Balancing traditional beliefs and medical science: mental health care in Bhutan

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ABSTRACT

In the Kingdom where Gross National Happiness is the most precious commodity, there is a growing awareness of the individual and communal toll that unmet mental health needs bring to bear on Bhutanese society. Even though mental illnesses are becoming public health issue, there is a tendency to neglect the care of mentally ill person in the general setting. The reason for the neglect is due to lack of understanding and poor management of mental illness by the health professionals and community at large. This article emphasizes the need to balance the traditional beliefs and medical science in order to provide a comprehensive mental health care in Bhutan.

Keywords: Mental health; Mental illnesses; Public health; Stigma.

INTRODUCTION

In the Kingdom where Gross National Happiness is the most precious commodity, there is a growing awareness of the individual and communal toll that unmet mental health needs bring to bear on Bhutanese society. Like the diagnosis of a mental disorder, naming a problem is less complex than understanding its evolution and finding its solution. Unlike the importation of prophylaxis anti-malarials or vaccinations for endemic disease, finding means of suitable prevention and efficacious treatments for mental illness and psycho-social maladies is not directly importable.

Conceptualizations of mental health needs, subsequent services or lack of services are firmly rooted deep in the cultural context of the people of Bhutan. Mental illness is becoming a public health issue in Bhutan. Besides there has long been a tendency to neglect the care of person with mental disorder in the general setting; the reason being the lack of understanding and poor management of mental illness by the health professionals and people[1]. Specifically this article addresses contextual necessities in improving the understanding in order to strengthen conceptualization, treatment and management of mental health needs in Bhutan. Any non-indigenous Bhutanese practice, such as western counseling theory, methods of addressing diagnosis, balancing religion and science must be carefully tailored to fit the need of the people in Bhutan.

Official records are scant; however, prior to 1997 when psychiatric services were initiated by a World Health Organization consultant, Bhutan provided no systematic care for people suffering from mental illness. In 1997, antipsychotic medications were added to the prescription medications available in Bhutan. The first qualified Bhutanese psychiatrist returned to Bhutan to practice at the Jigme Dorji Wangchuck National Referral Hospital (JDWNHR) in 1999. In 2004, a separate psychiatric ward opened, and in 2010, detoxification services were added.

With the advent of modernity, Bhutan's proud and resilient people are on the cusp between traditional ways of conceptualizing their mental health and mental illness and the promise or threat of modern explanations, intervention and care. In a Buddhist country, explanations of mental illness are ubiquitous with accounts of past lives, karma, samsara, and of demons and ghosts[2]. Yet transition to democracy, new world materialism, social media, increasing urbanization confounds more traditional ways of life. Redefining family and gender roles, challenges to conventional Buddhist values, are introducing if not instigating unprecedented risks to the emotional well-being of Bhutan's people.

The premise for this article is, therefore, to emphasize the need to balance the traditional beliefs and medical science in order to provide comprehensive mental health care in Bhutan.

Cases

The following two cases are presented to highlight some of the traditional beliefs and practices seen commonly in our practice. They represent actual patients whose details have been altered to protect their identities.

1. Tashi, a 20 year-old female, tells a medical doctor, "I am worried and troubled; for several weeks now I am being followed by someone who disappears when I turn-around, no matter how quickly. I have black shadows coming toward me and beckoning me, even in my dreams. It frightens me." Of late Tashi is unable to work, she instead sleeps. Her arrival at the district hospital is because her mother caught her cutting long thin lines across her arm with a shard of glass. Her mother also states that Tashi experienced similar episodes in the past,

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beginning when she was 16 years old.

2. Kuenga Dorji is a 19 year-old whose father brings him to see the village lama (Buddhist monk). The father says, "Kuenga was a good boy, a good student, now he barely speaks and barely moves. He does nothing but sit like a piece of wood. On few occasions he does speak, he appears to be communicating with demons or spirits as I cannot understand a word of what he is saying. He stares off into space but his eyes sometimes move as though he is watching something or someone. Nothing happened after our recent puja (a Buddhist ritual of purification and healing). May be he is even worse. Please tell us what to do."

DISCUSSION

Tashi, the 20 year-old female introduced above, represents a typical presentation in Bhutan of an individual who does not fit neatly into DSM or ICD categories of mental illness. Is she paranoid and delusional, really believing someone is following her? Is she actually seeing the black shadow coming toward her and is she therefore hallucinating? Although "troubled", she is not demonstrating as much distress and life disorganization as would be expected if she were psychotic. She is not describing any mood symptoms, yet her behavior, the self- injury, excessive sleeping and the inability to work, might indicate she is depressed. Also very typical of people living in a culture that does not routinely connect or understand the link between events in one's life, their resultant emotional impact and the associated manifestation of mental health issues; she cannot pinpoint or articulate any precipitant to these symptoms, either in the present or in the past. However, it is widely accepted that many adolescent or young adult women self-injure for reasons related to relational issues and/or abuse[3]. As well, relational violence and domestic abuse is common in Bhutan. Nearly 68 % of Bhutanese women interviewed in 2010 accepted domestic violence as justified when she does not perform her duties up to the expectation of her spouse. Knowing this, the wise counselor will explore these possibilities in detail while working with Tashi. Equally important will be exploration of any suicidal ideation, as 90% of the people who commit suicide have mental health issues, especially depression (Suicide Study, 2009-2013, Bhutan).

Treatment for Tashi will likely include psychoeducation about the connection between feelings, emotions and behavior, as well as helping her decode the symbolic significance of being followed and seeing a black image (death?) coming toward her. She will probably also be quite willing to take antidepressant medication, because this fits with her understanding that when you are "sick", medicine makes you better. The counselor will also need to be aware that when she begins to feel better, she may stop taking her medication, because, she will no longer "be sick", so education will also be required related to the necessary duration of the antidepressant treatment. Finally, the counselor will need to attend to all of the relevant issues in this single session, as returning for subsequent counseling sessions rarely happens.

People in Bhutan typically expect that when they go see a medical doctor, they will be immediately given that magic pill that cures all[4]. Returning for counseling or mental health treatment means the individual might face the cultural stigma and shame often associated with having mental health issues. As one returning client recently reported, "All my friends are now calling me 'psycho' and 'crazy' because I am coming for counseling and they are not sure if they any longer want to hang out with me". In a second example, a suicidal adolescent's older brother interrupted the interview saying, "Doctor, you are wrong, my little brother cannot really be suicidal, I know him well and he has nothing to be depressed about." For many, there are feelings of shame associated with the fact that they did not have the courage to resist the spirit, demon, or depression that has over taken them.

The scant details provided in the case of Kuenga Dorji also describe a typical scenario. In this deeply Buddhist country, karma and 'samsara', evil spirits and deities are still widely blamed for illnesses and misfortune. In fact, any means of externalizing responsibility is used as a way to avoid both the stigma and shame associated with having a mental disorder[5]. According to a 2010 paper published in the Journal of Bhutan Studies, 83% of 106 patients surveyed performed at least one religious ritual before coming to the hospital, and of those, 41% had already done five or more[6]. It is equally common for families to bring relatives to the hospital seeking treatment and also to be simultaneously arranging another meeting with an enlightened or gifted lama. Kuenga's father believes that a spirit or demon has possessed his son's body and this is likely a result of deeds in his past life. He is skeptical that medicine can alter his son's karmic destiny. However, his brother who is a monk explained to him that karma is a dynamic force and that what one does in this life can have an effect on one's subsequent and future lives and that what an individual has done in past lives does not predetermine their present life. Change can happen. He also convinced the father that he could show compassion for Kuenga by taking him to the hospital where he has seen many people helped in similar circumstances[4].

Without doing a more in depth assessment, it is difficult to know the extent of Kuenga's symptoms and whether or not he is hallucinating. However, if he is hearing voices, these voices are more likely to be benign rather than the violent command hallucinations more often heard in Western individualistic societies, as there appear to be significant differences in the presentation of psychotic symptoms in both Schizophrenia and Bipolar Disorder within different countries and cultural groups[7]. Diagnosis, schizophrenia or bipolar disorder, would be in keeping with a 2006 WH0-AIMS Bhutan report that states in community-based inpatient psychiatric units, mood disorders (inclusive of bipolar disorder), schizophrenia and substance abuse disorders predominate[8]. Kuenga appears to be out of touch with his surroundings and experiencing some kind of psychotic disorder.

Even his Buddhist monk brother supports that he may respond better to antipsychotic medication than to religious rituals. The fact that Kuenga has been brought to the hospital and that his father is asking for help bodes well for the prognosis, as both father and son will likely respond positively to the fact that medication may provide the answer. Also, research indicates that although symptoms of psychosis and schizophrenia vary across cultures, living in a collectivistic culture means one is more likely to accept the views and opinions of others, thus is more apt to be compliant with the treatment protocol established at the hospital. In addition, people living collectively are more likely to remain involved and connected in the lives of others, and are encouraged to continue to be a productive contributor to one's family, all of which are also positive prognostic correlates[5]. Like in other cases discussed, both Keunga and his father will need psychoeducation related to his illness, its biologic correlates, as well as education about the medication and its duration of usage.

WAY FORWARD

The two cases presented here will resonate with experiences of most health providers in Bhutan. The social changes over the recent decades have catapulted its people into the present while inevitably challenging its infrastructures, resources, and capacities. There is an urgency to respond to growth's opportunities and challenges. To educate its citizenry with regard to mental health is paramount. As psychological well- being is one of the "9 domains" of Gross National Happiness (GNH), the mental health of Bhutan's people is a vital indicator of the nation's success in meeting its national objectives[9]. Current move toward capacity building, international support, paraprofessional and professional health volunteers; increased media and educational campaigns to inform people of resources available for overall health are all unquestionably forward steps[10]. Yet the obstacles to care for cases like Tashi and Kuenga are confounding–they represent socially constructed narratives that present themselves daily to Health staff, to physicians, nurses and paraprofessionals, to the religious leaders, lamas, nuns and monks, to family members, friends, teachers and co-workers.

Through capacity building measures such as increasing the availability and access to community members trained to be mental health workers, culturally competent steps to educate the public, efforts to reduce stigma and marginalization of individuals with mental illness[11] as well as a growing cadre of mental health professionals in Bhutan, progress is inevitable. The responsibility to care for those in Bhutan with mental health needs must be shared across a broad range of community members, from family and neighbors, paraprofessional and professionals, religious guides and leaders. Nowhere more evident than in Bhutan is the necessity for international as well as locally conceived, culturally adapted prevention, education, assessment, intervention and follow-up to meet the needs of its people. Providing vital resources to elevate the mental health of the Kingdom's often most vulnerable citizens will inevitably strengthen the whole of Bhutanese society.

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