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Citation for published version:
Jain, S 2012, 'Clinical appeal of Cultural Formulations in Rural Mental Health:: A Manual'. in BS CHAVAN, N Gupta, P Arun, A Sidana & S Jadhav (eds), Comprehensive Textbook on Community Psychiatry in India. 1st edn, JAYPEE BROTHERS MEDICAL PUBLISHERS (P) LTD., New Delhi, pp. 560-565.

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Preprint (usually an early version)

Published In:
Comprehensive Textbook on Community Psychiatry in India

Publisher Rights Statement:
© Jain, S. (2012). Clinical appeal of Cultural Formulations in Rural Mental Health:: A Manual. In B. S. CHAVAN, N. Gupta, P. Arun, A. Sidana, & S. Jadhav (Eds.), Comprehensive Textbook on Community Psychiatry in India. (1st ed., pp. 560-565). New Delhi: JAYPEE BROTHERS MEDICAL PUBLISHERS (P) LTD..

55 Clinical Appeal of Cultural Formulations in Rural Mental Health: A Manual

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The term 'culture' although popular in Indian lay health terminology, remains alien to psychiatric vocabulary in the country. Its usage is primarily as an epidemiological variable within Social Psychiatry. This chapter argues that for 'cultural sensitivity' in a rural context, to be relevant and effective for both professionals and patients, it is necessary to re-examine the cultural identities of mental health professionals themselves, in their clinical encounters with rural Indian patients. The chapter also examines how mental health clinicians could find practical ways of engaging with her rural patient. Through a discussion of what is culture, emerging theory in clinical anthropology, recent developments in the field of cultural formulations, together with a clinical case vignette that suggest alternatives to enhance the outcome of traditional doctor-patient encounters, the chapter proposes avenues that offer both theoretical and practical value to both patients and health professionals. The case vignette has been extracted from field notes of ethnographic enquiries conducted by the authors in contemporary rural mental health settings in northern India.

WHAT IS CULTURE?

Culture has no single definition (Helman, 2007). It has different meanings in different contexts. For the purpose of this chapter, 'culture' can be understood as the sum of dynamic beliefs, values and behaviors of a particular group. Thus, culture as a concept can refer both to the community in which a health care worker works, and also to the beliefs, values and behaviors of the health professional and her own changing health system.

Why are Rural Values and Beliefs Important?

It is common and not surprising for mental health professionals to dismiss rural people's beliefs about mental illness as superstition and non-scientific. This attitude is very prevalent amongst city people, including doctors, who view themselves as better educated and more civilised than rural people. Often rural people are made to feel inadequate as a result of such attitudes. Beliefs amongst rural people are helpful for coping with many aspects of their lives. Similarly, many rural values are positive, insightful and may even benefit health professionals' own personal and professional growth. Rural values may also contribute to the development of indigenous mental health theory and practice. These include deeply cherished ideas that value the family as a source of support, the strength of traditional community ties, and the cultural psychological relevance of various religious rituals and festivals. Attempting to dismiss such beliefs might be very cruel to the patient and their community. You may be potentially taking away the patient's ability to cope with a whole range of misfortunes including everyday suffering, and family and community problems. In some situations, local beliefs may also reflect ideas about ecological concerns including natural and man-made disasters. Therefore, rural beliefs are not to be viewed simply as linked exclusively with a specific medical diagnosis or illness.

In mental health care, a relationship of trust and respect between the health professional and patients is critical for treatment. Despite the best available treatment, unless there is a good relationship established between the health professional and the patient, treatment will not be accepted. Rejecting rural people's beliefs at the outset is a poor way to build an effective relationship with patients and family members and may result in people dropping out from treatment programs. As well intentioned as it may be, professional health training might result in alienation from local cultural and rural values. It is an axiom that understanding cultural factors which shape illness experience, meaning and behaviour is necessary for devising an effective treatment program, both for the individual and the community. Consequently, if illness

experience does not match with the theory of health professionals, then it is the theory that must change to reflect this. Most research on this topic unintentionally or intentionally accord blame to their patients, including their values, state of literacy, superstition, backwardness, and lower intelligence for medico-cultural conflicts in India (Jadhav, 1995).

How can you Work with Rural Beliefs?

Although as a health professional, you may be a member of the local community, it is important that you specifically enquire about patients and their families' cultural beliefs. The very *act* of enquiry is in itself important in establishing a relationship of trust, respect and empathy. The *process* of enquiry is also important. In turn, your patient will feel respected and valued. As a preparatory step, you must also become aware of your own attitudes and beliefs. This would involve reflection on:

a.   The culture of the family and community in which *you* grew up. Think about the values and beliefs that your family and community emphasized as important. Also consider ideas about health and illness that you have developed.

b.   The culture of the *health system* and *health institution* in which you work. Think about the values and beliefs that are emphasized in this system. Also consider how the health clinic views the beliefs of local communities. Reflect upon beliefs that you hold both as an individual, and as a clinical team delivering mental health care to rural Indians.

As part of this exercise, you should become aware of your own assumptions and attitudes toward the local beliefs of the communities in which you work. For example, what do you think about treatment by traditional healers or supernatural explanations of illness? Do you think the people your clinic serves, might trust you? Do you trust them? Consider, for example, why you reach out for a prescription as soon as you have made a diagnosis? What frustrates you most about your clinical role? The final step in this self-reflection is to try to put aside your own ideas and assumptions in the process of listening to patients and their family members talk about their problems in a non-judgemental atmosphere. This will allow you to be a more effective listener and thus develop a better rapport.

In your discussions with patients and family members, it may be necessary to specifically ask them in an open-ended way about their own understanding of their problem. This may involve gently probing for what troubles them most. Inquire about their ideas of causation including supernatural explanations, family and community factors affecting care

and help seeking, and wider economic and social issues that shape their suffering.

Seven Simple Questions to Engage with Cultural Beliefs

Here is one way of doing that. First you have to be genuinely curious to know more about your patients suffering. If you are not, then your patient is likely to lose interest and disengage with you. Also, if you are not keen to know more about your patient, then you will run out of questions to ask and be unable to hold a meaningful conversation with your patient. Remember the first meeting with your patient is very important. Impressions and relationships develop very quickly. One meeting is never enough.

Begin by introducing yourself. Introductions are of different types and there is no right or wrong way to share information about yourself with your patient. It would be helpful if you could for example, state your full name, your ethnic background, the languages you speak, and the place where you trained and currently reside, and the positive reasons why you are at the clinic. You could then request your patient to introduce herself. Often this is a way to allow your patient to introduce herself in a manner that will permit important disclosures. Such disclosures are invaluable both in developing a good rapport and also providing information that links their cultural identity with their suffering. You could follow up by saying that you are keen to hear their own views, and that there is nothing right or wrong about any of our views. Consider giving an example as follows:

Example of Crop failure: Some farmers might think crop failure is due to bad luck, or bad stars or bad deeds in past life. Others may think it is due to not enough water or electricity. Some might think that jealous neighbours might have cast a curse or an evil eye, and some might consider it due to poor quality seeds or fertiliser. Similarly, when someone develops a psychological problem, we all tend to develop different explanations. I am therefore keen to hear your own explanations, not the ones given by doctors and nurses at the clinic or the hospital. This is very important for us as it will help us understand your suffering, and therefore help you better (Weiss, 1997).

Remember, many patients may feel shy to discuss these issues. This is also because such beliefs are often not elicited by health staff. Similarly, poor people, those from backward castes, women and other marginal groups might feel ashamed or scared to be asked these questions. They may fear that you want to hear the 'correct' answer as they often accord you a higher status. Finally, don't rattle these questions off like a text book chapter or arithmetic tables. Please give enough time to explain and listen. If possible, conduct a role play with some of your trainees.

Here are some useful questions:

1. Tell me, in your own words, what troubles you most?
2. What name or phrase would you give to your problem?
3. How does this 'problem' cause you suffering (use patients own words for the 'problem' for the remaining questions 4, 5 and 6)?
4. What is the worst you fear from this 'problem' that will happen to you and to your family?
5. What treatment do you think will help you best for your 'problem'? How? Why?
6. What do you expect will happen without treatment and with treatment, to your 'problem'?
7. Do you think my own background may affect the care you receive at this clinic? Why? How?

The vignette detailed below illustrates the value of ethnographic formulation. This case study has been derived from research experiences during anthropological field work in rural parts of northern India. It is therefore written in a first-person style. Although this case study does not follow the sequence of questions detailed above, it highlights the role of cultural context and anthropologically guided inquiry in understanding and engaging with rural patients.

Ethnographic Vignette

Clinical Formulation

Ratana Bibi is described in the rural psychiatric clinic case notes as a 65 year old female, with a 'TDI' (total duration of illness) of 5 days. Her symptoms as noted by the clinical team in English, included: running away from home, sleeplessness, senseless talking, crying, and no bathing and eating. A diagnosis of 'psychosis' was made and she was prescribed anti-psychotics. Ratna Bibi was known to the clinic staff as non-compliant with her treatment. A mental health professional at the primary health care centre summed up Ratana Bibi's frequent non-attendance at the clinic as follows*: "The problem with these people is that if you spoon feed them they don't come."*

Cultural Context and Identity

Ratana Bibi and her husband Mohammed lived in the furthest corner of the village in the Muslim area just behind the dominant caste's neighbourhood. The couple, in their late 60s, have three married daughters and three unmarried sons. Entering Ratana Bibi's house, I noticed a blue tarpaulin covering our heads. She would frequently express her biggest worry: building a roof on the entire house so that she could get her first son married. The house has one finished room where the family sleeps. Cooking is done in an outer area under a staircase that leads upwards to the future roof. A second room is unfinished and full of construction materials.

Mohammed had once been a wrestler but his habits of smoking ganja and drinking had taken a toll on his body. He had a reputation in the area for smoking and selling ganja. I first met him in his fields working by himself on a small plot of land planted with potatoes. It had been a bad year. The small fields were barely enough to sustain the family. The youngest son had broken his leg after falling from a tree resulting in significant private medical expenditures. Their watermelon seeds had failed to germinate. The potato crop had rotted in part due to Mohammed's addictions.

There were additional family dynamics connected to her problems. Ratana Bibi complained bitterly about how her husband was often away and sons did not bother about her. Mohammed's attitude was largely related to his addictions. The sons seemed preoccupied with their own work – and struggled to earn a living. The eldest son worked as a truck driver, the second son drove a tractor and the youngest son studied in high school.

Their social and economic position within the village amplified family dysfunction. The family had little land and the son's were dependent on daily wage income from the dominant caste families. As one of only a handful of Muslim families in the village, the family occupied a marginal position in their own community and as Muslims within the wider village.

Cultural Explanation and Help Seeking

Ratana Bibi stated that her immediate problems were 'running away' and 'head aches'. She told me that groups of men or women would surround her and say 'chalo' (Lets go). These imaginary people would scare her. In fear she would go with them and run towards the highway. Usually another villager would find her and bring her back. Mohammed and his sons would claim they were getting her treatment and were largely indifferent except when she would 'run away'. And once she was a bit better, the medication would be stopped. Ratana Bibi said the medications caused 'nasha' (drowsiness). Repeated bouts of 'running away' would follow.

These views of medication related to the family's perception of the problem. Ratana Bibi told me that seven or eight 'bhooths' (ghosts) bothered her. Mohammed claimed that she had picked up these ghosts before marriage when she went to the 'shamsan ghat' (cremation area on the riverbank) to listen to music. The family had 'jhar-phook' (exorcisms) conducted by both Muslim and Hindu healers. Ratana Bibi told me that she distinguished between the problem of 'running away' and the 'headaches'. The former were caused by ghosts while the later she linked to 'marz' (illness). She told me that treatment by exorcism addressed the root of her problems.

Reflection and Reformulation

Ratana Bibi's story illustrates how a web of social, cultural and economic factors shapes suffering. The clinic formulates her problems in a one-dimensional manner: duration of illness, symptoms, diagnoses and treatment. Her responses to the problems she faces reflect her options as a poor and elderly woman in a patriarchal society. Dependent on an addict husband and pre-occupied sons, she responds to economic and social stressors by expressing her problem through idioms that might evoke concern: ghosts and illness. The family responds to these calls for help, at least in a limited way, by engaging with healers and doctors. However, these responses are of limited value: they do not change her social reality of being an elderly woman.

The role of the family as a unique 'Indian' resource in community mental health care is often cited in the literature (Nunley, 1998). The intersections between gender, patriarchal family structures and mental illness in the Indian context have been examined in both formal epidemiological studies (Chakraborty, 1990) and ethnographic research (Das & Addlakha, 2001). Ratana Bibi's experiences highlight the ways that the social and economic position of women limits the options that women have to express distress. It also illustrates the constraints that complex familial relationships place on a help-seeking—in Ratana Bibi's case her son's and husband's neglect of her condition was shaped by a breakdown in the socially expected role of her husband.

How might this cultural formulation help mental health professionals engage with rural cultures? The mental health professional's response detailed at the start of this vignette reflects a general frustration with the public's lack of 'cooperation' with a service that professionals perceive as being 'good' and 'useful' for them. The nature of this 'gift relationship' (Mauss, 1967) is measured by the former as an expense of time, energy and long journeys which is not reciprocated by the rural communities they serve. In the words of one of the clinic staff to a patient who had arrived late to the rural clinic: *'We are driving all the way here, the government is spending on fuel, and you can't reach on time'.*

There is extensive published literature of the 'doctor' as a kind and benevolent person attempting to help someone who is distressed. This benevolence is considered a healing attribute. Such an existing 'asymmetrical' relationship between doctor and patient is further skewed in an Indian rural mental health setting staffed by urbanized public sector health professionals. This benevolent attitude together with social class differences lead to an expectation amongst clinicians that the patient ought to make compromises justified by the clinician. The demand that patients should come to the clinic rather than the clinician visit their patients' homes is a consequence of this 'charitable' attitude on the part of the clinican and her team visiting the rural clinic. Consider the reverse. The clinic staff might well find it helpful to also conceptualize the *clinic as a non-attender* to the patients' home instead of the patient as non-compliant. It could also be argued that if rural patients with little material resources, often make long and expensive journeys to consult reputed private psychiatrists in high tech hospitals as part of an indigenous mental health tourism industry, the reverse does not match up. Consider why mental health professionals do not visit rural patients' homes?

In a larger context, the clinic denies itself the opportunity to capture the role of ecological landscape that shape patient suffering. It could be argued that cultural formulations based on a series of questions would not necessarily bring about the changes that the authors suggest. However, the sensitivity generated through this process and the attempt to construct cultural formulations, in itself will generate both an imagination and richer understanding of the suffering experienced by patients, and identify the source of their problems.

The vignette described here is an example of how urban health professionals experience challenges in the clinic, and might be able to better engage with concerns articulated by a rural Indian people. The authors do not claim that this would necessarily solve more intractable social pathologies including poverty, oppression, and inequalities. However, the very process of engaging with local culture offers hope and imagination that might fuel and shape a richer and more meaningful mental health policy for India's rural people.

DISCUSSION

The role of language in the clinic is of paramount importance. Although language is multi-faceted and includes both non verbal and verbal expressions, the clinical discussion is confined to verbal expressions and exchanges both in the rural clinic and in this chapter. The language of the clinic and that of the patient are very different. There are two aspects to this language. First, is the professional jargon or vocabulary that the clinician is trained through their text book. Second, is the difference between rural and urban linguistic styles in expression. These include the local metaphors or idioms of expression (Lakoff & Johnson, 1980), and description of patients problems (symptoms) written by clinicians in their case notes. There is a huge gulf between the two. In view of the short time, and large numbers of patients to be assessed, clinicians often resort to abbreviations, and medical codes that are familiar with their colleagues. For example, one such abbreviation to describe a multiple bodily problem reported

by patients, is *'somatization +++'*. Consider alternatives styles that might be more faithful to the patient's world of rich descriptions that convey multiple meanings through their body. Somatisation could be viewed in different ways. Although taught as a 'jargon' to denote a range of bodily symptoms expressed by patients, somatic complaints could also be understood to convey rich and profound cultural conflicts (Jadhav, 2000; Kirmayer & Young, 1998). More over, patients often use a language that they think might be familiar and pleasing to the clinician. Often, the vocabulary of the clinic diffuses out into the local community, and is then used by patients in order to ensure the clinicians can be engaged. It is ironical that patients spend effort and time to attempt engagement with their health professionals. The reverse does not match up. This topic is in itself worthy of further investigation and research, and beyond the scope of this chapter.

Health professionals often complain about the little time they have at hand to address psychosocial issues. The reality is that there is barely enough time to elicit patient clinical histories, make a diagnosis, and write out a prescription. Clinical practice in such settings is clearly unable to address the complexities of social and economic stressors of village life. How ever, consider the amount of time lost in providing consultations to frequent attenders whose problems could be understood with an additional investment of 30 minutes spent in making a cultural formulation and conducting a rich and meaningful consultation. Consider also the re-organisation of time spent by other members of the team that staff the rural clinic: the initial screening, diagnosis, investigation, dispensation of medicines, and checking of prescriptions and tablets dispensed. Contrast this with the potential value that social workers and psychologists in your team might legitimately provide through their expertise and time invested in conducting a cultural formulation. Think about the rewards to both patients and clinicians as a result of engaging and understanding the broader problems that shape their suffering. Try to distinguish physical time from cultural time. The latter need not match with the former and often may be less in many instances. Also, the very process of *documenting* the concerns of patients and communities can inform policy makers of the range of issues that the rural clinic often is unable to address. This upward flow of information from the rural clinic to city based policy makers can be viewed as data that will in itself allow the voices of marginalised people to be heard by the State. At present, this is missing from district mental health programmes. As a result, policy makers conclude that their models ought to work since there

is no evidence that challenges it. Your documentation of the issues highlighted in the case vignette will challenge policy and force a re-consideration of the State's efforts in addressing the concerns you raise.

Earlier on in this chapter, the authors cautioned against a simplistic association between beliefs and diagnostic categories. To extend this discussion further, it is equally untrue that the urban-rural divide is the only factor that bears on the relationship between mental health professionals and patients. Additional factors include the role of gender, social class, caste, personality, and wider community relations between the health professional and her patient. However, for the purpose of this brief manual, the authors have confined themselves to exploring the clinical encounter between more urbanized mental health professionals and their rural patients. It is crucial to make note of this caveat. To re-iterate, the authors caution the reader against adopting a simplistic dichotomy of rural-urban divide. However, the authors' field work experiences suggest that although problematic, this divide is still valid for analysis of clinical consultations in the majority of primary health care settings and indeed in many urban and semi-urban psychiatric clinics in India. Perhaps, this may serve as a useful starting point for further research on the broader topic of how cultures of mental health professionals shape the assessment, diagnosis, treatment and outcome of their patients. Until recently, the emphasis on patient's beliefs (lay explanations, explanatory models, health beliefs, lay beliefs, etc.) has dominated the field. More recent literature in the field of clinically applied anthropology suggests that a narrow focus on patients alone yields little about wider concerns around clinical engagement and compliance with mentally unwell people. In fact, it may be deeply patronizing to focus on patients and exclude the 'Other': the health professional and her own beliefs including the ideologies of the health care institutions through which they operate.

Returning to the main theme of this chapter, the authors argue that health encounters are shaped by the cultures of multiple protagonists. A singular focus on patients alone is problematic and limiting. It risks not addressing the concerns of the rural patient and counter-therapeutic to clinical care provided by mental health professionals. It blinds us to the reality of India's rural people. In doing so, it also falsely re-affirms the 'scientific merit' of sacred text books on mental health and policies which are not to be questioned. Stated more provocatively, it may be worth asking ourselves as mental health professionals: are existing clinical approaches in community mental health care 'instruments of violence' (Jadhav, S. *What is Cultural Validity?* In this book).

SUMMARY

The Culture of rural people must be understood in order to provide good quality care:

1. Enquire families and patients about their understandings of the problem.
2. Be curious to find out ways in which they have dealt with their problem.
3. Do not dismiss patient's beliefs at the outset but rather work with them and only intervene after you have discussed this with your senior colleagues, and reflected upon them yourself.
4. Seeking help from non-allopathic sources such as temples, astrologers, faith healers, etc. is not wrong unless it is causing clear damage. It is very common, just like the way people in cities shop in the market to get the best results.

Reflect upon the internal culture of health care including official mental health institutions and how this may shape your encounter with patients.

1. Recognize your own assumptions and beliefs about mental health and illness.
2. Be humble and try to learn from your patients beliefs, and educate your health colleagues in turn.
3. Be open to rural values as these might well change you, sometimes for the better.
4. Language is not value free. This applies to both patient complaints as well as your own style of editing, reframing, and writing down what they have to say. Think carefully when you write what you have interpreted from your consultation with the patient. As far as possible, try to use the vocabulary of the patient, with appropriate quotes, rather than short hand styles. Ask yourself what your patients are trying to say and try to understand the meaning of their words and local metaphors. Generate a discussion about this with your colleagues, and discuss how well this language matched with your own case note language. Draw up a list of common phraseology that patients express at your clinic, and write out the symbolic meanings, their origins, and popular appeal. This could develop into a 'field manual' to share with you colleagues who may wish to contribute and develop it further. Just as clinicians try to modify their style of verbal expressions to suit their patients, the former also try hard in the reverse direction to please the health professional. Such as effort might also result in material that might be useful for teaching trainees at your own department, and indeed in contributing towards future editions of this textbook.

BIBLIOGRAPHY

1. Chakraborty A. Social stress and mental health: A social-psychiatric field study of Calcutta. New Delhi, Sage Publications, 1990.
2. Das V, Addlakha R. Disability and Domestic Citizenship: Voice, Gender, and the Making of the Subject. Public Culture 2001;13: 511-532.
3. Helman C. Culture, health and illness. London, Hodder Arnold, 2007.
4. Jadhav S. The ghostbusters of psychiatry. The Lancet 1995; 345: 808-810.
5. Jadhav S. Cultural construction of western depression. In: Anthropological approaches to psychological medicine: crossing bridges. Edited by Cox J, Skultans V. London, Jessica Kingsley Publishers, 2000, pp 41-65.
6. Kirmayer LJ, Young A. Culture and somatization: clinical, epidemiological, and ethnographic perspectives. Psychosomatic Medicine 1998; 60: 420-430.
7. Lakoff G, Johnson M. Metaphors we live by. Chicago, University of Chicago Press, 1980.
8. Mauss M. The gift: forms and functions of exchange in archaic societies. New York, Norton, 1967.
9. Nunley M. The Involvement of Families in Indian Psychiatry. Culture, Medicine and Psychiatry 1998; 22:317-353.
10. Weiss M. Explanatory Model Interview Catalogue (EMIC): Framework for Comparative Study of Illness. Transcultural Psychiatry 1997; 34: 235-263.