

# 'Genetic loading' or 'evil mind': current conceptions of depression in Myanmar from the perspective of healthcare professionals

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**In Myanmar, a country that has just recently opened up to the international community, Buddhist and traditional healing methods are still widely applied to various diseases and conditions. The aim of this study was to ascertain how professionals from the biomedical healthcare system in Myanmar experience interactions with patients with depression, based on the professionals' conceptualisation of this disorder. Six problem-centred interviews were conducted and analysed with grounded theory methodology. The interviewed professionals conceptualised three ways of understanding depression, including different treatment strategies: a biomedical, a contextual and a Buddhist concept of depression. Concerning the patients' perspective, the professionals mentioned somatic, religious and supernatural explanatory models, as well as corresponding help-seeking behaviour. Our results suggest that by taking a biomedical approach, professionals risk neglecting both the needs and resources of Myanmar patients with depressive symptoms.**

In epidemiologic studies, depressive disorders are found to be the most common mental disorder worldwide. There is an increasingly negative effect on both individual psychosocial functioning, physical health and national economy in general (Lépine & Briley, 2011). There is still a widespread lack of information about current mental health issues in Myanmar that are accessible to the international community. After decades of economic and political isolation, Myanmar has seen a tremendous political and social transformation in recent years. The history of the Myanmar mental healthcare system is embedded in its turbulent and violent political past.

With the defeat of the last Burmese Kingdom in 1885, the indigenous healing system was increasingly challenged by Western medical concepts and the developing colonial healthcare structures. Myanmar's first psychiatric hospital, the Rangoon Lunatic Asylum, was opened by the British in 1886 in Yangon and housed homeless individuals, criminals and people with psychiatric

illnesses (Khin Maung Zaw, 1997). The current mental health legislation dates back to The Lunatic Act, passed by the British in 1912. It has been considered as still only partially implemented by the World Health Organisation (WHO, 2014). After the Second World War, psychiatrists trained in Britain struggled to introduce these latest medical standards in Myanmar mental healthcare. They also tried to maintain relations with the World Health Organization (Adler, 2007). The civil war between political and ethno-nationalist groups that occurred after independence in 1948 eroded the economy as well as the infrastructure of the formerly wealthy Burmese Kingdom. The mental healthcare system was particularly affected.

In 1990, the self-installed military interim government implemented mental healthcare as part of the National Health Plan by further training general practitioners (Adler, 2007). The only in-depth analysis of the mental healthcare system is a report by the World Health Organization in 2006. It recorded 25 out-patient clinics, 17 community-based in-patient clinics and two psychiatric hospitals in Yangon and Mandalay. In 2006, there were 89 psychiatrists and 127 specialised nurses and only 4 clinical psychologists employed in mental healthcare. The treatments provided were found to be limited to pharmacotherapy, whereas psychosocial interventions played an insignificant role (World Health Organization, 2006). Currently the Myanmar medical education system offers medical doctors a 3-year master's programme, specialising in psychiatric care.

Religious and traditional medicine continue to coexist with the biomedical healthcare system (Adler, 2007). Skidmore (2008) found that Myanmar initially seek help through changing their diet or taking traditional Myanmar medicine. Only when enduring severe illness do they consult a medical doctor from the public or private healthcare system. The financial situation, individual illness beliefs, severity of the disease and the accessibility of biomedical healthcare all influence patients' help-seeking behaviour.

Buddhist monks and monasteries play a major role in Myanmar education as well as in healthcare, especially in rural areas. It has been assumed that individuals consult Buddhist monks for their mental problems (Tint Way, 1985). About 87.9%

of Myanmar people are Theravada Buddhists (Central Intelligence Agency, 2017). Briefly summarised, Theravada Buddhist theory states that all living conditions are prone to impermanence and are thus considered *Dukkha*, or suffering. The Buddhist law of *Kharma* claims that every impure mental, verbal and behavioural action will affect one's present and future condition, including any form of physical and mental illness. By pursuing the *Noble Eightfold Path*, including the practise of Vipassana meditation and mindfulness, individuals seek to purify their mind until they reach the state of enlightenment, or *Nirvana* (see Rahula, 1974). Importantly, in Buddhist theory mindfulness is strongly embedded into the Buddhist ethics and religious assumptions. It is not interchangeable with mindfulness techniques in Western psychotherapy. The current practise of Theravada Buddhism in Myanmar is the result of an intricate and complex interaction between Myanmar local spiritual beliefs and traditions, as well as sociopolitical factors (Walton, 2015).

Kleinman *et al.* (1978) stressed the need to explore patients' concepts of both cause and healing strategies for their mental distress (known as explanatory models) in psychiatric consultations. He argued for a differentiation between disease, the supposed underlying psychopathology or perspective of professionals, and illness, the subjective experience and causal attribution of the persons affected and their social group. This position has been criticised for neglecting the idea that the professionals' perspective is construed by the social norms and scientific tradition of modern medicine itself (Gone & Kirmayer, 2010). Nonetheless, his emphasis on the negative effect upon treatment adherence and satisfaction of conflicting explanatory models between professionals and their patients cannot be underestimated.

### **Purpose of the study and research design**

This pilot study was designed to explore current concepts of depression among Myanmar professionals and the influence of these conceptions on doctor–patient interaction. The different stages of the research process (data collection, transcription of the interviews, coding the material and data analysis) were based on the methodology of grounded theory (Glaser & Strauss, 2010). The ethical principles of informed consent, confidentiality and avoiding harm were followed rigorously. In December of 2013 and January of 2014, the first author conducted six problem-centred interviews (Witzel, 2000) with Myanmar healthcare professionals working in government or private mental health facilities. The principle of 'minimum and maximum contrast' (Strauss, 1987) was followed when selecting new interviewees. The interviews were conducted in English, but the interviewees were encouraged to name relevant Myanmar idioms. The first author's Myanmar language skills allowed him to translate these idioms during the interview or afterwards.

Additionally, he collected educational material on depression and was occasionally granted permission for participant observation. The data was analysed to understand phenomenology, cause and/or meaningfulness, treatment of depressive complaints and handling of patients' perspectives.

### **Professionals' conceptions of depression**

Results suggest that Myanmar professionals apply the term 'depression' to a wider scope of symptoms and ailments than suggested by the DSM or ICD. Within their perspective, three conceptions of depression have been differentiated.

Taking a biomedical perspective, depression was defined as a psychiatric disease based on a 'genetic loading'. The interviewees referred to the model of a chronic disease, wherein stress activates a genetic disposition. This concept distinguishes a population prone to develop depression from a 'healthy' population. The main treatment strategy is pharmacotherapy.

Professionals with a more contextual perspective emphasised that depression is caused by stress and expressed mainly by somatic complaints. They attribute this not only to a lack of health education and the stigma of mental illness, but also to social norms proscribing overt presentation of negative emotions and interpersonal conflicts. Financial problems were named as one of the primary causes for depression in Myanmar. Professionals also hinted at the influence of specific psychosocial factors in Myanmar. They mentioned the higher burden on women because of role expectations, as well as the prevalence of depressive symptoms among the young when migrating from rural to urban areas. In addition to pharmacotherapy, psychosocial interventions were considered as essential component of effective treatment. These may include psychoeducation, normalisation, relaxation and suggestive techniques (e.g. hypnosis) and advice. According to the interviewees, international psychosocial aid after Cyclone Nargis in 2008 generated an increased interest in psychiatric–psychotherapeutic interventions among the professional Myanmar mental health community.

Conceptualising depression from a Buddhist perspective, it was defined as a state of past or present 'evil mind', caused by the attachment to states of mind such as greed, jealousy and anger. Additionally, the open expression of aggressive affects and behaviour may be considered as manifestations of a 'depressed mind'. Professionals recommend reading Buddhist texts, the practise of mindfulness and Vipassana meditation to detach oneself from these unwholesome states. The interviewees claimed that patients often regard present and past impure actions as causes for their depressed state in a concretistic manner (e.g. headache because they harmed someone's head with a hammer in past lives). The Burmese idioms for mental distress and depressed mood, *seik nyit tae* (contaminated mind) or *seik shote tae* (chaotic

mind), reflect their Buddhist origin. It has to be stated that these conceptualisations are highly influenced by the individual receptions of Buddhist theory and its amalgamation with Myanmar folk beliefs and traditions.

Importantly, findings suggest that the perspective held for an individual case depends on a combination of the severity of the patient's condition as well as the professional's personal preference, education and economic incentives.

### **Information on patients' conceptions of depression**

According to the information gathered from the professionals, somatic as well as supernatural explanatory models dominate among the lay population. They explained that directly taking psychiatric help is highly stigmatised, and thus rare and dependent on access and health education. Moreover, the lay population displays an inability to differentiate depression from other mental disorders. Therefore, self-help and help-seeking behaviour is non-specific in early stages of mental illness, including depression. Three self-help strategies have been found in the data.

- (a) Seeking refuge in Buddhist or other religious practices and rituals (e.g. making merit, chanting and reciting Buddhist prayers), taking Vipassana meditation (retreats) and non-specific self-help strategies.
- (b) Seeking help from a Buddhist monk, traditional healer, general practitioner or other medical specialists, therefore avoiding the stigma of a psychiatric diagnosis.
- (c) Accepting themselves as a psychiatric patient and consulting a psychiatrist.

These strategies seem to reflect a gradual aggravation of mental illness and depression. Minor states of depression often remain undetected. Mostly psychiatric help is sought after receiving advice from others, such as a general practitioner, Buddhist monk or relative, or when symptoms persist or worsen.

### **Professionals' handling of their patients' beliefs and help-seeking**

The professionals expressed a need to consider both their patients' religious and spiritual practices, or risk their patients dropping out of treatment. Although supernatural practices are silently accepted and mostly not explicitly addressed, professionals with a more a Buddhist or contextual conception of depression regard their patients' religious beliefs and practices as a resource. For instance, they recount Buddhist mythological stories about the circle of life and death to foster the acceptance of suffering as an inevitable part of life. Of special interest is the finding that professionals encourage different religious practices, loosely named 'meditation', depending on the severity of the patient's condition. Vipassana meditation is only recommended when suffering from minor symptoms or after the

acute depression has been cured. In cases of severe depression, depression with psychotic features as well as agitated depression, they restrict the patient's Vipassana meditation practise because of the risk of decompensation. Instead, professionals advise worshipping in Buddhist pagodas or reading religious texts.

Interestingly, some professionals revealed conflicting viewpoints concerning the scientific view on psychological phenomena after the formal interviews had concluded. One professional openly expressed his struggle to reconcile his scientific knowledge with his personal religious and supernatural beliefs. Another suggested a friend to go to a religious healer after he had just stressed his disbelief in such healers during the interview. The findings indicate that senior professionals showed the highest flexibility toward integrating scientific and religious and/or cultural concepts.

### **Discussion**

A plurality in the conception of depression was observed among Myanmar professionals. In addition to the lack of resources in the Myanmar healthcare system, there are further barriers to be considered that appear to foster the preference of a biomedical treatment. First, by promoting a mainly biological cause of mental disease (including depression), professionals hope to fight the stigma of mental illness rooted in supernatural or religious explanatory models. Second, by providing pharmacotherapy both professionals and their patients avoid addressing psychosocial conflicts and negative emotions, in line with Myanmar sociocultural norms. More broadly, the pervasive climate of fear and repression under the military government in the past decades meant that the open discussion of psychosocial conflicts was highly discouraged. The results of this study nonetheless suggest that by taking a purely biomedical approach, professionals risk neglecting both the needs and resources of Myanmar patients.

The Buddhist religious practice of mindfulness and Vipassana meditation were identified as one of the main help-seeking behaviours. However, the number of people who successfully cope remains unknown. In cases of severe illness, decompensation was named as a major risk of Vipassana practise. Thus, the careful application or integration of mindfulness and Vipassana meditation into the treatment of depression can be considered a very promising and economical intervention strategy. In future research, the integration of religious practices, mindfulness and, in particular, Vipassana meditation may be investigated in focus group discussions and further individual interviews with both professionals and patients. Culture and language interpreters should be recruited to overcome the language barrier. Regarding the weak infrastructure, especially in rural areas, it may be worthwhile to explore the potential of cooperation with the

more accessible religious institutions, such as Buddhist monasteries and meditation centres.

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