to him. There are many examples in narrative psychotherapy or in the stories from literature, religion, etc.*"), because for some people spirituality may be repulsive. In conclusion, some psychiatrists are being optimistic that once the medicine will realize the potential of spirituality, biological methods will soon lose their value (P#1: "*I think we will very quickly switch to spirituality and stop using medicines*.").

TREATING DEPRESSION NATURALLY

Many psychiatrists realized that milder forms of depression can be treated in a natural way. On the one hand, some stress the fact that the vast majority of depressions can be cured on their own, but it takes time and it is very unpleasant (Naeem et al, 2004).

The patient will be unable to go to work and to function normally and many are in danger of committing suicide before their spontaneous recovery (P*#9:"What we do is not necessarily needed, depression might pass, and in most cases it does pass on its own. The time period is important.")* However, others stressed that cases of spontaneous remission are very rare (P#4: "*In most cases, it does not disappear; it usually gets worse*.").

They claim that it is possible to treat mild or moderate forms of depression without medication, but not the deep or acute phases of depression (P#4: "*It is very critical if a depressed person becomes suicidal or even attempts suicide. It is also critical when a person with severe depression and psychosis presents a danger to himself or those around him. In such cases we cannot wait for a spontaneous remission and expect that conversations alone will help.*").

Some psychiatrist cited studies which demonstrate that the level of effectiveness of non-drug treatment is between 30 and 40 percent and with the drugs the success rate is just over 60 percent. This means that only medications are not enough, because psychosocial intervention or the motivation of the patient is still needed.

Problem of the Slovenian practice (and probably elsewhere) is that psychiatrist are aware of the importance of this model but treatment is not carried out in accordance with it. Psychiatrist also considered these findings together with the person's faith and concluded: if you believe in the treatment (placebo effect), you will experience different results than you would if you did not believe in it.

THE NEED FOR COOPERATION

The majority of psychiatrists supported the idea a greater cooperation between both. They cited the example of cancer treatment. They believed that orthodox medicine itself is not enough, because a patient usually needs something more, e.g. religion, homeopathy or transcendental meditation. Psychiatrists claimed that CAM helps with the side effects of medical treatments (**P#4**: "*If we improve things with alternative medicine, of course, I do not expect the patient to be healed completely, but if their quality of life improves because of, I do not see why we could not combine the two*").

Most of the psychiatrists pointed out that they should get more knowledge on complementary medicine (during their studies at the faculty already), and that representatives of complementary therapies should have proper education certificates and a working license. Psychiatrists were also convinced that a person should receive both approaches of treatment in one place (**P#7**: "*It's like if you took the car to service and they would only replace the spark plugs, but if you want to change the oil too, you need to go elsewhere. I would not like that.*"); the more people there is in the treatment team, the greater benefits the patient receives.

Obstacles for the implementation of a more cooperational approach were seen in the statutory restrictions (**P#6**: "*The problem is that we as physicians have signed a statement that we will not perform or participate in non-medical treatment. That means we should not collaborate.*") and in the available time frame. Comprehensive treatment is time consuming (**P#6**: "*For full consideration, we need time because doctors need to know more about the patient. For example, what their background is, the type of family they are coming*

from, what kind of life experience they have; and meanwhile there are three other patients in the waiting room.").

This means that the waiting times will be prolonged, so some psychiatrists pointed out that theoretically the idea of collaboration is great, but difficult to apply in practice. They stated that such an approach would be almost impossible in outpatient treatment (**P#9**: "*I could not see my 12 patients a day and meet the requirements of the insurer.*") and would be much more feasible as a hospital system, where supporting therapies are actually much more common.

Psychiatrist highlighted the need for interdisciplinary programs, following the example of Germany. For illustration, one of the psychiatrists indicated an example of a friend who suffered from cancer 10 years ago and has monitored the whole healing process. When the friend passed the first phase (the operation), he went to the institution where a team of ten experts (masseurs, nutritionists, acupuncturists, Ayurvedic physicians, surgeons, chemotherapists and radiologists) were sitting at the same table to create an interdisciplinary treatment plan.

One of the psychiatrists has even stated that he tries to work with the "alternative healers". Sometimes they have joint meetings; otherwise they keep contact through e-mails and phone. He pointed out that cooperation is very important in order to avoid interference, because sometimes different ideas from different groups at the same time do not give good results (**P#1**: "*Currently I have a situation where the patient is included in an alternative, spiritual realm and it is very important that we are being consistent. If I would not work sporadically, it may not be too good for the patient since he would be getting too much support; there is too much good advice, too many proposals for changes. We know that changes are welcome to some extent but it can be stressful if the line is crossed. It becomes harmful.*").

Sometimes, the advice for changes is based on knowledge and theories, which have not yet proven to be effective. Psychiatrists pointed out that sometimes a person's lifestyle, which might be unhealthy according to some criteria, could actually be protective in some way and the change could worsen the condition (**P#1**: "*This is also a common phenomenon with many alcoholics, who begin to abstain from drinking and develop depression. On one hand you see someone quite healthy although they have been drinking for many years and on the other hand, people die from heart attacks, hard-working people who exercise every day and eat healthy. Myocardial infarction is not only caused by an unhealthy lifestyle. There are many such cases*"). They suggested a coordination of the treatment plan in stages. Therefore, one of the psychiatrists (**P#1**) emphasized that it is always necessary to consider individuals in their own ecology, in their own environment and to use common sense, which is also important in treatment.

Another psychiatrist has questioned the need for cooperation. He pointed out that complementary medicines cannot be considered strictly as science. For him,

complementary medicine is more a philosophical set of beliefs, an ancient school, which comes to certain conclusions on the basis of experiences (**P#10**: "*Those are now carried forward, and the procedures that are implemented are working to some extent, but there is no scientific system that would allow experiments. It's hard to combine systems of beliefs with a scientific field that is based on experiments.*").

He thought the paradigm shift should happen so that people would begin to believe. His argument is illustrated in the case of genes, for which it has recently been determined that the current believe about the 90 percent of genes being inactive is incorrect. He pointed out that this means that the person is no longer determined according to Darwin, but for example, it is possible to force our genes in a particular direction with a long-term meditation, which will be transferred to the egg, blood and reproductive cells. He cited on the long-standing dogma, which claimed that the adult brain cannot produce new cells and has now also been discredited. In this way, the whole field can change; dogma changes. However, this linear progress, which is typical for Western science, is not seen in Ayurveda. He interpreted Ayurveda as a static set of beliefs of ancient schools that do not grow and do not change. This interpretation cannot stand because every single tradition varies and is not frozen in time. For example, Ayurveda today also includes biomedicine and combines its methods of diagnosis with biomedical ones. However, the development is going on also inside Ayurvedic medicine.

Although he did not see the point in coopetation, he did stress that it would be much more useful if patients were free to choose their method of treatment. He believes that by doing so it would be interesting to create equal conditions for all. That means that a person would not have to pay for the services of complementary medicine; on this basis we could prove effectiveness of different methods (**P#10**: "*Because there is no placebo effect which comes with a big investment and therefore much is expected.*"). However, a placebo effect could also occur due to something else.

CONCLUSION

Through the psychiatric and Ayurvedic (de)construction of knowledge about depression, the book intervene in two universes, two realities and made a step forward in "translating" Ayurvedic epistemology and the understanding of it. Although those methods are conceptually still different, the interpretations, approaches and ways of treating depression are in some segments similar yet they differ in others. The book has identified eight meta-themes.

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

I argue that both medical systems understand the aetiology 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. In addition, both consider psycho-social and cultural environment as important factors of depression.

However, the Ayurvedic understanding of depression is wider than the bio-psychosocial model because of the inclusion of spiritual component. This component contribute a significant advantage in the understanding of depression for the adherents and practitioners of Ayurveda since depression (as well as any other disease) 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 and sweet gland channels. Due to the blocked channels *doshas* and *gunas* cannot flow either and so the imbalance occurs. This illustration also presents the psychopathological mechanism of depression, which is still unclear in biomedicine/psychiatry. Ayurvedic understanding of man is holistic – he is seen as psychophysical continuum that includes both the obvious physical parts as well as the subtle psychic faculties.

I argue that Ayurvedic conceptualization of depression represents a significant upgrade of the current understanding in our still prevailing concepts of medical theories and practices in the field of mental health. Eastern traditions emphasise the integration and holism, which means that everything we think, experience and feel affects the chemistry of our cells and vice versa. Within these traditions, fluid imbalance in the brain is therefore the result of biological, psychological, social, cultural and spiritual influence. The fact that psychosocial environment determines the biology and chemical structure of an individual was partly also recognized by the official psychiatry, which is yet to become homogeneous in this belief. There are still no exact answers whether the psychosocial environment or biology itself is responsible for the chemical imbalance or if the depression alone is a consequence of such imbalance.

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, de-stigmatization, poverty, living environment, longer lifetime and transition from the traditional to post-modern/(post) socialist society. When Slovenia gained independency many social changes happened that are in concordance with those causes and correspond to current neoliberal paradigm, which maintains this type of climate in the society.

I argue that depression is a multi-faced disease what supported patients prehistories where four types of depression were found that are intertwined. The majority of informants reported several types or at least two types of depression:

- *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. Thirteen informants or 65% reported about this type of depression;

- *Long-standing, unresolved and inappropriate relationships* – with parents, partner, child. Fourteen informants or 70% reported about this type of depression;

- *Working environment* – transfer to another job, dissatisfaction with working environment, overload and burnout, poor conditions and unpleasant incidents. Eight informants or 40% reported about this type of depression;

- *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. Seven informants or 35% reported about this type of depression.

The ethnographies revealed six "cultural" features of depression in Slovenia. Firstly, typical examples are burned out individuals, who may develop depression because they are excessively exhausted due to their work (job). We live in a society that dictates us to work increasingly more, because a person is only worth as much as they work. In Slovenia work is cultural charactesistic as well as a reflection of the postsocialism where work still fundamentally defines a person. According to the study of Stanojević (2005: 377) for the majority of Slovenians, work "makes life meaningful", and the growing materialism within families further emphasises the importance of (hard) work. Eurofound study also showed that Slovenes appear at the top in the EU due to intensity of work (http://eurofound.europa.eu/sl/news/news-articles/other/press-release-17-september-2007). In addition, in Slovenia another cultural phenomenon is interesting that is related to work and death. When someone dies, people are explaining how a man "worked until the end".

Secondly, importance of work is related to another cultural feature of depression -

individualization. There is visible 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, because they have to deal with the expectations of their surroundings even in adulthood.

Thirdly, another characteristic of "cultural" features of depression in Slovenia is the fact that many people (especially men) are obviously paralyzed by the great fear of failure since Euro barometer shows that Slovenians are among the most pessimistic nations in the EU (Modic, 2014). It is still not acceptable for a man to cry, to be hurt or express his feelings, which is why they suffer in silence. Interestingly, psychiatrists stressed that depression in Slovenia is as frequent in women as it is in men, which contradicts the Slovenian statistics. There is supposed to be a lot of repressed anger and internal aggression in a depressed person. It is also culturally unacceptable to express anger. I still remember the remarks of my family (which can still be heard in society today) when they were telling me not to get mad, because that does not make me beautiful. Angry girls are not pretty. Or as one informant stressed: "*The society expects that a person will keep smiling and be constantly in a good mood, which results in people often pretending in order to fit into the social context and keeping the negative feelings hidden inside."* It is similar when it comes to men. Depression can affect both genders equally, but women seek help and express feelings sooner than men, whose distress more often ends in suicide. In 2011, 436 people committed suicide, amongst them 347 men and 89 women (Statistical office, 2012).

Fourthly, this cultural feature of depression is related to another since depression in men can reflect in alcohol abuse. Alcohol abuse reflects another Slovenian problem since 100.000 to 200.000 people suffer from alcohol addiction.

Fifthly, there are also visible structural components, such as a threat of or an actual long-term unemployment (the level of which is currently around 13% in Slovenia, according to the Statistical Office of RS) which creates uncertainty and fear. Due to lack of social and financial security people quickly grow afraid, they feel alone and utterly helpless.

The last cultural specific of depression that has been detected is the lack of warm and supportive relations within families, which are the crucial part for a healthy childcare, as literature (Dozois, Beck, 2008; Moran at al, 2008; Essau, Sasagawa, 2008) indicates. Obviously, the Slovenians are facing a problem of expressing (positive) emotions. The Slovenian social life is still caught at the intersection of both individualistic and socialistic rationales. Many Slovenian families negotiate within these contesting ideologies in their everyday life. Our relationships are becoming fluid, flexible and also fragile because we are living in an increasingly neo-liberal society of idelogy of choices and autonomy. But choices and autonomy have their price. Although in post socialist society it is easier for a person to realize their ambitions and desires, yet this brings a lot of uncertainty and frustration, because many of these desires are not realized and relationships become fragile, judging by the number of divorces. Today there is much more choice available

but that also contributes to more raised risk for depression.

Since family and partnership can be two of the most important sources of mental distress, Ayurveda and psychiatry have also proven to be similar in regards to the belief that cooperation of relatives is a very important segment of the treatment process - especially with children and adolescents. As practice proves, this is the fundamental social and cultural difference between India and Slovenia. According to the narratives of Indian informants, patients there never seek help alone; they are always accompanied by at least one family member. In Slovenia, the situation is the opposite and more complicated. In the process of psychiatric and Ayurvedic treatment, no family members were involved in taking part in the therapies. Nevertheless, one could still observe that half of family members were involved in the Ayurvedic treatment process separately. Therefore treatment of depression should be more family oriented.

The cooperation of relatives is also a part of the obstacle that the process faces and it is mainly socio-cultural in nature (individualism - collectivism, traditional society - postmodern society). Ayurveda understands the social environment as an important component of depression which greatly contributes to a more effective prevention and treatment of depression. Current psychiatric treatment focuses largely on the biological and psychological components of depression and more often than not the socio-cultural component is not considered enough in practice. This is actually the main criticism of the modern treatment of depression in the context of psychiatric practice. Essentially, psychiatric treatment includes an interview and analysis (and supportive medication therapy) to help the psychiatrist reveal the reasons for the emergence of depressive disorder in an individual, but the causes and the understanding of the course of depressive disorders differ in Ayurvedic medicine and modern psychiatric treatment.

Here is about another parallel with socialism/ post-socialism/ neo-liberalism. In short, fragmented social environment, conflicts in surrounding brings imbalance and causing mental disorders (both in Ayurveda and Western science - psychology, sociology of Durkheim those facts are largely undertaken). However, Ayurveda emphasizes the harmony and a good social environment, but the sick individual is treated in a sick environment.

Individual is co-responsible for depression.

The third similarity between both medical systems is that Ayurvedic doctors/therapists and more than half of psychiatrists had identical opinions regarding the co-responsibility of the individual in the development of depression. They both 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. My findings indicate that the process of seeking help is often too long and usually begins at home in the form of self-treatment. Patients helped themselves with herbal antidepressants and sedatives, work, alcohol, change of environment, complementary medicine (homeopathy, bioenergy, chiropractic or acupuncture), and turning to philosophy (Buddhism, Yoga and vegetarianism). According to experts' opinion, many people with depression begin their treatment very late when they might have already developed a severe depression.

Here should be noted that the informants talked about co-responsibility in their past from today's perspective, after analysing the causes or factors of the individual's problems. Back then, when informants were looking for help, they were not aware of this.

Responsibility, which in the old socialist state was in some sense postponed due to the nature of institutions, authorities etc., is now shifting to an individual level in many areas. Today we can all monitor "in vivo" how the old socialist paradigm is breaking down and disappearing. Many people still have the perception that someone else will take care of them. But, in the meantime proactivity has emerged and the individual is expected to do something for his own health, education, work etc. But due to the lack of individualization many people refuse to take responsibility for their actions and blame others. It seems that our society still has not entirely realized this conceptual break and many expect old socialist certainties.

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

I argue that 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. Those measures were only offered to three informants, but all three were in a different relationship with the psychiatrist - they paid for the psychiatrist's services or were in a friendly relationship with him/ her.

A treatment that combines these aspects in practice is more the exception than the rule but one has to take into account different perspectives: unequal access to psychiatric services throughout regions; lack of patient's recognition of psychotherapeutic elements; counselling therapy does not appear as classic psychotherapeutic session and only contains specific psychotherapeutical interventions; for some patients medication is the most appropriate starting method; long waiting lists for psychotherapy; combined treatment could be depended on the patient's financial background and patient's connections; psychiatric profession is not united in the field of treatment; economical reasons and the influence of pharmaceutical industry.

I argue that psychiatry largely uses a method of psychopharmacological agents for

treating depression and rarely other models of 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.

However, lack of access to combined treatment of psychotherapy and other supporting therapies presents a problem inside the system. Although some of those therapeutic models have been incorporated within the psychiatric practice in Slovenia, patients in mental distress often cannot be offered more than a prescription for pills. Such an approach implies the prevailing interpretation that the patient's mental distress is primarily of chemical and biological nature and can be 'fixed' with medication.

There are many economic reasons behind the current psychiatric practice: a psychiatrist has been allocated minimal time for diagnosis and treatment, pharmaceutical industry strongly promotes pharmacological treatments and people in mental distress expect quick recovery. In Slovenia, due to the deficits in the context of psychiatric care, we cannot expect the introduction of new multi-level approaches in the treatment of depression any time soon.

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.

The fourth similarity is that both medical systems approach a depressed patient in a very comprehensive way, but there are some differences between the two. Ayurveda first tries to obtain a deep insight into the biological / physiological functioning of the body – depression as a result of imbalance of *doshas*, and then the psychosocial factors. Otherwise, there is no common practice in psychiatry to get physiological data first. Following Foucault (1994) I could say that the medical gaze in Ayurveda is more profound than in psychiatry. Ayurveda observed the visible aspects of the patient's illness more deeply in order to construct a narrative that includes the less visible aspects. A doctor or a psychiatrist in his diagnosis relies much more on the symptoms of depression than trying to search for factors that stand behind the symptoms. While Ayurveda can (mainly by pulse diagnosis) quickly acknowledge the reality of the patient's problems, this book (as well as for example the study by Lafrance - 2007) demonstrates how misunderstood the doctor-patient relationship can be, when there are obvious doubts on the doctor's side and the feeling of not being taken seriously on the patient's side. Although one has to take into consideration that until 2011 family doctors in Slovenia did not have proper education concerning depression and recognition of its symptoms.

The psychiatrists cannot always work within a psychosocial model in full, because they lack enough time to establish confidential therapeutic relationships. Some patients choose Ayurveda, because the biomedical treatment was not enough. In fact the quality of the therapeutic relationship is far the most evident difference between Ayurveda and psychiatry as well as expecting more directs counselling. The holistic approach is more common in Ayurveda since it dedicates more time for each individual patient and includes much more ideology (for example about the world, the person, health, illness, treatment method, nutrition, life-style, spirituality ...) etc. This is why the Ayurvedic patients were the ones who more often recognized the psychotherapeutic elements in Ayurvedic sessions.

Both psychiatric and Ayurvedic informants were mostly familiar with the diagnosis, and the majority of informants had already been diagnosed when they turned to Ayurveda. The psychiatric interpretation of the cause of problems and the factors that have an impact on the individual's development of depression was present in the majority of cases. In most of the ethnographies a much more individual approach of Ayurveda came to the foreground, while in biomedicine a collective approach i.e. more or less identical approach for everyone was prevailing. Although Ayurveda also often approached the individual with similar tools, an approach that is more focused on the person rather than the disease could be observed through the testimonies of the informants.

A significant difference between psychiatry and Ayurvedic medicine has been found when the role of the patient who is an indispensable part and extremely important in the treatment process was observed, as indicated by psychiatrists and Ayurvedic doctors / therapists. Although the psychiatrists reported using a wide variety of methods (physical activity, group engagement, use of relaxation techniques, writing a mood diary, solving crossword puzzles, taking a short sick leave, reading popular psychological literature, using complementary methods, coming up with a plan to reduce the stress factors), informants most frequently reported being prescribed two: to engage in physical activity and an to increase their social interaction. The difference between the two approaches is that Ayurveda recommends the use of certain guidelines and techniques (meditation, yoga, physical activity, dietary guidelines, communication, etc.) to all patients, while in the other segment it highlights the individual guidelines in accordance with the patient's specific problem.

The results of my fieldwork in the Ayurvedic consulting room suggest that establishing a friendly and confidential relationship between the patient and the Ayurvedic doctor through telephone conversations and communication via social networks on the internet was beneficial. Indeed, Ayurveda provides significantly greater daily support for the patient when he needs motivation for a change. That kind of relationship is not entirely possible for psychiatrists who need to strictly respect the boundaries of the doctor-patient relationship. However, some patients were allowed to contact their psychiatrist when they were in distress.

Patients were generally satisfied with their psychiatrists, although three informants changed their specialist up to three times. However, my informants were missing 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. Compared to psychiatric patients, Ayurvedic patients were much more dissatisfied with the relationships they had had with their family doctor or psychiatrist. The following key differences were highlighted when evaluating and comparing the relationship of the Ayurvedic practice with the traditional one: lower level of formality, therapist's willingness to listen and understand, mindfulness, a more personal and active dialog, getting support and hope with solving problems, time component, pragmatic guidance (advising, guidelines on what to do in a certain situation). The therapeutic relationship and informants' active engagement in recovery may play distinct roles in driving long-term change.

People choose Ayurveda based on experience of other people.

I argue that 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, Ayurvedic patients made the decision (for Ayurvedic treatment) based on the experience of others – friends, acquaintances or family member. One could say that people in Slovenia are facing a problem when deciding which complementary method to choose, because there are so many varieties or methods of treatment that they have to rely on someone they can trust.

Due to the lack of a verifiable register, psychiatrists are facing a similar dilemma when patients ask for advice and opinion. Psychiatrists are well aware that the methods of psychiatric treatment are insufficient; therefore they see complementary medicine as a logical addition. However, patients themselves stressed the following reasons for turning to Ayurveda: depression itself, dissatisfaction with the psychiatric care, fear of medication's side effects, somatic and psychological complaints, failed attempts of biomedicine, the fear of prescription drug dependency, searching for natural, safer methods, searching for a different view, different interpretations, explanations of their problems and curiosity. Most patients were treated with Ayurveda exclusively, only one was using it complimentary to psychiatry.

Informants did not turn to Ayurvedic medicine because of disagreement with the diagnosis, but because of the treatment methods. They were afraid of medication side effects or they did not believe in medication. Informants turned to Ayurveda, because they believed that it is body-friendly and more natural and because the psychiatric treatment might be more stigmatizing, compared to complementary treatment. There is still a lot of hidden depression, especially in the rural areas. Ayurvedic patients that originate from rural areas reported that their social surrounding (family, friends, and neighbours) did not understand them. They pointed out that people in rural areas have

more prejudices and lack the knowledge and information.

One of the reasons why CAM is very acceptable for many people is because they see the biomedicine as fragmented and based more or less on consumption of drugs and Ayurveda as better, holistic and natural way of treatment.

Ayurveda offers two complementary processes – individualization and connectedness

Ayurveda helps patients who lack personal individualization to become more individualized by thinking about themselves, to learn who they are and what they want. Ayurvedic philosophy postulates that unrealistic wishes can be a source of the disease. Since in the neoliberal reality there is not enough for all, Ayurveda somehow corresponds to such neo-liberal ideology by stressing the importance of not wishing too much.

I argue that in many ways, 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 (lack of therapists). It fit in the neoliberal circle also by highlighting the importance of individualization. Furthermore, Ayurvedic philosophy postulates that unrealistic wishes can be a source of the disease. Since in the neoliberal reality there is not enough for all, and for many people their wishes remain unfulfilled, Ayurveda somehow intriguingly corresponds to such neo-liberal ideology by keeping wishes and desires under control. The neoliberal reality is cruel and in general it does not satisfy people's wishes, for that reason people should follow the Ayurvedic principle of not wishing too much.

But when we observe the material, psychological and spiritual relationships, these causes become more complex. On the other hand Ayurveda is a rebellion against the growing neo-liberal ideology that emphasizes material prosperity and wealth. According to Ayurveda, people's lives must be balanced in order to be healthy and stay that way.

However, due to the emphasis on interconnectedness of all living beings within Ayurveda, these same patients feel connected, especially with others. This fact should also be taken into consideration in the increasingly neoliberal Slovenia (compared to the situation in socialism). In short, the same modality (Ayurveda) offers two complementary and important processes – individualization and connectedness with others.

Adherents believe Ayurvedic medicine to be a safe, non-toxic and non-polluted system which requires a fair amount of "self-activation" and self-perseverance – particularly lifestyle changes, which is not easy and it can be considered as a negative side of Ayurvedic treatment. It is necessary to focus on self (similar is happening in psychotherapy), on your inner self which is somehow contradictory to the Western way of life. People tend to forget about themselves, to deal with themselves, which leads us to the fact that we do not know ourselves well enough (if at all) and that we are bereft of the basic and

fundamental knowledge, the knowledge of oneself – who we are, what we think, what we feel, what we want.

In Slovenia, basic elements of Ayurvedic practice are missing.

Although in Slovenia Ayurvedic treatment could be comparable to the Indian one in some parts, there are still many obstacles and limitations which prevent it from becoming a recognized medical system. In Slovenia there is a lack of institutional Ayurvedic treatment and access to Ayurvedic medicines. A person needs to be in an Ayurvedic institution where they go through detoxification panchakarma and after that they receive certain food and herbal preparations. Patients can only learn proper pranayama techniques, yoga asanas, meditation, nutrition etc. if they stay at such place, because outpatient treatment cannot fully provide that. In Slovenia, however, such practices are often reduced to beauty treatments (for example Ayurvedic massage).

The problem with outpatient treatment is that practitioners cannot monitor what is happening outside the clinic so they do not have an overview, if the patient is following instructions on a regular basis. On the other hand some hotels in Slovenia and "The House of Ayurveda" in Ljubljana provide Ayurvedic services with the possibility of in-patient care, but are often unaffordable or unknown to many. In Slovenia there is also lack of Ayurvedic medicines. Some Ayurvedic herbal formulas can be found in form of food supplements. Many Ayurvedic medicines have already been registered at the EU level but still numerous Ayurvedic products remain impossible to obtain in Slovenia.

The results of my fieldwork in an Ayurvedic consulting room have shown that the main method of treatment in Ayurveda, *panchakarma*, is implemented only partially and without the use of Ayurvedic medicines. That means that patients do not receive a complete Ayurvedic treatment or the same treatment of depression as I observed in India. In this respect Ayurvedic treatment can be seen as incomplete.

Additionally, when Ayurvedic practice in Slovenia is compared to the Indian one, another difference appears: the integration of biomedicine and Ayurveda in India is present in the public health care, medical education and pharmacy but it is most obvious in the therapeutic practice. The Ashram was equipped with biomedical instruments, in the Ayurvedic psychiatric hospital the impact of biomedicine could mostly be felt in the diagnosis. In India people trust the technologically advanced biomedicine, but in contrast to Europe and Slovenia, there are also plenty of complementary approaches and their followers, who search for a more complete practice.

In Slovenia the Ayurvedic practicioners are also divided - there are supporters of the old school and supporters of modern schools. In addition, Ayurveda is facing powerlessness in cases when Ayurvedic techniques are not effective enough. Ayurvedic doctors in the psychiatric hospital admit that in the acute conditions biomedical interventions are

needed. Ayurvedic informants from the psychiatric hospital in India stressed that there is a difference in what they can and what they cannot treat, while Ayurvedic doctor from ashram was convinced that Ayurveda alone can successfully treat depression and that there is no need for outside help. Some informants from Slovenia also like to point out conditions they can treat and less the ones they cannot.

Another difference is that in India Ayurvedic medicine and biomedicine are integrated what is present in the public health care, medical education and pharmacy but it is most obvious in the therapeutic practice. In Slovenia, there is no officially collaboration between biomedicine and complementary medicine. Medical Chamber denies the need for any connection what could be problematic. A1: "*If an individual wants to be treated with Ayurveda, he needs to take sick leave. To do that he needs to lie to his doctors and hide Ayurvedic therapies from them, because doctors might lose their licenses if they work with other methods*."

Although some insurance companies in countries like the US, Australia or Germany cover the costs of CAM treatments - a practice that turned out to be cost-effective and efficient - Slovenian health policy maintains the opposite view. Currently NGOs can participate in some health funds supporting with mental health programmes, which complement the psychiatric care. If CAM would be implemented in Slovenia's health care system this could imply fewer resources for psychiatric programs. In this aspect reluctance of Slovenian health politics and certain doctors for passing this kind of law might be seen as justified.

However, CAM becomes the starting point for convincing clarifications and fruitful discoveries. More and more techniques and methods are emerging in psychiatry which are being included spontaneously rather than through formal integration or medical pluralism. Psychiatric treatment of depression has been continuously changing and adapting to the socio-cultural context over time. These shifts (of paradigms) can reflect some actual paradigms in psychiatry – for example revival of positive psychology and cognitive-behaviour approaches. Some Eastern practices have already been acknowledged as legal approaches in psychiatry – autogenic training, autosuggestions, breathing exercises, yoga and meditation. For example: Yoga workshops were introduced in the psychiatric hospital in Maribor in 2012.

The increasing use of complementary methods can encourage a reflection on the state of Slovenian medical concepts regarding the human body. Scientific epistemology based on the verifiability theory is considered to be the antithesis of dogmatic religious interpretations of the world and the life inside of it. Among the supporters of the relevance for different perspectives and methods is also Paul Feyerabend, who resolutely set aside some sort of "anarchism" in the field of knowledge. As he says in his introduction: "So, if we want to expand the freedom and live fulfilled and content, if we would like to further reveal the secrets of nature and man, then we should abandon all the extensive measures and all the rigid traditions" (Feyerabend, 1999: 11).

In case of psychological interventions, it could be argued that differentiating between "complementarity" and other medicine(s), including biomedicine is irrelevant. This is because Moerman argues that despite more than 418 psychotherapeutic and psychological practices, interventions and theoretical approaches that underpin them, *"they are all equally effective"* (Moerman, 2002: 90) as long as a meaningful response is elicited in the strong therapeutic relationship. It was not the aim of this present book to argue superiority of Ayurveda in regards to other methods even though it indicates that Ayurvedic treatment of depression might be particularly attractive to some because of its at least two distinctive characteristics.

Even though in the recent years psychiatry has progressed in the treatment of a man more holistically, this book demonstrates two particular advantages of Ayurvedic treatment. One is directiveness, which means that my Ayurvedic informants particularly appreciated being given direct advice from their Ayurvedic practitioners. Those of my informants who underwent Ayurvedic treatment also praised daily support given to them during their treatment period via social networks or telephone. As informants' narratives suggested, both are effective in practice yet both are not allowed in psychiatry.

Rather than arguing superiority of one approach over another, the important contribution of this book 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 book 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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POVZETEK

Monografija raziskuje »veliko depresijo«, ki se uvršča v psihiatrični kategorizaciji duševnih motenj v spekter motenj razpoloženja. Predmet raziskovanja je (de)konstrukcija znanstvene vednosti depresije z vidika indijske medicine – ajurvede in biomedicine/psihiatrije na eni strani in razumevanje ter zdravljenje z omenjenima medicinskima praksama v Sloveniji v luči pacienta z diagnosticirano *veliko depresijo* na drugi strani.

Knjiga predstavlja vsebinsko večplastno obravnavo izjemno aktualnega področja duševnega zdravja – soočanja in spoprijemanja z depresivno motnjo razpoloženja, kot eno izmed najbolj razširjenih oblik težav z duševnim zdravjem. Pri tem sem (1) primerjala konceptualizacijo in zdravljenje velike depresivne motnje med psihiatrično in ayurvedsko prakso, (2) proučila ajurvedsko prakso preneseno v drugo kulturno okolje, t.j. v Slovenijo v primerjavi z okoljem iz katerega izhaja, t.j. v Indiji, (3) skozi pripovedi pacientov opredelila ključne dejavnike, ki so jih spodbudili k zdravljenju v okviru ajurvedske oz. psihiatrične prakse, (4) analizirala in primerjala potek ter izid zdravljenja z obema pristopoma ter (5) skozi pripovedi udeležencev raziskave preverila razumevanje depresije iz vidika psihiatrične in ajurvedske prakse.

Knjiga preučuje tudi razlike med obema pristopoma zdravljenja depresije, ki izhajata iz različnih konceptov razumevanja vzrokov, poteka in posledično terapevtskih intervenc. Zanimalo me je, kaj bi lahko bile prednosti / pomanjkljivosti primerjanih praks, kot jih doživljajo pacienti z depresijo. To vprašanje je zlasti pomembno zato, ker depresijo danes uvrščamo med eno najpogostejših oblik duševnih motenj, njena pojavnost pa je glede na zdravstvene statistike v porastu. To seveda ni nujno odraz povečevanja obsega motnje kot takšne, ampak tudi boljšega prepoznavanja, večje ozaveščenosti stroke in prebivalstva.

Učinki ajurvedske prakse na področju obravnave duševnih motenj so še vedno relativno slabo raziskani, prav tako prenos ajurvedske medicine v drugo kulturno okolje. Študije o zdravljenju duševnih motenj z ajurvedsko medicino v luči izkušnje evropskega uporabnika pa trenutno še vedno predstavlja veliko praznino v raziskovalnem polju.

Skozi psihiatrično in Ajurvedsko (de) konstrukcijo vednosti o depresiji, knjiga poseže v dva svetova, dve realnosti in naredi korak naprej pri »prevajanju« Ajurvedske epistemologije in njenem razumevanju. Čeprav so te metode konceptualno še vedno različne, so interpretacija, pristopi in načini zdravljenja depresije v nekaterih segmentih podobni, vendar se razlikujejo v drugih. Knjiga je opredelila osem meta tem.

Prvič, čeprav oba medicinska sistema razumeta depresijo znotraj bio-psihosocialnega modela in potemtakem Ajurvedsko razumevanje depresije ustreza biomedicinskim konceptom, Ajurveda gre dlje, ko vključi še duhovni vidik razumevanja depresije. Ajurvedsko razumevanje človeka je holistično – človek je psihofizični kontinuum, ki ga

sestavljajo tako očitni fizični deli, kot tudi subtilne psihične sposobnosti.

Drugič, aktualni bio-psihosocialni model razumevanja depresije je nezadosten. Depresija je bolezen mnogoterih obrazov, kar so podprle tudi etnografije pacientov, med katerimi so bile prisotne štiri oblike depresije, ki so hkrati razkrile tudi šest "kulturnih" oblik depresije v Sloveniji.

Tretjič, posameznik je soodgovoren za razvoj depresije, vendar samo za segmente na katere ima vpliv in jih lahko spremeni. Tukaj je treba poudariti, da so pacienti informatorji govorili o soodgovornosti v svoji preteklosti z današnjega vidika, po analizi vzrokov oziroma dejavnikov posameznikovih težav. Takrat, ko so informatorji iskali pomoč, niso bili enakega mnenja.

Četrtič, bio-psihosocialni model je redko uporabljen pri zdravljenju depresije; kombinirano zdravljenje depresije v Sloveniji (zdravila plus psihoterapija) je prej izjema kot pravilo. Težave so predvsem na sistemski ravni, poleg tega tudi finančni model ne podpira več-nivojskega zdravljenja depresije.

Petič, bistvena razlika med obema pristopoma zdravljenja je terapevtski odnos, ki je v Ayurvedi manj formalen in vsebuje bolj oseben in aktiven dialog. Bistvena razlika med obema pristopoma zdravljenja je v direktnem svetovanju, pragmatičnem usmerjanju in stalni opori v času trajanja terapevtskega procesa in zatem.

Šestič, ljudje se odločajo za Ajurvedo na podlagi izkušenj drugih ljudi – družinskih članov, prijateljev, znancev in ne zato, ker bi jim bile ideje in prepričanja Ajurvede blizu. Le eden od informatorjev je imel predhodno zanje o Ajurvedi. Večina pacientov je bilo zdravljenih izključno z Ajurvedo, le eden je rabil Ajurvedo kot dopolnilo psihiatričnemu zdravljenju.

Sedmič, Ajurveda ponuja dva komplementarna procesa - individualizacijo in povezanost. Ajurveda pomaga bolnikom, ki jim manjka osebna individualizacija, da postanejo bolj individualizirani. Zaradi poudarka o povezanosti vseh živih bitij v Ajurveda, ti isti bolniki čutijo povezanost, še posebej z drugimi.

Osmič, v Sloveniji manjkajo osnovni elementi Ajurvedske prakse, predvsem institucionalna Ajurvedska oskrba in dostop do Ajurvedskih zdravil, ki so že registrirana na ravni EU. Na oboje pa vpliva tudi neurejenost in manko preverjenega registra izvajalcev komplementarnih metod zdravljenja.

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The work is such an important contribution not only in Slovene, but also on an international scale due to its methodological exhaustiveness and numerous conceptual treatments and novelties. I am sure that the monograph will be interesting for (medical) anthropologists and social scientists in general, as well as for those representatives of official medicine who are interested in different treatment approaches of depression.

dr. Barbara Potrata, Independent researcher, UK

Such a study substantially improves the gap in the knowledge of the differences between the biomedical model of mental disorders and the Ayurveda discourse, provides important data for users and experts of biomedical model, Ayurveda model or both, and allows evidence based discussion. I recommend reading the study to everyone who is interested in the content and who encounters people who are experiencing depression.

Prof. Mojca Zvezdana Dernovšek, Psychiatrist, Ljubljana

INŠTITUT KARAKTER