Using ethnography to study the role of culture in health systems development

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Keywords*:*

Bhutan, clinical ethnography, mental illness, culture, development

Abstract

Ethnography can illuminate the complexities of health systems development and the role of cultural ideas and assumptions in developing countries. The author describes a specific approach called clinical ethnography, which involves combining traditional study of the local community with clinical practice as a member of local treatment teams.

One area in which my research aligns with the focus of Norbuling Rigter College is my interest in the topic of culture and development. I am mainly interested in health systems development. I was trained as an anthropologist, learning about cultures through immersive fieldwork, and as a clinical psychologist, treating patients suffering from mental illness. My main approach to research is ethnography, which involves living in the communities studied for extended periods, getting to know local ways of life, and interviewing local people on their views of illness and healthcare. I also incorporate local volunteer clinical practice with patients, as a member of indigenously controlled treatment teams. I call this interdisciplinary approach "clinical ethnography." This method aims to generate insights that inform clinical services and to create socially contextualised clinical understandings.

I first used this approach during my two years living with a Native American tribe, the Navajos, which included a year of volunteer treatment of adolescent patients, working alongside Native American healers and clinicians. Publications from this project included an ethnographic book (Calabrese, 2013) as well as publications aimed at a clinical audience (e.g., Calabrese, 1997).

My aim is to collect data from several different contexts, which are each experienced directly by the researcher, to illuminate the role of cultural diversity in illness, healthcare, and health systems development. A central question is: are there areas in which modern healthcare development needs to take into account the distinctiveness of the local context and culture? At the most practical level, which allocation of resources resonates with the needs of the local culture and ways of life?

To give a simple example from my work with Native Americans, the traditional dwelling of the Navajos is a circular log cabin called a *hogan*. Traditional healing rituals are also held in these structures. The mostly non-indigenous doctors at the local Indian Health Service hospital worried that Navajo patients were leaving their hospital-based treatment to attend rituals, so they built a *hogan* next to the hospital for patients to use for their ceremonies. They had good intentions. However, the *hogan* was never used because, in the local understanding, healing rituals should never be held at a site where someone has died. And the local community was aware that many people die at the hospital. If anyone at the hospital had done an ethnographic study – or even just asked a traditional Navajo person about building a *hogan* next to the hospital – they would have avoided wasting time and resources building the *hogan*.

I applied this approach in Bhutan during three summers as a volunteer psychologist at Jigme Dorji Wangchuck National Referral Hospital, working closely with the country's chief psychiatrist, Dr. Chencho Dorji, treating psychiatric patients and mentoring clinical staff. Bhutan provided an interesting natural experiment in relation to the relativist and social constructionist critiques in anthropology which claim that mental illness is a local invention of the West. What interested me about Bhutan was that it has not been indoctrinated into so-called "Western psychiatric ideology." The mental health system was founded only in 1997 and modern understandings of mental illness are still new in Bhutan. And Bhutan was never colonized. It has remained relatively isolated from the West. So, as a clinical psychologist volunteering in Bhutan, would I see radically different patterns of mental illness? Or the same patterns to which I have become accustomed?

During my five summers in Bhutan thus far, I have collected data which I have just started to publish, beginning with a journal article on traditional and modern approaches to mental health, co-authored with Dr. Chencho Dorji (Calabrese and Dorji, 2014) and a chapter I was invited to write for the *Routledge Handbook of International Development, Mental Health and Wellbeing* (Calabrese, 2019).

My finding after several summers of fieldwork and clinical practice is that we definitely see the same sorts of psychiatric illnesses in Bhutan that we find around the world, though they are often interpreted by Bhutanese as spiritual afflictions. It is important for doctors working in Bhutan to understand that many Bhutanese see the landscape as populated by invisible entities who can affect moods, identity states and mental health. However, even given the local interpretations, in the cases I helped to treat, I saw lots of classic presentations of familiar disorders I have seen elsewhere.

Even though the population as a whole has not adopted modern psychiatric thinking, research and clinical practice in Bhutan revealed that cases of major depression, anxiety disorders, suicide, psychotic disorders, and other typical

mental disorders take a similar shape in Bhutan that they do in other countries. So, an important lesson in relation to culture and development is that differences in cultural views do not equal differences in observable medical reality.

I found that fancy anthropological theories that argue that mental disorders are just a way of unnecessarily marginalizing cultural nonconformists (e.g., Foucault, 1989; Szasz, 1974) all fall flat in the face of the real human suffering experienced by people with mental disorders. So clinical ethnography can illustrate the continuities of our shared human experience across cultures as well as local variations in viewpoint that should be taken into account. Clinical ethnography allows for detailed observation of illness patterns, local therapeutic intervention and outcomes, patients' understandings of illness, therapeutic narratives, and the use rituals or plant medicines.

Ethnography is also a useful method for getting to know individual people in the society, as well as sub-groups, which reveals the diversity *within* a culture. When looking at culture and development, our model or definition of culture should have some complexity. The anthropologist Anthony Wallace (2009) argued that culture is not simply a replication of uniformity, culture is also an organization of diversity – and fieldwork can reveal this.

Some features of my clinical practice in Bhutan did contrast with my experiences in the West. There were more cases of catatonia, with patients exhibiting immobility, withdrawal, and an inability to speak. However, this can be a side effect of long untreated mental disorders. Catatonia has become rare in Europe and the US because these patients usually get treated sooner. There were also more cases in Bhutan of psychological distress manifested as physical symptoms, such as paralysis.

We treated one young man who was brought in by his father, who interpreted the catatonia as the effects of a *shindre*. He kept seeking pujas, Hindu, then Buddhist and then Christian church – but none helped. The team treated the son with medications which brought him out of the catatonia, allowing him to move and speak again, but it was still difficult for the father to accept that the condition was purely physical rather than spiritual.

Another case, which I discuss in my co-authored paper with Dr. Chencho Dorji, involved a middle-aged woman who was carried into the Psychiatry Department by her husband, with apparent paralysis from the waist down. She had been in hospital for over a month and many expensive medical tests revealed nothing wrong, so she was finally referred to Psychiatry. The team almost immediately noticed that the woman did not seem upset about the loss of functioning in her legs, but seemed to enjoy the attention her husband was giving her. We quickly determined that this was a conversion disorder, in which psychological distress is "converted" into a physical symptom, and this symptom was being

inadvertently rewarded by the husband's attention and care. The patient was not 'play acting' – this was an automatic, unconscious reaction that allows the person some agency in relation to their problem.

We learned that she was afraid for her husband, who was a soldier working along the southern border. 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. We asked the husband to begin to allow his wife to do more on her own and to only show her lots of affection and attention when she attempted to walk. 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. This case illustrated the usefulness of having psychological expertise in a general hospital.

In some cases, my anthropological knowledge of other non-Western cultures helped me better understand a Bhutanese case. For example, we sometimes saw women under stress who were said to be possessed by *shindre*. Anthropologists have described many cases in which people under stress, especially women, begin speaking in another voice expressing their grievances. A well-known example is the *zar* cult in East Africa. Similar to the women with pseudo-paralysis, this is not 'play acting' but is instead an unintentional unconscious shift to an alternate personality with a voice – the voice of a spirit – that must be taken seriously and responded to by the society.

In one such case, we found that the woman seemingly possessed by a *shindre* and speaking in a different voice was overworked in a family business and her husband may have been making moves toward having a second wife. Our diagnosis was dissociative identity disorder. We encouraged rest in the hospital and undemanding attention from family members, which brought the patient out of her alternative identity state., whereas pujas had failed. In this case, the patient's family did recognize that there had been a shift in identity, but they assumed it must be an invading spirit rather than an internal shift within the patient's mind related to stress. So, there were many cases in which the cultural interpretation got some aspect of the clinical picture right, though the attempted cultural treatment didn't work.

This was also the case in patients with epilepsy. In one instance, a young monk was having a seizure in the inpatient ward and a nurse, approaching him to help, was told by the people standing around, "No sister – don't touch … it's contagious." The idea that epilepsy is contagious is common in Bhutan. People seem to focus on the foam that sometimes comes out of the person's mouth. However, we can demonstrate that epilepsy is a disorder in the electrical activity of the brain. Because it is a reaction to overstimulated nerve cells in the brain, it is not contagious. Foaming from the mouth is just saliva mixed with air. However, the belief in contagion results in people keeping a distance. This is

dangerous because it prevents effective first-aid and prevention of injury. And misguided avoidance of the person may result in them becoming stigmatized and socially excluded. So, epilepsy comes with real physical risks, but also with disabilities from social stigma and cultural misunderstandings.

According to Lham Dorji and colleagues (2015, p.116), “In Bhutan, most people believe that epilepsy (often expressed as disease related to pig) can be healed by prostrating oneself before a wooden tub used to feed pigs. Some people believe that forcing a person to smell foul odour during an epileptic fit can help. These acts signify some disgrace or stigmatisation.” Here, again, cultural beliefs may contain an aspect of truth. Dr. Chencho Dorji (personal communication) says that, in MRI studies, they find that 17% of Bhutanese patients diagnosed with epilepsy have cysts in the brain caused by pork tapeworm. So, there is indeed some connection with pigs.

However, when sorting through the relationship of culture and development, we need to assess how important and central a cultural belief is. In the case of epilepsy beliefs among the population, I did not feel that the belief that it’s contagious was a deep aspect of Bhutanese culture and identity – it was simply a popular assumption. Much more ethically relevant is our ability to intervene to help these people to receive effective care, avoid injury, avoid disability, and avoid stigma. So, I wanted to convey the message that epilepsy is not contagious.

I consulted people in the community about how to get out effective public health messages. I was told that adding dramatic performance and music will effectively draw attention to messages. So, I used some of my British Academy funding to hire a group of Bhutanese actors and musicians. We collaborated on a script dramatizing the fact that epilepsy is not contagious and outlining first-aid approaches. And we put on an educational street theatre in the main vegetable market in Thimphu.

We also warned about the danger of an over-the-counter painkiller called Spasmo-proxyvon. Spasmo-proxyvon is among the most abused substances in Bhutan, which is unfortunate because the pill bundles together a deadly combination of the opioid tramadol with paracetamol. You become addicted to the opioid in the pill, so you consume more and more paracetamol, which in sufficient dose is a deadly liver poison. I saw a lot of very young Bhutanese with very damaged livers, as if they were older chronic alcoholics.

To conclude, clinical ethnography in Bhutan revealed both our shared humanity in the classic forms familiar mental disorders we see around the world as well as the subtle local variations and the important role of cultural ideas and assumptions, which can hinder effective treatment in some cases and, in others, provides spiritual reassurance that might benefit mental health.

Clinicians in training often note a radical change when they move from book learning about illnesses to working with actual patients … they say the learning process starts all over again. The same is the case with research on mental illness and health systems development across cultures …working with actual patients gives one a deeper and more realistic understanding of the complexities of the local situation and the role of culture.

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