

Traditional and Modern Understandings of Mental Illness in Bhutan: Preserving the Benefits of Each to Support Gross National Happiness

Dr Joseph D. Calabrese and Dr Chencho Dorji¹

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“While poverty alleviation and other material development measures are consistent with physical well-being, the misery of mental conditions that is independent of material living conditions cannot be addressed by favourable material circumstances alone.” (Jigmi Y. Thinley 2007)

For most non-Bhutanese who are aware of the country, Bhutan is associated with happiness. Bhutan's Gross National Happiness policy, which implies a critique of one-sided economics-dominated development goals, has become well known around the world. For example, the United Nations recently adopted Resolution 65/309, initiated by Bhutan, to include measures of happiness and well-being as indicators of development (United Nations 2011) and the government in the UK has also expressed an interest in "happiness economics" (Layard 2006). However, even in Bhutan, there are people who, through no fault of their own, or of their social system, are at a special risk for unhappiness. These are the Bhutanese who suffer from mental illnesses.

The pursuit of appropriate mental health treatment in Bhutan must bring together and balance the need for the most advanced and appropriate medical and psychotherapeutic interventions with the need to avoid the disruption of very useful cultural traditions that are already in place in Bhutanese communities. A crucial question, in view of this priority, is: which conditions are modern psychiatric and psychological treatments the best for and which conditions are adequately addressed with traditional approaches, including traditional medicine (*gSo-ba Rig-pa*), shamanic ritual treatment, or Buddhist rituals and practice?

In this paper, we approach this question as clinicians who have worked with Bhutanese psychiatric patients and as researchers of international mental health and traditional healing practices. Our goal is to view mental health and mental illness in Bhutan through the lens of Medical Anthropology, in terms of our clinical training and practice in Clinical Psychology and Psychiatry, and in terms of Bhutan's Gross National Happiness policy and the related idea of “development with values.” The latter ideas resonate with anthropological critiques of the dominant narratives of international development, which often naively equate progress with Westernization.

¹ Dr Joseph D. Calabrese is Head of the Medical Anthropology Section at University College London and Volunteer Psychologist at the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH). Dr Chencho Dorji is Consultant Psychiatrist, JDWNRH, and Technical Advisor to the National Mental Health Programme, Bhutan.

Medical anthropology is a discipline that studies health and illness in many different cultural contexts around the world. It takes each local context very seriously and pays close attention to cultural differences in illness patterns and treatment needs. The default position for modern clinical sciences is that there is one correct answer to a particular problem: the approach developed by modern Western science. The default position in anthropology is that there may be several “correct answers”: several paths to effective intervention, especially in the areas of mental health and mental illness in which understandings of pathology sometimes reflect deviation from local cultural or moral norms rather than a medical illness. However, the question of which interventions work best for a particular illness in a particular context is ultimately an empirical question, requiring careful study of illness and intervention in the local context.

Our main research question of which mental health conditions are best treated with modern psychiatric and psychological treatments and which with traditional approaches can be broken down into several sub-questions. The important health policy questions we address in this paper include:

[1] Is increased support for modern psychiatric treatment in Bhutan an indication of unnecessary Westernization or is it vitally needed to help sufferers out of misery and into a productive, happy life?

[2] Do we find similar types of mental illness in Bhutan (a country in which modern ways of understanding mental illness are still very new) as we do in other countries, or are mental illnesses here unique?

[3] Do Bhutanese patients respond to the standard psychological and psychiatric treatments? Or do we need to radically alter our treatment approaches?

[4] Are there local healing practices already in place that may be useful? For which types of mental illnesses are they useful and for which are they not?

[5] How can we best support the goals of Gross National Happiness for those people with mental illness?

The Lives of People with Mental Illness in Bhutan

In our research and broader clinical experience with Bhutanese patients, we find that Bhutanese people having severe forms of psychiatric disorder are often marginalized and neglected. They are often stigmatized with words like “*choelo*,” or “psycho,” especially if their symptoms make them act strangely or people see them going into the “*choelo gi ward*.” Like people with mental illness around the world, their problems are often not understood by those around them, who may simply tell them “it’s all in your head” and lose patience when they are not able to immediately change their behaviour. Some families become burned-out in trying to manage them and may even seek to abandon their ill relative while some families show great compassion in continuing to seek treatment.

In our work at the Jigme Dorji Wangchuck National Referral Hospital, we have encountered patterns of psychiatric illness that would be familiar to most clinicians trained in modern psychiatry or clinical psychology. This includes patients who were from very remote areas of Bhutan who have little knowledge of modern concepts and categories of mental illness.

We find psychotic disorders, including those who hear voices (auditory hallucinations) or become extremely confused or who are very socially withdrawn or paranoid. In one of the more tragic of these cases, we treated a man from a rural village who became acutely psychotic and stabbed his wife to death in response to command auditory hallucinations, after which he felt great remorse. We find depression, manifesting itself in low self-esteem, loss of enjoyment or interest in activities, excessive sleeping or suicide attempts.

We encounter many Bhutanese with stress and anxiety, including panic attacks, in which anxious thoughts and activation of the sympathetic nervous system trigger a “fight or flight response” in the body, causing heart palpitations, dizziness and other symptoms that cause the person to fear they are having a fatal heart attack or are “going crazy.” We even encounter obsessive compulsive disorder, such as the case of a woman from rural Bhutan who kept washing the family’s clothes over and over again, never drying them or letting anyone wear them.

There are also Bhutanese with bipolar affective disorder, in which manic episodes may lead to excessive anger, or euphoria, or out-of-control sexual behaviour, or simply racing thoughts and the non-stop talking that we call “pressured speech.” We encounter dissociative disorders, sleep disorders, sexual dysfunction, personality disorders, and even some recent cases of eating disorders. We also encounter Bhutanese with epilepsy and other neurological conditions throughout the country.

Alcoholism is a major problem in Bhutan. According to the National Statistics Bureau (Lham Dorji 2012), deaths from alcohol-related liver disease increased steadily from 2003 to 2009 and in 2009, alcoholism became the top cause of death in the Jigme Dorji Wangchuck National Referral Hospital. The most ALD deaths occurred in the 35-49 age group. The adult deaths due to all other causes occurred mostly in the age group 65-79. Alcohol abuse is thus a major cause of early death in Bhutan. Alcohol abuse is also a leading cause of domestic violence and divorce for the patients we have seen and one person’s alcoholism often creates psychiatric problems for his spouse and children.

In short, we find the entire range of mental illnesses listed in the DSM-5 or the ICD-10. However, mental illnesses often go unrecognised due to the lack of understanding of these conditions among the population, especially in the rural areas. Either they are unaware of concepts like panic attacks or bipolar disorder or they are in denial that they have a problem. For example, as we write this paper, we currently have a woman in the detox ward who reports that she drinks three bottles of *ara* per day, but also claims that she only drinks a little.

The specific presentations of these illnesses reflect their Bhutanese context in many ways. Because severe mental illnesses may go untreated for many years, we see many cases of catatonia (in which the individual is frozen in a motionless state for extended periods and may be mute and unresponsive). Catatonia has become rare in many other countries in which psychiatric care is more established.

Another aspect of illness presentation in Bhutan that differs from standard presentations in the West is that psychological distress is often manifested as somatic symptoms, such as bodily pains or gastrointestinal complaints, rather than in psychological or emotional terms. This phenomenon, called “somatization,” is very common throughout Asia and in non-Western societies generally (Kirmayer 1984).

A related concept to somatization, and also very prevalent in Bhutan, is “conversion disorder.” Conversion disorder occurs when the somatic presentation involves motor or sensory symptoms, for example paralysis or blindness, that suggest a neurological disorder or another medical condition. In either situation, no medical condition can explain the symptoms ... test results come back normal.

In Bhutan, perhaps a third of patients who come to district hospitals with apparently physical symptoms actually have psychological problems that are expressed as somatic symptoms. Simply treating their somatic symptoms without getting at the underlying social and emotional distress that is being expressed with the body can result in a significant waste of time and resources.

A Case of “Paralysis”

To give an example from our work in the Department of Psychiatry, we recently received a female patient who was seemingly paralyzed from the waist down. Many expensive medical tests and other examinations were done but they found nothing wrong with her physically. She had been in the hospital for over a month and the most advanced medical science did not have answers for how to help her.

When we received the patient in the Department of Psychiatry, we immediately formed an idea of what was happening. For one thing, we saw all the attention that this woman’s husband was giving her, supporting her and carrying her. We also noticed that she had an atypical indifference to her predicament of loss of functioning in her legs. She remained cheerful and seemingly unconcerned about her paralysis.

We quickly determined that this was a conversion disorder, in which psychological distress is “converted” into a physical symptom. She had some psychological distress that was being expressed through the body rather than through emotional complaints. And it seemed to us that the large amount of attention that this lady was receiving from her husband was rewarding the behaviour, keeping the symptom going. In behavioural terms, he was reinforcing her performance of the sick role.

We asked the husband to begin to allow his wife to begin to do more on her own and to only show her lots of affection and attention when she attempted to walk. The patient also had a long discussion with one of our trained psychiatric nurses, to whom she expressed the nature of her distress: her husband is a soldier who patrols the dangerous southern border area and she was afraid he would be killed. We worked to increase the woman's acceptance of her husband's job and suggested that if she was functional at home, he would be less distracted in his work, and thus safer. Nursing staff also encouraged the patient to begin moving her legs while on the bed and, soon after, with much encouragement, the patient was able to begin walking again. She was discharged soon after this.

So here we see an example in which psychological forms of intervention, based on an understanding of the social context and relationships of the patient, were much more effective than expensive biological tests and treatments. For this reason, an adequate understanding of mental health and behavioural medicine is crucial for general medical education and practice as well as specialist education in psychiatry.

Understandings of Mental Illness in Bhutan

Medical Anthropologists have found that people around the world typically describe the causes of illness in one of two ways. Naturalistic explanations find the causes of illness in the impersonal forces of nature, such as germs, parasites, injury, imbalances, or, most recently, genetics. Personalistic explanations, however, find the causes of illness in the acts or wishes of a person, such as a witch, or a nonhuman being, such as a ghost, an evil spirit, or a deity (Foster 1976). Common explanations for illness in personalistic medical systems include the capture of one's soul or being possessed by a nonhuman spiritual entity. Personalistic explanations tend to externalise the problem, seeing its origin as outside of the individual patient, and they seek solutions outside the patient, such as in the shaman's negotiations with spirits to release the captured soul.

Bhutan has two main naturalistic systems for interpreting illness: modern allopathic medicine and *gSo-ba Rig-pa* or traditional medicine. The personalistic system, focused on spirits, ghosts, black magic, demons, and deities, is also very prominent. We find that personalistic explanations are the most typical explanations applied to mental illnesses in Bhutan. We commonly hear phrases like "her soul has been affected" or there is "spiritual interference." Patients and their families actively seek answers in terms of a violation of some spiritual rule. Astrologers or oracles consulted by patients or family members may confirm that the patient has been witched or that a local deity has been angered and has cursed the patient. Or the patient may exhibit behaviours that suggest possession by a spirit, such as a *gshin-'dre* (the spirit of a person who has died).

Spiritual forces are typically seen to be at work in the situations we would call mental illnesses and ritual treatments are sought as the primary response. This might take the form of consulting Buddhist monks, a shamanic ritual in which the person's lost soul is returned by placing a spider on his or her head, or even, if one is Southern Bhutanese, the sacrifice of a chicken to the Hindu Goddess Durga (we recently encountered this as an intervention for a case of depression). This tendency to see mental illnesses in personalistic/spiritual terms

creates challenges for the provision of modern psychiatric services. We often only see patients after they have spent years getting ritual treatments that have not worked, which results in a chronic mental illness.

A Catatonic Boy

We have found that the spiritual understanding of illness is very persistent in Bhutan even when modern psychiatric methods have effectively treated the problem. Last year, a boy with catatonic schizophrenia was brought to the ward by his father. The boy's body was very stiff, he was very unresponsive, and he could only speak in a whisper.

The boy's father was very loving and was trying everything he could, but he interpreted the boy's condition in religious terms. He thought the illness was caused by the spirit of a dead person. So he kept seeking *pujas*, healing rituals, to cure his son. He is a Southern Bhutanese, so he began with Hindu *pujas*. Then, when these did not work, he added Buddhist *pujas*. When these did not work, he became Christian and sought a solution in the Church. Then, in desperation, he finally brought his son to the hospital. But he still had trouble accepting that his son's condition was due to mental illness. He kept asking about problems with the boy's nose, which of course could not have caused his son's catatonic state.

We put the son on psychiatric medication. Several weeks later, we saw the father and son when they came in for a follow up appointment. The son was looking much better. He was able to smile and talk and was not stiff any more. The medications were working. However, the father asked us if his mixing of different religious traditions was the thing that was responsible for the illness. He did not seem able to understand or accept that the problem was due to the long-untreated mental illness and that the psychiatric medication was what was helping his son. A year later, this inability to understand resulted in a relapse of catatonia due to the discontinuation of the son's psychiatric medication.

Karma

The other extremely prevalent traditional way of explaining illness and misfortune in Bhutan is in terms of *karma*. From the perspective of medical anthropology, *karma* is fascinating in the way it combines elements of a personalistic explanation (one's own actions in a previous life that have set up karmic ripples causing illness or misfortune) as well as elements of a naturalistic explanation (due to the fact that the "law of karma" or the "karmic cycle" are often discussed as a sort of impersonal natural law).

Meaning literally "action" or "doing", *karma* is a theory of causation in which one's actions in this life cause the form of one's subsequent rebirth. One's misfortunes in this life can also be attributed, through the law of *karma*, to doings in one's previous existence. For example, if one is blind, this may be attributed to an immoral act in a previous life that involved one's eyes. Max Weber (1958) called *karma* the "most consistent theodicy ever produced by history." He was using the term "theodicy" to refer to a resolution to the basic human problem of unequal suffering in the world.

The initial question the non-Bhutanese first author had in relation to karmic explanations of illness was whether locating the cause of one's illness or misfortune in a prior existence implied personal responsibility that might result in stigmatization. Does saying that a person is blind or mentally ill because of his or her actions in a past life result in blame attached to the person's current incarnation? In other words, does it result in blaming the victim for his or her own misfortune? Or does it absolve the person of responsibility and stigma by shifting the blame to some unknown past incarnation?

We find that most Bhutanese we have asked about this feel that *karma* does not blame the victim. Saying that a person has an illness because of *karma* seems to go hand in hand with compassion for that person. It is also interpreted as a comforting explanation for the sick person. This is in line with a chapter by Charles Keyes (1983), in which he wrote: "In practice, karmic explanation of present misfortunes carries both for Buddhists and for Hindus, few if any connotations of personal responsibility." *Karma* is construed as "an impersonal force ... the law of karma... over which one has no control." So it seems that, in general, one is not blamed in this life for one's actions in a past life, so *karma* does not seem to contribute a lot to the problem of stigma.

Karma also seems to inhibit interpersonal resentment in some cases. For example, a Bhutanese friend of ours who is blind said that seeing his blindness in terms of "his" own actions in a past life means that he does not blame his parents for the condition (his blindness was attributed by doctors to a nutritional deficiency, so he could have blamed his parents for not feeding him better).

From the perspective of medical anthropology, *karma* serves as a "culturally embedded therapeutic emplotment" (Calabrese 2013): a shared narrative account of human existence that contributes to a unique sort of Bhutanese mental health, making unequal suffering and misfortune comprehensible while preserving a vision of a just universe. It is thus an important resource for the preservation of mental health and interpersonal harmony in Bhutan.

Traditional Approaches to Treatment

There are three main traditional approaches to healing in Bhutan, each with a different relationship to mental illness: ritual treatment by a shaman, traditional medicine (*gSo-ba Rig-pa*), and Buddhist monastic rituals.

Shamanic healing

Most of the alternative treatments for mental illness used by patients we have encountered in the National Referral Hospital involved shamanic ritual healing rather than *gSo-ba Rig-pa* medicines or procedures, aside from the occasional use of a traditional medicine, such as wild bear bile, as a home remedy. From the traditional point of view that would prescribe *pujas*, mental illness is often understood in terms of the action of spirits, angry deities or black magic.

Bhutanese acknowledge a variety of types of spirits that they share the country with, including *lha* (gods of various sorts), *tse*n (local spirit), *gyalpo* (“king” of malicious spirits), *gshin-’dre* (spirit of a dead person), *soendrey* (spirit of a living person that wanders around and causes illness at night), *lu* or *nagas* (subterranean snake spirits), *dud* (spirits living in dark, secluded places), *mamo* (demon spirit), and many others. Spirits may capture the life force of the person, especially when the person is frightened while travelling through the spirit’s domain, or a spirit may possess a person’s body.

People may compare the ill person’s symptoms with characteristics of a person who has died to identify the *gshin-’dre*. For example, “if the person suffers from symptoms similar to labour pain, it is a sure sign of spirit attack of a woman who had died in the locality from child delivery complications. Likewise, if a person fell from a tree or tripped over a ladder, it is the spirit of someone who has died from a similar accident” (Peday 2010:24). Other characteristics of the symptoms may suggest a different type of spirit, for example if the symptoms only occur at night, this may indicate a *dud*.

The aim of most rituals is to negotiate with the attacking spirit, make offerings of food to it, and convince it to release its hold on the victim. The shaman may go into a trance in order to communicate and negotiate with the unseen entities. In one such ritual that is often encountered in Bhutan, hours of shamanistic performance in trance culminates in the location of a spider, which is placed on the head of the patient to signify that the life force has been returned.

These rituals reflect the rich cultural heritage of Bhutan and they may result in the alleviation of symptoms, especially when the illness is due to somatised distress, dissociative or conversion disorders, or psychosomatic conditions. From an anthropological perspective, rituals often involve sophisticated manipulations of suggestibility, expectation, and consciousness accomplished through music, dramatic performance, and the symbols and meanings embedded in the ritual (Calabrese 2013).

Rituals and astrology seem to be important modes of maintaining positive psychological well-being and a healthy Bhutanese identity. Many Bhutanese share stories of a severe illness that was miraculously cured by a shaman’s performance. We have heard such stories from many reputable sources, including medical doctors, who turned to a shaman in desperation and were later at a loss to explain how the cure was accomplished. We do not know how to evaluate these reports. However, we have not encountered cases in which a severe, chronic mental illness such as a psychotic disorder was effectively treated using rituals alone. We have encountered many patients who were brought to the Department of Psychiatry after years of *pujas* had not helped and many of these people, as a result, have become chronically mentally ill. So we encourage the use of *pujas* but not as the primary treatment for severe mental illness.

Traditional medicine

The Bhutanese system of traditional medicine, called *gSo-ba Rig-pa*, is often described as a humoral system that focuses on problems with one or more of three humors: *rLung* ('Air'), *mKhris-pa* ('Bile') and *Bad-kan* ('Phlegm'). These are manifestations of desire, hatred and delusion. At a very basic level, illness is seen as deriving from ignorance, *ma-rigpa*, which gives rise to the three poisons of desire, hatred and delusion that are manifest in the three pathogenic agents.

However, *gSo-ba Rig-pa* is more complex than this account would suggest. For one thing, the causes of illness are not limited to the three humors; there are also various forms of illness caused by spirits, which demonstrates that shamanic traditions and traditional medicine share a similar view of the universe as peopled with both seen and unseen beings. *GSo-ba Rig-pa* is thus not an exclusively naturalistic system in the anthropological sense. It encompasses a personalistic focus on spiritual forces that can cause illness.

Illness is diagnosed in this tradition through pulse readings, analysis of urine, examination of the eyes and tongue, and interview of the patient. Bhutan was historically known as *Lho-menjhung* or "Land of Medicinal Herbs" and *gSo-ba Rig-pa* treatments include traditional herbal medicines as well as diet and behaviour recommendations, acupressure with golden or silver needles, bloodletting, cupping, nasal irrigation, and herbal baths or steam baths. The reputation of one traditional herb, the fungus *Cordyceps*, approaches that of a panacea for many Bhutanese, with many incredible healings reported for a variety of ailments, though not for mental illness in our data. Practitioners also prescribe spiritual healing practices, including meditation and other faith related practices, for spirit-caused mental illness (Wangchuk, et al. 2007).

We interviewed several prominent *drungtsos* (traditional doctors) at the Institute of Traditional Medicine. When asked about *gSo-ba Rig-pa* approaches to mental illness, they said they did not really have standard approaches for this sort of illness. They said they do not typically treat patients for mental illness and there are no traditional specialists for mental illness at the institute. However, they did say that mental illnesses would usually be understood as reflecting a problem related to *rLung* (wind or air). In addition, one *drungtso* is developing a form of Buddhism-based counselling and another is attempting to clarify the use of traditional medicines for mental illness.

Psychiatric illnesses are most commonly attributed to a problem with *rLung* (the wind humor) or a spiritual force. A *drungtsho* who has been observing patient care in the psychiatric ward in Thimphu compared depression to a deficit of *rLung* and mania to an excess of *rLung* and viewed psychosis as a spirit related illness, which might be treated with an herbal mixture called *be-me-la*. According to the Institute of Traditional Medical Services, *be-me-la* is used for "insanity, restlessness, loss of memory, accelerated respiration, thoracic pain and mild epilepsy." The herbal ingredients of this medicine are *Myristica fragrans*, *Terminalia chebula*, *Terminalia bellirica*, *Phyllanthus emblica*, *Shorea robusta*, *Aquillaria agallocha*, *Bubalis bubalis*, *Ferula foetida* Regel, *Syzygium aromaticum*, *Bambusa textiles*, *Elettaria cardamomum*, *Carthamus tinctorius*, *Amomum subulatum*, *Carum carvi*, *Santalum album*, *Pterocarpus santalinus*, *Cedrella toona*, *Mucuroa recurva*, *Allium sativum*, and *Geranium tuberaria*.

However, our analysis of the medicines used by the Institute of Traditional Medical Services reveals that, in addition to *be-me-la*, there are two other medicines also used for “insanity”: *a-gar-20* and *a-gar-8 pa*. In addition, the medicine *sems.bde* (which contains the word for “mind” in its name) is used for “mental diseases,” *khrag.sman-11* is used for “hallucination,” *go.snod.snum.tsugs* is used for “disturbed mind,” and *Rin.chen.byur.dmar-25* is used for “brain diseases” and “nervous disorders.” A comparative analysis of the composition of these medicines revealed that six out of the seven contain *Myristica fragrans*, five contain *Aquillaria agallocha*, and four contain *Cedrella toona*. *Myristica fragrans* is the nutmeg tree and nutmeg is psychoactive in high doses because it contains myristicin, a monoamine oxidase inhibitor. *Aquillaria agallocha* is the source of agarwood, which has been found to be a central nervous system depressant (Okugawa et al. 1993). *Cedrella toona* seems best known within a traditional medicine context as an astringent and for the treatment of dysentery.

A monoamine oxidase inhibitor is a type of substance that has been used as a medicine in modern psychiatry, most commonly to treat depression. It acts by inhibiting the enzyme monoamine oxidase, which breaks down the neurotransmitters dopamine, serotonin, and norepinephrine, thereby increasing their availability in the brain. Currently, another class of antidepressant – selective serotonin reuptake inhibitors – are more favoured in psychiatry because they are safer to use and have fewer side effects. Central nervous system depressants also have many uses in modern psychiatry and the use of *Myristica fragrans* and *Aquillaria agallocha* in *gSo-ba Rig-pa* seems to indicate a knowledge of the psychopharmacological properties of plants. However, a modern psychiatric practitioner would feel very limited if he could only use a monoamine oxidase inhibitor and a general central nervous system depressant to treat all mental illness.

Our clinical involvement has indicated that, apart from the occasional use of a traditional medicine as a home remedy, we don’t encounter a lot of psychiatric cases at the National Referral hospital that have previously been treated primarily with *gSo-ba Rig-pa*. Much research remains to be done on the efficacy of *gSo-ba Rig-pa* treatments generally, however. Many of the *gSo-ba Rig-pa* medicines are compounds combining many plants, and it may be the case that the interaction of various plants in the same medicine may produce unanticipated effects.

Buddhism

The practice of Buddhism is intimately related to mental well-being and the alleviation of suffering, approaching this goal through the elimination of psychological attachments and aimed at the eventual release from the cycle of rebirth, *samsara*. The practices of ordinary followers focus on the cultivation of compassion and kindness and other activities that bring *sonam* or merit. More advanced practitioners may develop skills in various forms of meditation that refine the mind and progress toward enlightenment.

In their pursuit of the goals of non-attachment, Buddhist practitioners have developed many insights and techniques for training the mind that have been acknowledged by Western

psychologists to reflect a deep understanding of human mentality. Techniques of cultivating mindfulness have been particularly useful as applied in psychotherapy for patients from many diverse backgrounds and with a variety of psychological problems. Kabat-Zinn (1994) defines mindfulness as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally.” It involves increasing awareness and acceptance of internal experiences (e.g., thoughts, feelings, memories, bodily sensations) while decreasing attachment to these experiences (i.e., seeing oneself as separate from one’s pain, thoughts, feelings, memories). Mindfulness thus works against compulsive, addictive behaviours and this is crucial for Bhutan at this point in history, in which alcoholism is destroying many lives and many families. From the perspective of cognitive psychotherapy, mindfulness helps the patient detach from negative automatic thoughts they may experience (such as “I’m worthless”), accepting them simply as thoughts that arise in the mind rather than assuming they reflect reality.

The practice of compassion and kindness in Bhutan, along with the interpretation of life in terms of *karma*, results in a generally very sane and peaceful society. Cows and dogs nap in the middle of busy roads, seemingly aware of the fact that automobile drivers will avoid the bad *karma* that would come from hitting them, and even taxis beep and slow down to avoid hitting a pigeon. Human life and animal life mean more here than in many other places. This way of seeing life as valuable and prioritizing compassion is another important resource for mental health at a societal level that Bhutan would do well to preserve.

The Development of Modern Psychiatric Treatment in Bhutan

The newest approach to mental illness in Bhutan is modern psychiatric treatment. Bhutan launched its mental health system only in 1997, with the opening of the Psychiatry unit at Jigme Dorji Wangchuck National Referral Hospital. Modern mental health practices were introduced into communities that had relied solely on traditional forms of treatment. Initially, only a few patients with suspected psychiatric disorders were referred to the unit and none came at their own initiative. Bhutanese knew little about psychiatry and those that did refused to see a psychiatrist because of the stigma attached. People believed that seeking treatment meant that they were “mad” or “insane.” However, the number of patients seeking treatment slowly increased as people witnessed improvements with treatment.

Modern psychiatric disciplines understand mental illness not in terms of spirits or soul loss but in terms of a combination of biological, psychological and social factors. This is known as the “biopsychosocial” model (Engel 1977). Many forms of mental illness have been linked to imbalances of chemicals in the brain called neurotransmitters. These substances are involved in communications between brain cells. Infections, injuries, genetic predispositions, or abuse of certain psychoactive substances may create biological vulnerabilities to mental illness for some people. Psychological and social factors, such as trauma, stress, loss, abuse, neglect, the development of dysfunctional habits, or even widespread cultural acceptance of excessive drinking, may also contribute to the development of a mental illness, especially in people who have an underlying biological vulnerability. Social factors such as stigma and discrimination also exacerbate the

symptoms of mental illness. The biopsychosocial model may thus be understood as having both naturalistic and personalistic elements in its understanding of illness, though the personalistic influences are limited to other human beings acting in non-magical ways.

Initially Bhutanese psychiatric patients were kept in the general ward, and doctors and nursing staff were ambivalent, as they had little prior experience in managing these cases. However, in 2004 for the first time in Bhutanese history, a separate psychiatry ward with ten beds was established in Thimphu, with two psychiatric nurses that were trained abroad. The nation's first psychiatrist reported in 2004 that over 1,500 patients with mental illness had attended the psychiatry unit up to that point (Dorji 2004). Among these patients, 40% had depression, 31% had anxiety and stress-related disorders, 8% had epilepsy, 7% had alcoholism and 6% had psychotic disorders.

Today, the ward has 18 beds but there are still only 2 psychiatrists and a few psychiatric nurses for the entire country. There are no clinical psychologists, social workers, or occupational therapists, and very little psychotherapy of any kind. The system relies heavily on medication, with some psycho-education for drug and alcohol patients who are detoxing. A study of patients admitted to the inpatient unit between 2004 and 2011 (Pelzang 2012) indicated that the most common psychiatric diagnosis was an alcohol use disorder (33.5%), followed by bipolar affective disorder (15.3%), psychotic disorders (11.8%) and depression (8.6%). These were followed by dissociative disorders (including conversion disorders), anxiety disorders, epilepsy, and somatoform disorders. Patients admitted for dissociative (conversion) disorders were found to be predominantly students, primarily female, between 10 and 19 years old. This study found that the annual number of admissions steadily increased from 127 in the first year to 376 in the seventh year and the study notes an increase in "difficult patients," particularly young male substance abusers.

Patients are usually brought to the ward by their families and the policy is that a family member must be admitted with the patient to help manage the patient and also to learn more about the patient's illness and rehabilitation. Involuntary admissions are common. However, the ward is not locked and restraints and seclusion are rarely applied. Patients on the inpatient ward meet with the multi-disciplinary staff three times per week during ward rounds. These meetings focus on the patient's status, response to medication, and readiness for discharge or referral to rehab (in the case of substance abusers). Clinical staff members also discuss treatment planning. Psychology has recently been added as a discipline through volunteers brought in by Health Volunteers Overseas and Bhutanese are beginning to be trained in psychology and counselling.

The first author's experience of providing psychotherapy in the outpatient and inpatient units reveals many challenges. Most patients encountered will not come for a second appointment, let alone several weeks of regular therapy, so sessions must focus on essential psychoeducation, normalization and removal of stigma, and provision of the most useful illness management skills. The hope is that the patient uses the skills, learns that they work, and returns for more advanced training. However, this rarely happens. The WHO-AIMS report (World Health Organization 2007) found the average number of outpatient contacts per user to be one. At this point in Bhutan's history, it seems that patients expect a "quick

fix” from the hospital rather than an on-going psychotherapeutic relationship and this severely hinders what can be accomplished with psychotherapy. However, in some cases a relationship can be developed and the first author has done multi-session work with couples, psychotic patients, children, and alcoholic patients.

The Department of Psychiatry at Jigme Dorji Wangchuck National Referral Hospital is a context in which modern understandings of mental illness and traditional understandings in terms of spirit possession, soul loss and black magic meet on a daily basis. However, we find that we are able to treat psychiatric illnesses effectively even when there is a significant difference between how the doctors understand the illness and how the patients understand it. We will illustrate this with one final case example.

A Woman Possessed by a gShin-‘dre

A middle aged lady was brought to the psychiatric ward. Her family stated that she had not slept in eight days. She did not want to stay in the house and was leaving to go walking. What was more troubling was that she began speaking in someone else’s voice, saying she had been mistreated. The patient runs a hotel in central Bhutan. She had worked very hard during a three day conference at the hotel and became sick. In her altered voice, she was identifying details of a girl who had died, who worked at another hotel. The patient wanted to wash her face over and over and the family equated this with the fact that the dead girl was thrown into a river. So the pattern the family saw was that of possession by a *gshin-‘dre* – a dead spirit. At a certain point, she was asking for a lot of food but was never going to the toilet. The family interpreted this as the behaviour of a “hungry ghost” and noted that she would eat very fast, in a very greedy manner. She became aggressive with her husband and mother and the family stated that two men could not hold her. She said “Until now, I have been working hard. Nobody knew what I was going through. Now I will make you work.”

This case can be interpreted in terms of what anthropologists and cultural psychiatrists have learned about spirit possession in other places. The classic anthropological theory in this area is that it seems that it is those people who are under stress or who feel a lack of power that become possessed by a spirit. Women become possessed much more frequently than men, especially in societies in which women do not have a lot of power to elicit attention and aid with their own voice. So they begin to speak with another voice and this elicits attention.

Let’s look at an example from another society. The *zar* cult is found in areas of North and East Africa and the Middle East. In these areas, Islamic religious life is dominated by men. Women have a passive role of submission. The word *zar* refers to a spirit that possesses people, most often women, causing illness. A good amount of mental illness cases in this location are attributed to *zar* possession. The spirit attack often coincides with a husband’s opening moves to marry a second wife. This may happen if the first wife has not given birth to a male heir.

The woman becomes possessed and begins to speak in the voice of the *zar* spirit. The spirit manifests itself through her body and makes known its demands, in return for which it should agree to restore her health and refrain from further jeopardising her well-being. The spirit often demands luxurious clothes, perfume, and valued foods from the woman's husband. Only when these demands are met, as well as the expenses involved in mounting a *zar* dance, will the symptoms disappear.

The anthropologist I. M. Lewis (1966) argued that this female affliction operates as a deterrent against the husband's abuse and neglect of the wife in a marriage relationship which is heavily biased in favour of the man. *Zar* possession allows women, who otherwise have no power, to express their grievances and gain some redress. Spirit possession thus provides women with a culturally sanctioned medium for articulating their distress. Our understanding in psychiatry is that they do not do this consciously. It is not simply an act. People know what sorts of behaviour will elicit support from the group. Their mind generates a personality – a voice – that can express their emotions in a manner that will gain the attention of the community. This happens unconsciously. It involves a dissociative state with similarities to a conversion disorder.

Anthropologists have described this phenomenon of spirit possession in many societies. Bourguignon and Evascu (1977) reviewed ethnographic descriptions from a large representative sample of 488 societies and found that 52% of the societies have beliefs that an individual's personality can be replaced by that of a possessing spiritual being. This situation is so well known that it is described in both the ICD-10 and the DSM-5 (the two most prominent manuals used to diagnose psychiatric illness globally). The DSM-5 (American Psychiatric Association 2013) includes spirit possession experiences under Dissociative Identity Disorder when they cause significant distress or impairment. The ICD-10 (World Health Organization 2010) includes "trance and possession disorders" under the category of Dissociative and Conversion Disorders and defines them as "Disorders in which there is a temporary loss of the sense of personal identity and full awareness of the surroundings. Include here only trance states that are involuntary or unwanted, occurring outside religious or culturally accepted situations."

So it seems that our *gshin-'dre* case (and potentially many other such cases) may be understood as an overworked woman's symbolic cry for help in a voice that people in her community will take notice of: the voice of an invading spirit. Like the case of "paralysis" we described above, it may be seen as an expression of psychological distress through other means. This woman's treatment at the hospital involved use of mood stabilizing medications and rest in the ward, surrounded by a very supportive and attentive family, which eventually brought her out of the episode and back to her original personality. Thus a condition understood by her family in terms of spirit possession was effectively treated using the methods of modern psychiatry and psychology. The first author was able to visit the patient later at her family's hotel and she was looking very well, was grateful for her treatment, and invited me to stay at her hotel.

Mental Illness and Social Change in Bhutan

Mental health problems have been exacerbated by social change in Bhutan, including the effects of rural to urban migration, changes in traditional modes of earning a living, changes in schooling and expectations for employment, and changes in family structure (for example, the separation of extended families and the growing prominence of nuclear families). One of our main research questions over the long term is: What is the impact of development and social change on mental health in the context of Bhutan?

From our perspective, working at the Department of Psychiatry, we see an increase in cases of alcoholism and domestic violence, youth violence and addiction, and those who have become unemployed or isolated from their families. These are often the result of new urban lifestyles, wage labour, lack of job opportunities, separation of extended families, and changing gender roles. NGOs have developed to work with female victims of domestic violence (RENEW) and with substance abusers (Chithuen Phendey Association).

Alcohol has been used in Bhutan since pre-Buddhist times to appease deities and within the Buddhist ritual context has been considered one of the five precious elements or *duetsi* and is offered in a cup made from a human skull (Dorji 2005). In everyday life, alcohol has been widely embraced as a necessary ingredient of social interaction or to mark important events, such as the *chhangkhoy* (a special homemade rice-based fermented drink) that is served after the birth of a child or the *Marching* used to evoke deities' blessings when embarking on any new ventures.

For different occasions alcohol is called different names: as *tshogchang*, *zomchang* and *febchang*, it is served to welcome guests; as *lamchang*, it sees off guests; as *tochang*, it is drunk with meals; as *jhachang*, *tashichang* and *tendechang*, it helps celebrate events such as marriages, promotions and acquiring new properties; as *menchang* and *tasachang*, it is taken to sick people; as *zimchang*, it induces sleep. The list goes on and on (Dorji 2005: 66-67).

There was a thus pre-existing drinking culture in Bhutan. However, the local alcoholic beverages took a lot of work to prepare from food grains, which limited the quantity of alcohol available. In addition, most traditional drinks, aside from the more powerful *Ara*, had an alcohol content of less than five percent. Development brought mass production, importation, greater alcohol content, easier transportation throughout Bhutan, disposable income, and new modes of sociality (e.g. drinking in bars after work). Opening a bar became a popular form of livelihood and there are currently more than 3000 licensed bars in the country. The current situation is one in which cheap and high-percentage alcoholic beverages are readily available and in which consumption is often not tied as closely to traditional ritual occasions.

We see the results in the psychiatry ward. We often struggle to bring to the patient's attention the fact that he or she is close to death from alcoholic liver failure. We read them their liver tests and clarify how many times above normal their enzyme levels have become. We send them to the medical ward to see end-stage liver patients. In too many cases, it is too late. Their brains have become too damaged and the power of alcohol too strong for

them to change their behaviour. The addiction has taken its hold permanently and there will be no hope of recovery for many.

Conclusions

On the whole, the range of mental illnesses identified by Western psychiatry exists in Bhutan, though the specific presentation of these illnesses may reflect local beliefs and understandings. We also find that Bhutanese patients often respond to standard psychiatric and psychological treatments. This is the case even given the fact that many Bhutanese are not aware of the viewpoints and categories of Western psychiatry and, instead, understand mental illness in terms of spirit attack, soul loss, or *karma*.

We find that local healing practices also play a role. Shamanic rituals may be very effective for certain mental illnesses that have a behavioural or social basis rather than a strongly biological basis, such as conversion disorders, dissociative disorders, or possession states. Traditional medicine may be helpful in the long-term management of certain chronic physical illnesses, though its uses for psychiatric illness (if any) have yet to be clarified. Buddhism and *karma* undoubtedly play a central role in the maintenance of mental health and the prevention of certain forms of disorder at a societal level by emplotting human existence in such a way that illness and misfortune are made comprehensible within a just universe. Buddhism has also contributed much to our psychological approaches on a global scale through its advanced understanding of mindfulness. In addition, many Bhutanese draw on these spiritual traditions to extend compassion to others, and this could form the base for a flourishing of compassion-based psychotherapeutic interventions in the future.

However, for many psychiatric illnesses, such as psychotic disorders, bipolar affective disorder, or severe alcohol withdrawal requiring medical detoxification, modern psychiatric care provides the only effective treatments available. For this reason, increased support for modern psychiatric treatment in Bhutan is not an indication of unnecessary Westernization; it is vitally needed to help sufferers out of misery and into a productive, happy life.

A common saying in Bhutan is “*men chu rim dro*” or “medical treatment should go hand in hand with performing the religious rites and rituals.” Modern psychiatric services and traditional approaches to well-being can co-exist and work together cooperatively if we understand the specific strengths and limitations of each.

At this point in Bhutanese history, shamanic healing and Buddhism are easily available. However, the modern psychiatric system remains dramatically under-resourced, which creates an on-going barrier to effective treatment of those at a special risk for unhappiness in Bhutanese society. Stigma is another significant barrier to seeking treatment for many people, who are hesitant to seek psychiatric services for fear that they will be labelled “psycho.” People with mental illnesses are not “psychos,” they are human beings who are experiencing problems that human beings everywhere experience. We have found ways to help these people with their problems and expanding these forms of help can only enhance Bhutan’s quest for Gross National Happiness.

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