

RELIGIOUS AND MEDICAL MENTAL HEALTH CARE IN WESTERN AND EASTERN CONTEXT¹

Subandi

I. INTRODUCTION

The fact that religion is not only concerned with spirituality and morality but also with physical and psychological health is reflected in the teaching of most religious traditions in the world. Within Hindu tradition, the Ayurvedic system which has been developed in accordance with religious rituals teaches how to achieve a better physical and mental health in order to live longer. The term Ayurveda itself literally means "knowledge of long life". Similarly, many kinds of meditation techniques in Buddhism, which aims to achieve enlightenment, have consequences for physical and psychological well-being. It is written in the Bible that Jesus instructed his 12 disciples to proclaim "the Kingdom of God and to heal" (Luke 9:2) Within Islamic tradition, it is stated in the Qur'an: "...and we send down from the Qur'an that which is a healing and a mercy to those who believe" (17:82) All other religions in the world have ideas concerning healing inherent in their teaching. Thus, it is understandable that since early times religious leaders are also curers or healers. For example, Coleman (1976) described the role of priests in ancient Greece and Egypt as a mixture of priest, physician, psychologist and magician. Religious institutions, then, have often become the center of healing practice.

Base on the above fact, Freedman, a former head of the American Psychiatric Association (APA), stated that there are two different key institutions in the world which are concerned with mental health care: religious institutions and the medical profession (see Hawari, 1997)². The responsibility for care and treatment of the mentally ill has been primarily in the hands of clergy and clinicians. Medicine and religion have worked hand in hand in healing mentally ill patients for a thousand years (Matthews, 1997). However, since these two institutions have different theoretical bases, there has always been a dynamic process of attachment and separation, conflict and resolution throughout the history. This paper tries to explore the relationship between these two institutions and their role in the process of healing of mentally ill patients both in Western and Eastern context.

¹ This paper was written as part of the Freeman Fellowship program in the Department of Social Medicine, Harvard Medical School, Harvard University

² The term "medical profession" in this paper not only refers to physician and psychiatrist but also to psychologist. They represent the professional sector of mental health care system (Kleinman, 1980)

II. WESTERN CONTEXT

Like in any other ancient civilization, religious tradition was dominant in ancient Western culture. The treatment for mental illness was primarily in the hand of priests. Since medical knowledge had also developed to a high level, a priest who treated people suffering from mental health problems also applied some medical knowledge. For example, in the temple of Aesculapius in Greece, the priest treated mentally ill patients with prayer and incantation, supplemented by psychological treatment such as suggestion, hypnosis and recreational measures (attending theatre, riding, walking and harmonious music). Other physical treatments were also practiced, including dieting, massage, hydrotherapy and gymnastic, hypnotism and education (Coleman, 1976). In Alexandria, Egypt, another center of Greek culture, the temples dedicated to Saturn were first-rate Sanatoriums. Similarly In Memphis, Egypt, probably around 525 B.C., the temple of the healing god Imhotep became a hospital and medical school. Mentally ill patients were treated by "incubation" or sleep therapy in the temple and encouraged to pursue artistic endeavors, travel along Nile, and attend dances and concerts (Rimm & Somerville, 1976).

In the late Greek and Roman civilizations, there were a number of great physicians who continued the work of Hypocrates, the father of Greek medicine. Among these physicians were Asclepiades, Aretasius and Galen. Along with the development of a more secular state, a split in the role between priest and physician appears to have occurred. However, they still worked together. Physicians and priests continued to work in temples within a single religious framework (Bughra, 1996).

The separation between religion and medicine began especially in the Middle Ages, which was marked by the decline of Roman empires invasion of peoples from the North and East and a tremendous revival of the most ancient superstition and demonology (Coleman, 1976; Zax & Cowen, 1976). The humanistic attitudes of early Christianity became less prominent as the Church was transformed into an organizational hierarchy and institutionalized religion. Rimm & Somerville (1976) described that at that time a sentiment against the science of medicine was rapidly developing, and both medical and philosophical perspectives were replaced by theological views. Saints replaced physicians as protectors against illness.

Since the idea that mental illness was caused by possession of demons and by witchcraft, the treatments applied were mostly supernatural. Coleman (1976) reported that the treatment of mentally ill patients in the middle ages was left largely to the clergy in monasteries. The therapy consisted of prayers, holy water, sanctified ointments, the breath or spittle of the priests, the touching of relics, visits to holy places and a mild form of exorcism. As theories concerning abnormal behavior and technique of exorcism technique became more fully developed, the treatment of the mentally ill became harsher. They were tortured by flogging, starving, chains, and immersion in hot water in order to make the body unpleasant so that the devil would run away.

During medieval times, it was in Islamic countries that the scientific aspect of Greek medicine continued to flourish (Coleman, 1976; Zax & Cowen, 1976). The translation of the works of Greek and Roman philosophers and physicians into Arabic, allowed Islamic scholars to continue the scientific tradition. Synchronizing the classical tradition with Islamic teaching and thought, Islamic scholars elaborated the Greek medical system and developed it into what is now called "Islamic medicine", "Tibb-Unani" or the "Greco-Islamic" medical system (Good & Good,

1992). In the tenth century, Arabian physicians established a section for the mentally ill in hospital (Zax & Cowen, 1976). Within a religious atmosphere the first mental hospital was established in Baghdad and followed by others in Damascus and Aleppo. The Islamic medical system can still be found in several Islamic countries at present day (Good & Good, 1992).

In the sixteenth century, with the spirit of the Renaissance spreading throughout Europe, the impetus of secular medical knowledge began to emerge in part due to reintroduction of Hellenic learning by way of Islamic scholars (Zax & Cowen, 1976). The identification and management of mental health problems moved from the hands of priests to the hands of physicians. At that time Monasteries gradually relinquished the care of persons suffering from mental problems to special institutions – asylums that were being established in increasing number. Coleman (1976) reported that in 1547 the monastery of St. Mary of Bethlehem in London was transformed into a mental hospital. However, the treatment for patients was not so much different from the previous time. They were often regarded not as human beings but almost as animals. They were chained, hanged, imprisoned and tortured. Most early asylums were not better than concentration camps (Coleman, 1976; Zax & Cowen, 1976). More humanized treatment, however, was found in some Christian shrines which arose in several places. The most famous one was at Gheel shrine in Belgium, where treatment by kindness and love stood out in marked contrast to generally prevailing condition (Coleman, 1976).

The reaction against the cruel treatment in mental hospitals emerged in the eighteenth century, when Philip Pinel removed the chains of the patients and promoted a more humanitarian approach. At the same time William Tuke, who condemned abuses at the York asylum, established another alternative institution called the York Retreat, where mental patients lived, worked, and rested in a pleasant country house in a religious atmosphere. The work of Pinel and Tuke in Europe was also reflected in the work of Benjamin Rush (the founder of the American Psychiatric Association) and Dorothea Dix in the US. They were instrumental in improving conditions of treatment for the mentally ill.

The humanitarian reform which is called “moral therapy” assumed that people labeled as insane were essentially normal people who could benefit other people. Despite the fact that moral therapy was remarkably effective, it was criticized as being “un-scientific”. This treatment system declined in the latter half of the nineteenth century due to attempts to provide hospital facilities for larger numbers of patients and more importantly due to the rapid growth of a more “scientific” treatment (Coleman, 1976).

The grow of scientific medicine was characterized by secularization of medical knowledge and practice. The separation between priest and physician, between religion (in this case Christianity) and medicine have become more apparent. Lipsedge (1996) describes the relationship between these two institutions as being uneasy, ranging from mutual suspicion and conflict to open hostility.

Mental health professionals increasingly assumed that the function of religion is limited to the explanation of the unknown, rituals and definition of values. Religion was regarded as the “opium of people”, a universal obsessional neurosis or equivalent to irrational thinking and emotional disturbance. It was also said that religion is potentially harmful because it induces guilt, and that it only attracted people who were mentally unstable (Fullford, 1996). The horror of religion

exhibited by the destructive power of fundamentalism caused fear and anger among mental health professional. Religion, therefore, became the “last taboo” in medicine. It was less commonly practiced in mental hospitals or discussed in professional meetings (Foskett, 1996).

On the side of religious institutions, it has become a popular belief that mental health professionals, especially psychiatrists and psychologists are atheists, uninterested in their patients’ religious beliefs, and discouraging of religious practice. Some research has supported this belief. Foskett (1996) cited research findings which indicated that psychiatrists hold far fewer religious beliefs than their parents or their patients. They also have made few attempt to explore the relevance of faith to illness and health. A national survey of religiosity of psychologists also confirmed that they showed low rates of conventional religious affiliation and participation (Bergin & Jensen, 1990). The suspicion became worst by assuming that psychiatrists and psychologists had become a new kind of priesthood, administering their own mysteries and conversing in their own “religious” language (Foskett, 1996).

In the later part of this century, however, the separation and conflict between priest and physician, between religion and medicine seems to have come to a partial reconciliation. Precipitated by the fascinating revivals of religious interest within western culture itself, religious issues have been reconsidered by professionals. With the growing interest in spirituality applied in general medicine, gradually religion has also began to be considered by mental health care professional. There have been an increasing numbers of psychiatrists and psychologists interested in aspects of religion that relate to their professions. Partly this is supported by a number of scientific studies in medicine which indicate the significant role of religion in the process of healing. For example, Koenig (1976) summarized some research findings:

“Those who are more religious, experience greater well being and life satisfaction, less depression, less anxiety, cope better with stress and are much less likely to commit suicide. Even when religious persons become depressed, they seem to get better faster than those who are not religious. Finally therapies for depression and anxiety that use religion as part of treatment result in faster recovery from illness than do traditional secular therapies that ignore a person’s religious resources“.

In professional meetings, it is no longer taboo to discuss religious issues. A topic entitled “religious issues in psychiatric practice” has become a permanent part of the agenda in the annual conference of the American Psychiatric Association, together with establishment of a special committee, i.e. “Committee on Psychiatry and Religion” (Hawari, 1997). Likewise, within American Psychological Association, there is a special section for Psychologists Interested in Religion. Finally, a Gallup survey in 1996 found that 83% of HMO professionals suggested that aspects of religion such as meditation, should be incorporated in medical training practice for (mental) health care (Matthews et. all. 1997)

On the religion side, as clergy feel the increasing need to be able to do more than offer advice and reassurance to the people with mental health problems, many religious professionals have sought to acquire counseling skills. The work of Anton Boisten is significant in this area (Foskett, 1996). He initiated a Clinical Pastoral Education (CPE) movement in which students of all major Christian denomination and some rabbinical students are require to do at least three months full time experience in hospitals, prisons and the community. This movement which inspired the

development of pastoral counseling has help established a constructive cooperation between pastors and other clinicians. The progress of pastoral counseling has also brought clergy and clinicians closer. According to Favazza (1983), who is himself a psychiatrist, pastoral counseling is a form of religious psychotherapy that is heavily psychiatric or psychological in orientation. In some places it is now usual to have clergy as part of multidisciplinary teams.

There are also some religious-medical groups dedicated to the care of mental health problems. For example, Frank Lake who is an Evangelical and a psychiatrist, established the Clinical Theology Association. Elly Jansen, a theological student, founded the Richard Fellowship which aims to develop a therapeutic community and Jane Landon formed the Association for the Pastoral Care of the mentally ill. The contemporary Christian and faith healing movement has also made some contributions. They not only practice healing but also reinterprets religious teaching in a contemporary scientific context. For example, Favazza (1983) a psychiatrist interested in Christian healing stated that evil demons are now equated with envy, pride, avance, hatred and obsession with alcohol and gambling.

The role of religious institution in mental health care has also been examined. The community mental health movement has called attention to the clergy and church as a community resource for mental health. Foskett (1996) stated that in Europe the church has continued to be one of the resources for those who experience mental health problems. In the US, the African American Church has also played an important role in mental health of the community. Sandoval (1979) reported the existence of "*Santeria*", the Afro-Cuban religion complex which constitutes a "...vital and dynamic mental health care system".

III. EASTERN CONTEXT

The separation between physician (science) and priest (religion) is perhaps a peculiarly Western phenomenon (Cox, 1996). In many non-Western countries (mental) health care is very closely attached to religious traditions. Only after Western medical practice was introduced, a small tension sometimes ocured. Recently, similar to what had happened in the West, there is also a new movement among some non-Western countries to consider the relevance of their own traditional and religious practices for (mental) health care. The following is the discussion of religious and medical mental health care in Eastern societies with Indonesia as an example.

As in many other developing countries, the official mental health care system in Indonesia is bio-medical in orientation. This system can be traced back to 1882 when the colonial government promulgated a Mental Health Act, followed by establishing a mental hospital in Bogor, West Java. It was reported that this first mental hospital in Indonesia was visited by a well-known German psychiatrist, Emile Kraepelin, which then sparkled his interest in the development of transcultural psychiatry and the role of culture in mental illness (Thong, 1983). The other 21 mental hospitals in the archipelago were set up by the colonial administration during the end of 19th century and the first half of the twentieth century (Connors, 1980). Most of these hospitals served to provide as custodial care. Patients were often admitted to the hospital through court orders. After independence, the Indonesian government adopted a modern mental health approach in which non-legal procedure of admissions became possible. Yet custodial care remained prominent. Only after a new health care policy was introduced, i.e Mental Health Law in 1966, was the mental

health care system directed more closely to the community. The services were extended outside of the confines of the hospitals and were broadened to include not only treatment but also prevention and promotion of mental health. These services are reflected in the slogan "Tri Upaya Bina Jiwa" meaning three pillars of mental health services: prevention, treatment and promotion (Salan & Maretzki, 1982)

At present, there are 34 state and 16 private mental hospitals with a capacity of approximately around 10,000 beds. There are approximately 350 psychiatrists and less than 100 clinical psychologists throughout the country. This is really a very limited mental health care resources for almost 200 million people in Indonesia. Therefore, in accordance with the policy of the current national health system, which focuses on a public and community health approach, the Directorate of Mental Health introduced a new policy in mental health in 1970s. This policy was intended to integrate mental health services with general hospital and community health centers at district levels. The policy allows the mental hospital to extend outpatient services into selected health centers so that mental health services can reach people who live in remote areas. Salan & Maretzki (1983) pointed out that integration of mental health services into community health centers has forced the mental health personnel to shift from exclusive medical thinking, from a narrow biologically oriented approach to inclusion of a wider community oriented approach.

Aside from the official system describe above, there are also several alternative approaches to mental health care in the community. One alternative derives from religious traditions. Since the majority of the population in Indonesia are Moslem, this paper will focus on the role of traditional Islamic institutions called *Pesantren*, with the leader called *Kyai*, as a system of religious mental health care.

The term *pesantren* derives from the word *santri*, meaning a student who studies Islamic religious teaching. *Pesantren* is a place for *santri*. Sometimes *Pesantren* are called *pondok* (dormitory). Often the words are also put together: *Pondok Pesantren*.

Most *Pesantren* are located in small towns or villages within a very pleasant surrounding, although some are found in urban areas. Typically, a complex of *Pesantren* consists of a large mosque in the center, surrounded by the house of the *Kyai* (the leader, the teacher and most often the owner of the *Pesantren*), and dormitories for *santri*. According to Geertz (1960) at the first glance the *Pesantren* reminded one of a Catholic Monastery in Medieval Europe. When it is examined further, however, the difference is quite clear. The *Kyai* is not a priest, the *santri* is not a monk and there is no rigid organization like that of the Catholic monastery.

At present, there are around three thousand *Pesantrens* in Java, large and small, with different names, such as *Pesantren "Suryalaya"*, *Pesantren "Roudhotul Muttaqien"*, *Pesantren "Tebuireng"*. Each *Pesantren* has different characteristics, depending upon the aspect of Islamic teaching focused on and the expertise of the *Kyai*. Some *Pesantren* focus on the *shari'ah* (the Islamic law), some on the *tafsir* (the interpretation and commentary of the Holy Qur'an and the *Hadiith*, the tradition of the Prophet Mohammed). Some *Pesantren* focus on producing the *hafidz* (one who memorizes the whole Qur'an verbatim), some others focus on *tasawwuf/tarekat* (Islamic mysticism).

Pesantren have existed in Java since the early Islamic era. According to Geertz (1960) *Pesantren* is a transformation of the Hindu-Buddhist monastery, because there have been

Pesantren-like institutions before Islam came. However, one can also argue that the pattern of monastery, in which clusters of student disciples collected around a holy man, can be found in all religious traditions. In the Islamic tradition, one monastery-like institution is called *Zawiyya* where a Sufi lives with his disciples. Binder (1960) also noted the similarity between the role of *Kyai* and the village *mullah* in Iran.

According to Koentjaraningrat (1985) *Pesantren* is an exclusive social unit that isolates itself from the large community. This view seems to lack empirical basis. The interaction between *Pesantren* and the outside world occurs all the time. It is evident from history that *Pesantren* have had a significant influence on all aspects of society. In response to demands of the society, *Pesantren* have also changed their system over time. In other words, the *Pesantren* is a dynamic institution which is always in dialogue with its surrounding, locally and nationally.

In the sixteenth century, the institution of the *Pesantren* became the main resource for the community to study, not only Islamic teaching, but also Islamic philosophy and science. The books of great Islamic philosophers such as Al-Ghazali are among the most popular Arabic texts studied in most *Pesantren*. One may also find the works of the great Islamic physician, Ibn-Sina (Avicenna) in some Javanese *Pesantren*.

During the Dutch colonial period, *Pesantren* became the centers of rebellion. Geertz (1960) stated that the colonial government had an intense fear and suspicion of *Pesantren* (especially Sufi *pesantren*), because they could create a sudden hopeless frenzy of armed revolt against the Dutch. They were seen as representing a “reactionary” and “troublemaking” force in village society. The political involvement of the *Pesantren* was also indicated by its close relationship with the Court. Woodward (1986) showed the linkage of *Pesantren* and the royal court in Java. Even several of the oldest *Pesantren* in Central Java were established by, and for many years sustained through, royal patronage. In modern Indonesia, *Pesantren* and *Kyai* continue to play an important role in politics from the local through the national level.

The educational system in *Pesantren* has also been transformed in accordance with social and cultural changes in the society. Geertz (1960) described that there were no academic “grades” in some old *Pesantren*, in the sense of “classes” or of “marks”. In more modern *Pesantren* a more structured and organized educational system has been developed in order to meet the demands of the society. While in the past *Pesantren* only focused on religious teaching, recent developments indicate that many *Pesantren* also teach secular subject, including math, sociology, economy, science and other foreign languages. Some large *Pesantren* also have their own modern University with religious and secular Schools/Departments.

The role of *Pesantren* in social and economic aspects of the society has also been examined. Rahardjo (1985) reported that in some *Pesantren* there is economic cooperation (*koperasi*) which serves as educational means to train the *santri* to run a small businesses. With assistance of the Indonesia government some *Pesantren* have developed animal husbandry and goat and milk cow raising. Other economic activities include craftsmanship and farming. Recently some *Pesantren* also run an Islamic Bank called *Baitul Maal wa Tamwil* (BMT). Further social roles of *Pesantren* indicates by their involvement in government sponsored developmental programs such as transmigration, environmental protection and health program, including immunization, school health program, family planning and family nutrition (Rahardjo, 1985).

Despite little attention from the Ministry of Health, *Pesantren* have also played an important role as a religious (mental) health care for a long time. In this regard, the role of *Kyai* is crucial. As Geertz (1960) mentioned that the role of *Kyai* in a *Pesantren* is not only as “teacher, leader and scholar”, but also as “curer and counselor”. This phenomenon has been explored by Woodward (1985) who stated that there are two primary traditional medical practices in Java -- one practiced by *wali* (saint) who is usually a *Kyai*, and the other practiced by the *dukun* (healer).

Although not all *Kyai* have the ability to treat physical and mental illness, most *Kyai* act as counselors for people in the society. A lot of people come to the *Kyai* to consult for their problems, not only religious problems but also social, family, marriage and emotional problems. Subandi (1996) has observed the practice of consultation of two *Kyai* in two different *Pesantren*. His report concludes, among other things, that people who came to the *Kyai* for consultations were not limited to person of low socio-economic status, but a lot of educated people from the city also came for the same purposes. The problems for which *Kyai* were consulted varied ranging from family problems (such as husband-wife relationships, parent-child relationships and married problems) to social problems (such as problem at work and in the community) individual problems (such as stress, anxiety and depression) and also supernatural problems (such as sorcery and possession).

With the rapid changes in society, resulting from modernization in Indonesia, the role of *Kyai* as counselor and healer is increasing. When faced with mental health problems of urban life, many people often turn to *Kyai* and *Pesantren*, particularly the *Pesantren* which are more oriented toward Sufism. Often parents from big cities like Jakarta, send their teenagers to be educated in *Pesantren* in order to avoid the negative environment of juvenile delinquency. Also, in response to the complex problems of a modernizing society, some *Pesantren* have begun to institutionalize their services by providing a special rehabilitation centre for mental health problems. For example, Horikoshi (1980) described an Islamic Institution in West Java called "Asrama" which served as a psychiatric clinic to treat mental illness using an Islamic approach. In East Java, there are *Pesantren* "An-Nawawi and *Pesantren* "Al Ghafur" which also have special clinics for treating mentally ill patients (Republika, 1994). Subandi (1994) also reports another Islamic institution called "Inabah" under the *Pesantren* "Suryalaya" in West Java which treats drug addicted and mentally ill patients. All of these phenomena reflect the contribution of *Pesantren* and *Kyai* as religious mental health care resources for the community.

The relationship between the official-medical and religious mental health care systems in Indonesia is still not satisfactory. Often these two traditions of healing are still in conflict. Each of them claim that their system is the most important one and they ignore the other traditions. Fortunately, a promising trend has developed recently. There are more and more professionals (psychiatrists and psychologists) who respect religious traditions as a partner in healing mental illness. For example, Dadang Hawari, former head of the Indonesian Psychiatric Association, has incorporated prayer therapy as part of the treatment for his patients. There is also a senior (Catholic) psychiatrist in Jakarta who developed a referral system with a *Kyai* in a *Pesantren* in Jakarta. He sometimes refers his patients to the *Pesantren* and the *Kyai* also asks the psychiatrist to provide a medical treatment for the patients (Good, 1997). On the side of religious institutions, it is also promising. With the spirit of modernization, a lot of religious institutions are now more open

to new practices and new ideas. There are more and more religious leaders and healers who are educated in Western oriented schools.

IV. CONCLUSION

It is clear from the above discussion that religious and medical mental health care systems have existed for a long time in the West as well as in the East. Therefore Matthew (1997) called them twin traditions of healing. Although in the past their relationship was characterized by suspicion and conflict recently many experts such as Cox (1996), Bhugra (1996), Matthews (1997), and Hawari (1997) have suggested that these two traditions of healing should cooperate in order to achieve what is called "holistic" therapy.

Essentially, religious and medical mental health care systems are not two contradictory systems. Rather they are complementary. Religious mental health care systems focus more on spiritual aspects, while medical mental health care focuses on physical and psychological aspect. Although they are different, they have many of the same goals.

The cooperation between these two twin traditions of healing suggested by many experts, will be impossible to be realized if both sides claim that they are the only authentic system for treating mental health problems. Therefore, openness, understanding and communication are extremely important.

V. REFERENCES:

- Bergin, E.P. & Jensen, J.P. 1990. Religiosity of psychotherapist: a National Survey. In *Psychotherapy*. Vol 22/Spring/1990/Number 1.
- Bhugra, D. 1996. Religion and Mental Health. In Dinesh Bhugra (Ed). *Psychiatry and Religion: Context, consensus and Controversies*. New York: Routledge.
- Coleman, J. 1976. *Abnormal psychology and Modern Life*. Illinois: Scatt, Foresman Company.
- Connors, L. 1982. Ships of Fools and vessel of the Divine: Mental Hospital and Madness, a Case Study. *Social Science and Medicine*, 16, 783-792.
- Connors, L. 1990. Scants and Spirits of the Dead Context an idiom. In *Symbolic Healing*. Oceania. 60:345-369.
- Cox, J.L. 1996. Psychiatry and Religion: A General Psychiatric perspective. In Dinesh Bhugra (Ed). *Psychiatry and Religion: Context, consensus and Controversies*. New York: Routledge
- Favazza, A.R. 1983. Modern Christian Healing of Mental Illness. *American Journal of Psychiatry*. 139:6 728-735
- Foskett, J. 1976. Christianity and Psychiatry. In Dinesh Bhugra (Ed). *Psychiatry and Religion: Context, consensus and Controversies*. New York: Routledge
- Fulford, K.W.M. 1996. Religion and Psychiatry: Extending the Limit of Tolerance. In Dinesh Bhugra (Ed). *Psychiatry and Religion: Context, consensus and Controversies*. New York: Routledge

- Good, B.J. & Good, M. D. 1992. The Comparative Study of Greco-Islamic Medicine: the Integration of Medical Knowledge into Local Symbolic Contexts. In Charles Leslie & Allan young (Eds). *Path to Asian Medical Knowledge*. Berkeley: University of California Press
- Good, B.J. 1997. Personal Conversation with Dr. Rusdi Maslim
- Hawari, D. 1997. Is Knowledge of Religion Necessary for Psychiatrist? Unpublished Paper
- Hawari, D. 1997. *Al Qur'an dan Ilmu Kedokteran Jiwa dan Kesehatan Jiwa*. Jakarta: PT Dana Bhakti Prima Yasa.
- Hirokoshi, H. 1980. Asrama : An Islamic Psychiatric Institution in West Java. *Social Science and Medicine*. Vol 14B pp. 157-165.
- Kleinman, A.M. 1980. "Patients and healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and psychiatry". Barkeley University of California Press.:
- Koenig, H.G. 1997. The Effect of Religion on Health: What the Science Has to Say. *Paper presented in conference on Spirituality and Healing in Medicine IV*.
- Koentjaraningrat. 1985. Javanese Terms for God and Supernatural Beings and the Idea of Power. In Ahmad Ibrahim, Sharon Siddique, Yasmin Hussein (Eds). *Reading on Islam in Southeast Asia*. Singapore: Institute of Southeast Asian Studies.
- Lipsedge, M. 1996. Religion and madness in History. In Dinesh Bughra (Ed). *Psychiatry and Religion: Context, consensus and Controversies*. New York: Routledge
- Mattews, D.A. 1997. The Faith Factor: Is Religion Good For Your Health?. *Paper presented in conference on Spirituality and Healing in Medicine IV*. Boston: Harvard Medical School Continuing Education
- Matthews, D.A.; Koenig, H.G.; Larson, D.B. 1997. *Paper presented in conference on Spirituality and Healing in Medicine IV*. Boston: Harvard Medical School Continuing Education
- Maretzki, T.W. 1981. Culture and Psychopathology in Indonesia. *Transcultural Psychiatric Research Review*. No 18. pp. 237-256.
- Rahardjo, M. D. 1985. The Kyai, the Pesantren and the Village: a Preliminary Sketch. In Ahmad Ibrahim, Sharon Siddique, Yasmin Hussein (Eds). *Reading on Islam in Southeast Asia*. Singapore: Institute of Southeast Asian Studies.
- Rimm, D.C. & Somerville, J.W. 1976. *Abnormal Psychology*. New York: Academic Press.
- Sandoval, M.C. 1979. Santeria as a Mental Health Care System: An Historical overview. *Social Science and medicine*. Vol 13B 137-151
- Zax, M. & Cowen, E.L. 1976. *Abnormal Psychology: Changing Conception*. New York: Holt and Reinhart & Winston.
- Salan, R & Maretzki, T. 1983. Mental Health Services and Traditional Healing in Indonesia: Are the Role Compatible? In *Culture, Medicine and Psychiatry*, 7 (1983) 377-416
- Subandi. 1994. Sufism and Drug Addiction: A case at Pondok Pesantren Suryalaya. *Paper. Presented in World Psychotherapy Congress*. Denpasar: Udayana University.

- Subandi. 1996. *Konseling Kyai Sufi. Paper.* Presented in National Seminar on Islamic Psychotherapy. Malang: Muhammadiyah University.
- Suryani, L.K. & Jensen, G.D. 1992. Psychiatrist, Traditional Healer and Culture Integrated in Clinical Practice In Bali. *Medical Anthropology.* 13:301-314.
- Thong, D. 1993. *A Psychiatrist in Paradise: Treating Mental Illness in Bali.* Bangkok: White Lotus.
- Woodward, M.R. 1985. Healing and Morality: A Javanese Example. *Social Science and Medicine* Vol. 21 No. 9 pp.1007-1021
- Woodwarh, M.R. 1989. *Islam in Java: Normative Piety and Mysticism in the Sultanate of Yogyakarta.* Tucson: The University of Arizona Press.