APPLYING NEPALI ETHNOPSYCHOLOGY TO PSYCHOTHERAPY FOR THE TREATMENT OF MENTAL ILLNESS AND PREVENTION OF SUICIDE AMONG BHUTANESE REFUGEES

Brandon A. Kohrt
The George Washington University School of Medicine, Washington, D.C.

Sujen M. Maharjan
Tribhuvan University, Kirtipur, Nepal

Damber Timsina
Grady Memorial Hospital, Atlanta, Georgia

James L. Griffith
The George Washington University School of Medicine, Washington, D.C.

Addressing mental health needs of 100,000 ethnic Nepali Bhutanese refugees relocated from Nepal is a new challenge for mental health clinicians in the receiving countries. A limitation of current services is the lack of knowledge about cultural understandings of mental health. Ethnopsychology is the study of emotions, suffering, the self, and social relationships from a cultural perspective. Nepali ethnopsychology can be used to develop and adapt mental health interventions for refugees. We discuss applying ethnopsychology to provide safe and effective mental healthcare for Bhutanese refugees, including cultural adaptation of cognitive behavior therapy, interpersonal therapy, and dialectical behavior therapy. Psychological interventions are proposed for the high rates of suicide among Bhutanese refugees. The contribution of ethnopsychology to applied anthropology and the growing field of neuroanthropology are discussed.

In the late 1980s, the Bhutanese government enacted legislation restricting the civil, political, and economic rights of ethnic Nepali Bhutanese, also known as Lhotshampa (Hutt 2003). They accompanied this legislation with state-sponsored confiscation of land, expulsion from professional and government posts, abduction of activists, and rape of Nepali Bhutanese women. This led to the exodus of Nepali Bhutanese into adjacent India and nearby Nepal. Since the early 1990s, over 100,000 Nepali Bhutanese have been living in refugee camps in southeastern Nepal. After nearly two decades of confinement to refugee camps, the United Nation High Commission on Refugees (UNHCR), the International Organization for Migration (IOM), and myriad resettlement agencies have been relocating Nepali Bhutanese to the United States, Australia, and Western Europe.
Thousands of these refugees have resettled in the United States. Ultimately, over two-thirds of the Nepali Bhutanese refugees will be resettled in the United States (Schininà et al. 2011).

Unfortunately, resettlement, often in impoverished and crime-afflicted areas of the United States and amid a nationwide shortage in employment opportunities, has not been an anodyne for a population that suffered persecution in their home country and a generation living in refugee camps. In the United States, many Nepali Bhutanese have been exploited in high risk employment settings or have been forced to travel long distances for work (Dahal 2011). Lack of healthcare has been a major challenge in the United States. In refugee camps the Bhutanese had medical care provided through UNHCR and IOM. In the United States refugees typically are limited to only a few months of healthcare, and this policy varies by state. Unfortunately, Nepali Bhutanese are being resettled in states in the South and Southeast United States that have the most limited access to healthcare.

Although resettlement is rarely an easy process, the current environment for resettlement in the United States may be exacerbating mental health problems. One of the most concerning health issues has been the rate of suicide among the Nepali Bhutanese in the United States. One estimation of the current rate is 35 in 100,000 (Schininà et al. 2011). This is more than three times the national average in the United States, which is 11 in 100,000 (WHO 2011). The rate is a significant increase from the rate in the refugee camps, which was estimated to be 21 in 100,000 (Schininà et al. 2011). The United States has the highest rate of suicide among countries where Nepali Bhutanese refugees have been resettled according to one estimate: the U.S. rate is almost 30 percent greater than other resettlement countries (Schininà et al. 2011).

Given the high suicide rates and other psychological sequelae of resettlement and trauma, one area of needed intervention is improved mental health services. Although mental health services in isolation will not address the underlying economic, social, and other structural processes that contribute to impaired functioning and health, improving mental health services can foster better coping and adjustment in the face of resettlement problems (Porter 2007; Porter and Haslam 2005). Mental health services can be tailored to promote assertive coping, strengthen social networks, and improve problem solving related to economic and other acculturation stressors (Kira et al. 2012).

The goal of this article is to discuss the application of ethnography with Nepalis to therapeutic work with Nepali Bhutanese refugees using ethnopsychology and neuroanthropology as heuristics for clinical interactions. This article provides a framework to increase awareness among health professionals and resettlement agencies about Nepali Bhutanese experiences and interpretations of distress. We outline Nepali ethnopsychological concepts of the mind, body, and mental illness, which we then apply to psychotherapy. We reflect on how Nepali ethnopsychology can be mapped onto neuroscience models of mental disorders to facilitate both theoretical and applied work. Moreover, we address the issue of suicide and propose approaches for reducing suicide risk. To illustrate therapeutic application, we employ examples from clinical experiences with Nepali Bhutanese patients treated in a refugee mental health clinic in the United States. This information
is intended to improve mental health and psychosocial functioning and help augment protective mental health factors to reduce the risk of suicide.

PART ONE: NEUROANTHROPOLOGY AND PSYCHOTHERAPY

Neuroanthropology is a maturing discipline with a mission to examine “the enculturation of the nervous system” (Lende and Downey 2012:56). Researchers interested in neuroanthropology take advantage of the growing field of cultural neuroscience, which uses neuroimaging to examine group and cultural differences in processing of experience (Lende and Downey 2012:64–65). Neuroanthropology provides a framework for transitioning anthropological theory into practice, such as our application of ethnography for mental healthcare. The underlying schema in this endeavor is that culture shapes experience, which shapes neural processes, which in turn produce behaviors that replicate and transform culture (Lende and Downey 2012). Psychotherapy is a microcosm of this process. Relationships and personal experience, shaped by neurobiological attentional and categorizing processes, produce individual differences in reactions to trauma, experiences of distress, and trajectories of recovery (Levine 2010):

Attachment styles shape how personal narratives are constructed. Social hierarchy selects which stories of one’s people are told and retold or ignored. Social exchange guides which interactions in one’s life teach moral lessons that are remembered in storied form. Neurobiology opens and closes shutters to the world—opening awareness of one person’s pain, closing awareness of another, marking certain scenes or interactions as alarm buttons for entering survival mode. [Griffith 2010:242–243]

Three mechanisms can be distinguished in enculturation from a neuroanthropological perspective: (1) behavioral reaction and reinforcement, (2) language and framing, and (3) defining of in-group versus out-group categories. These processes are most salient in child development. A child’s behavior and language are shaped by the reaction and reinforcement behaviors of others in his or her social world (Vygotsky 2006). Language helps frame and label behaviors, groups of people, and types of experiences. Enculturation leads to categorization of in-groups and out-groups based on behavioral patterns, language use, and other group symbols (Cozolino 2010; Goffman 1963).

Psychotherapy operates along these three neuroanthropological domains of enculturation as well (Cozolino 2010). The therapist is trained to react to and reinforce specific behaviors, which will vary based on the therapist’s school of practice and training (Sparks et al. 2008). The therapist uses certain language and encourages reflection on language by the client or patient, and shifts in language and interpretation occur alongside changes in framing of experience (Epston et al. 1992; White 2004; White and Denborough 2011). Both shamanic healing and psychotherapy use manipulation of languages and symbols to produce change in emotional states (Dow 1986). The therapist also works with the client or patient to examine group association. People may arrive in therapy because of a lack of felt association with an individual, family, or group (Klerman et al. 1984). Others may define themselves as part of group characterized by a certain emotional or behavioral
impairment. The therapist's model of the patient also should change from seeing the client in his or her group role to seeing him or her as a unique individual (Griffith 2010).

The neuroscience of enculturation during child development is echoed by the neuro-processing changes observed during therapy (Cozolino 2010). The frontal lobes, which are involved in planning, inhibition, social regulation, and an array of executive functions, develop over the longest period of time and are the last to reach their mature and functional state. During psychotherapy, the frontal lobes are the main site of change, with increased frontal lobe activity observed during and after cognitive behavior therapy (DeRubeis et al. 2008).

The major components of psychotherapy are (1) hope and expectancy of change, (2) extratherapeutic and contextual factors, (3) therapeutic alliance, and (4) specific psychotherapeutic technique (e.g., cognitive behavior therapy vs. interpersonal therapy; see Miller et al. 1997). Mobilizing hope is a therapeutic process in which the client or patient sees him or herself as having the agency to affect change and the ability to identify pathways for change (Griffith and D’Souza 2012; Snyder et al. 2002). This process draws on the neuroanatomical circuits for motivation and planning, which are influenced by development and enculturation (Cozolino 2010). Contextual factors refer to those processes outside the therapy session ranging from amount of social support to availability of employment (White 2004). The cultural contexts that reinforce or discourage certain frames of self-appraisal are important contextual factors that influence if and how therapy will work. The therapeutic relationship refers to the bond and trust that develop between therapist and client or patient (Winston and Muran 1996). Cultural differences in appraisal of authority, models for self-disclosure, and the shared language between therapist and patient all influence therapeutic relationships (Jordans et al. 2007; Tol et al. 2005). Below, we discuss using ethnography to build ethnopsychological models for psychotherapy grounded in neuroanthropology.

PART TWO: FROM ETHNOGRAPHY TO ETHNOPSYCHOLOGY

Ethnopsychology refers to cultural models of understanding emotions, the self, social connections, perception, and cognition (Bock 1999; Kirmayer 1989; Kohrt and Harper 2008; Kohrt and Maharjan 2009; Shweder and Sullivan 1993; Westermeyer 1976; White 1992). Historically, Western culture’s ethnopsychology has been characterized by a split between mind and body, often referred to as Cartesian duality (Scheper-Hughes and Lock 1987), as well as an associated split between thoughts—rationality and feelings—emotions (Damasio 1994). Another division is between the soul and the body, which was instantiated in Christian religious doctrine (Lindland 2005). Individualism is a hallmark of Western ethnopsychology, with the assumption that individuals are separable from their familial and social relationships (Carrithers et al. 1985; Markus and Kitayama 1991). These cultural beliefs are reflected in aspects of Western healing systems such as the division of physical and mental health, therapies that focus on emotions and cognitions as separable phenomena, and individualized approaches to mental health care (Kleinman 1988). However, neuroscience and psychology research are modifying Western
ethnopsychology into a system that challenges many of the earlier divisions of emotion versus rationality, the body versus the mind, and the self versus the collective (Damasio 1994, 1999, 2003).

An overly simplistic division of Western from non-Western ethnopsychology holds that while dualism characterizes the former, holism is the trademark of the latter (Scheper-Hughes and Lock 1987). However, when non-Western ethnopsychologies have been studied by anthropologists and psychologists, this does not bear out (Fox 2003; Keys et al. 2012; Kohrt and Harper 2008; Kohrt et al. 2004). In reality, there is tremendous heterogeneity in ethnopsychologies, and some aspects considered hallmarks of Western ethnopsychology are common in other cultures. For example, mind–body divisions have been observed from West Africa to the Indian subcontinent (Desjarlais 1992; Fox 2003). Gendered frameworks of emotions are present from Pacific islands to Himalayan mountains (Lutz 1988; McHugh 1989, 2004). Other aspects of ethnopsychology, such as the role of the spirit or soul, are important in both Western psychotherapy (Griffith 2010; Griffith and Griffith 2002) and in other cultural healing practices (Desjarlais 1992; Wikan 1989).

In Nepal and among the Nepali diaspora, including Nepali Bhutanese, it would be misleading to claim that there is a single ethnopsychology. Nepal is home to greater than 40 ethnic groups and 100 languages (Bhattachan 2008). This diversity also is represented within Nepali Bhutanese. That said, through our ethnographic work, we have been able to cull core components of the self that should be incorporated into mental health treatment for Nepali Bhutanese refugees ranging from Sanskrit-language speakers to Tibeto-Burman language speakers. Both Sanskrit languages and Tibeto-Burman languages have terms referring to heart–mind, brain–mind, and souls (Desjarlais 1992; McHugh 1989, 2001). Thus, for the purposes of this article, we will refer to “Nepali ethnopsychology” while being cognizant that this is an oversimplified heuristic to function as an entry point into mental health dialogues, which can then allow for further exploration and nuance related to one’s linguistic, religious, educational, and geographic background.

In Nepal, over a decade of ethnography was used to develop an ethnopsychological model that captures Nepali ways of understanding the self and emotions (Kohrt and Harper 2008). Our ethnographic work included participant-observation with traditional healers, biomedical mental health professionals, and psychosocial NGO workers. The types of complaints, ways of framing illness and healing, and myriad practices for restoration of well-being were documented. This work revealed the importance of bodily complaints in expression of distress, as well as the realization that both physical pathology and psychological distress contribute to the somatic presentation of suffering (Kohrt and Schreiber 1999; Kohrt et al. 2005, 2007). Ethnography of the biomedical clinical encounter revealed commonalities with traditional healing in regard to self and emotion terminology. These commonalities helped establish a foundation for understanding a generalized ethnopsychological model (Kohrt and Harper 2008). The next phase of research was an examination of psychological trauma, which was addressed not only with traditional healers and psychiatrists but also with NGOs that viewed suffering through the lens of human rights violations (Kohrt and Hruschka 2010; Kohrt and Maharjan
These ethnographic experiences, taken together, are integral to understanding the experience and narrative surrounding ethnic Nepali Bhutanese refugees’ interpretation of mental health services. Since the arrival of Bhutanese refugees in the United States, further observations have evolved out of clinical endeavors with recently relocated individuals and families.

Nepali ethnopsychology, not dissimilar to Western ethnopsychology, includes multiple divisions of the self (see Figure 1). The main components are the physical body (Nepali: *jiu* or *saarir*), the heart–mind (*man*), the brain–mind (*dimaag*), the spirit (*saato*), the soul (*atma*), and one’s social status (*ijjat*) (Kohrt and Harper 2008; Kohrt and Hruschka 2010). Other important divisions are the family (*pariwaar*), which includes the extended family, and the spiritual world, especially connections with one’s ancestral deities (*kul devta*). For mental health treatment, the heart–mind and brain–mind are crucial topics. The heart–mind is the locus of memory and emotions. When one desires something, it is felt in his or her heart–mind. A bad or good memory arises from the heart–mind. Traumatic or intrusive memories often are identified as wounds or sores on the heart mind (*manko gaau*). Worries and anxiety are located in the heart–mind (e.g., *manmaa kura khelne* [thoughts playing in the heart–mind]). The heart–mind is what makes every person unique through their personal desires and wishes. In contrast, the brain–mind is the organ of cognition, attention, and social regulation. The brain–mind, when working correctly, will monitor thoughts and desires from the heart–mind, then inhibit socially inappropriate desires or actions. When someone acts in a socially inappropriate manner, such as when drunk, he or she is considered to have problems in the brain–mind. Someone who does not follow appropriate gender or caste norms is considered to have brain–mind problems. In some context, a woman who is not subservient to a man may
be accused of having a brain–mind problem. Violence and uncontrolled anger are also problems of the brain–mind. Lastly, psychosis and severe mental illness are brain–mind problems that are highly feared and stigmatized.

Not surprisingly, social implications of heart–mind and brain–mind problems vary considerably. Heart–mind problems are considered commonplace. Individuals often will share openly about “thoughts playing in the heart–mind” or “worries in the heart–mind.” However, to discuss a brain–mind problem invokes a heavy social stigma. Because of the social unpredictability of brain–mind problems, people with these symptoms and behavior are shunned. Many who have brain–mind problems are imprisoned within their homes and have severely constrained social lives. A family in which one person has a brain–mind problem will find that other family members have difficulty with arranged marriages. Having a family member with a brain–mind problem also can lead to job loss, exclusion from cooperative work or investment activity, or rejection from public festivals. Moreover, some brain–mind problems, such as psychosis, are considered communicable by sharing a cup or a plate.

Based on our experience working within Nepal and with Nepali Bhutanese patients in the United States, there is an important liminal state at the intersection of heart–mind and brain–mind problems. Although heart–mind problems are socially acceptable, there is also a concern that a prolonged intense heart–mind problem eventually can lead to a brain–mind problem. Child soldiers, in a multiday workshop in which they gradually developed rapport with facilitators, eventually disclosed that they were concerned that they may be going crazy (paagal) and that their brain–mind was going “out” (dimaag out bhayo) because of chronic heart–mind problems (Karki et al. 2009; Kohrt et al. 2010). Nepali Bhutanese patients similarly stated that they thought their brain–minds were becoming impaired and could no longer socially regulate the emotions and desires in their heart–minds. Love and lust are powerful emotions in the heart–mind that need to be controlled through the brain–mind. Overwhelming love is thought to make one irrational and thus impair his or her brain–mind making him or her do “crazy” things. Lust must be controlled by the brain–mind to prevent engaging in socially inappropriate acts. There is a traditional healing practice in Nepal conducted by shamans (dhami-jhankri) in which the heart–mind is ritualistically bound (man baadne) to calm its desires and intense emotions, ranging from jealousy to sadness to love, so that the brain–mind is not overpowered and socially acceptable behavior can be maintained (Kohrt in press).

The other parts of the self and society are associated with the heart–mind and brain–mind. The ijjat or social self is maintained by appropriate functioning of the brain–mind. If the brain–mind is not operating properly one suffers bejjat (loss of ijjat, or social status), which is associated with social marginalization and in extreme cases “social death.” Historically, certain socially inappropriate acts, especially those where caste or gender norms were violated, resulted in social death in the form of banishment from a village or town (Höfer 2004). Because of the importance of the social unit, bejjat (loss of status) also is experienced by family members of the person with a brain–mind problem.

The saato is the spirit. It is a supernatural part of oneself connected to the supernatural world of ancestors and spirits of places and animals. In most Nepali ethnopsychologies,
people are thought to have multiple spirits. The *saato* is crucial for vitality and physical health. When one becomes frightened or possibly cursed, the spirit may be lost (*saato jaane*, spirit goes) (Desjarlais 1992; McHugh 2001). As in many cultures with the concept of “soul loss,” the loss of spirit leads to vulnerability to other supernatural and physical maladies (Rubel et al. 1984; Simons 1985; Wikan 1989). A child who has lost his or her spirit may then develop a life threatening diarrheal disease, respiratory infection, or fever. Although adults do not lose their *saato* as easily as children do, they also become vulnerable to disease and generalized weakness when the *saato* is gone. Losing one’s spirit has important mental health implications. A trauma or sudden fright, which intensely activates the heart–mind, can dislodge the *saato* resulting in its loss. Therefore, after a traumatic or frightening event, individuals are vulnerable to physical maladies and may be overcome with generalized weakness. Healing by *dhami-jhankri* shamans is used in these instances to call the *saato* back to restore health and vitality. The *atma*, often translated as soul, has some overlap with *saato*. *Atma* is referred to by persons who have learned to read Sanskrit religious text and is thus an aspect of the self more salient to religious scholars.

The physical body (*jiu, saarir*) is the site of physical suffering and pain. For physical problems, individuals may seek home remedies, the care of a *dhami-jhankri* shaman, or go to a health clinic. When the physical body is sick or in pain, this leads to worries in the heart–mind. It is not unexpected to have worries in the heart–mind translate into bodily pain, headaches, stomach upset (*gyastrik*), and numbness and tingling sensations (*jham-jham*; see Kohrt et al. 2005; Kohrt et al. 2007). Within the physical body, the *dimaag* is located in the head. The location of the heart–mind may be in the region of the chest. However, interpretations of its location vary. The *saato* and *atma* do not have specific locations in the body.

A study of suicide and ethnopsychology among Bhutanese refugees found that 55 percent of family members of suicide completers felt that the suicide victim had problems in the brain–mind, 25 percent felt that the suicide victim had problems in the heart–mind, and 10 percent felt the suicide victim had *ijjat* problems (Schininà et al. 2011). These family perceptions focusing on behavioral control (brain–mind problems) more than sadness and depression (heart–mind problems) parallel epidemiological data about suicide studies in Asia (Hendin et al. 2008). In China and India, suicide shows only a weak association with depression and other mood disorders (Hendin et al. 2008). Mood disorders are especially rare among women in South Asia who have attempted suicide (Maselko and Patel 2008; Zhang et al. 2010). The disorders commonly associated with suicide in Asia and in low-income countries in general are impulse control disorders (Nock et al. 2008), which would be considered *dimaag* or brain–mind dysfunctions in ethnopsychological terms. In contrast, in the United States three-fifths of suicides are associated with mood disorders (Nock et al. 2010), which would be heart–mind problems.

Nepali ethnopsychology overlaps with neuroscience partitions of functioning. In mental disorders ranging from posttraumatic stress disorder (PTSD) to depression, there is increasing emphasis on the division between the prefrontal cortex and the limbic system, especially the amygdala (Canli 2005; Kemp et al. 2007; Ressler and Nemeroff
In both depression and PTSD, the amygdala may have increased activity (Bryant et al. 2008; Siegel et al. 2007). Conversely, the prefrontal cortex is considered hypoactive (Goldapple et al. 2004; Putnam and McSweeney 2008). The interaction of the prefrontal cortex and the amygdala parallel the ethnopsychological divisions of the *dimaag* and the *man*. The heart--mind is the locus of fear similar to the amygdala. The prefrontal cortex is the center of planning and social appropriate behavior comparable to the brain--mind. In the famous case of Phineaus Gage, it was damage to the prefrontal cortex that led to impaired social behavior and recklessness (Damasio 1994). In Nepali ethnopsychological terms, Gage undoubtedly would have been suffering from a brain--mind dysfunction. Mental health workers providing care for Bhutanese refugees could choose to include a psychoeducation component that gives credence to a neurological basis for the brain--mind and heart--mind division. This may be fruitful for some patients, but more work is required to determine if a biomedical interpretation of Nepali ethnopsychology would impact patient–doctor alliances or treatment adherence behavior. Instead, we feel that a key application of ethnopsychology is for psychotherapy.

**PART THREE: PSYCHOTHERAPY FOR NEPALI AND BHUTANESE PATIENTS**

Nepali ethnopsychology can be applied to psychotherapies such as cognitive behavior therapy, interpersonal therapy, and dialectical behavior therapy. One indispensable element with any of these approaches is that an effective therapist also acts as an ethnographer. Taking on the role of Other, rather than seeing the patient or client as Other, leads to elicitation of individual ethnopsychologies, rather than imposing biomedical models: “From a position as Other, a clinician can ask questions that might never be addressed to a patient from within his or her world. These questions can be asked with authenticity, concern, and respect, but their unique value lies in their otherness” (Griffith 2010:251).

**Cognitive Behavior Therapy**

Aaron T. Beck developed cognitive behavior therapy (CBT) as an approach to treat depression, which he conceptualized as a disorder in *thinking* that resulted in the negative *feelings* associated with depression (Beck et al. 1979; Rush et al. 1977). CBT is based on the model that activating events lead to behaviors that result in negative consequences (Beck 2011; Trinidad et al. 2011). The activating events trigger automatic thoughts that lead to the specific behavioral responses. In CBT, automatic thoughts are one of three types of cognitions, the others being conditional beliefs and underlying schemas. Treatment is based on short-term weekly therapy combined with homework to build insight for associations among thoughts, feelings, and behavior. CBT has been tested in numerous randomized control trials for multiple types of mental illness (DeRubeis et al. 2008; Harvey et al. 2003; Mehta et al. 2011). CBT consistently outperforms treatment as usual, and CBT has performed equally well to psychiatric medication in some trials (DeRubeis et al. 2008).

Kamal is a middle-aged Nepali Bhutanese refugee man who was brought to a mental health clinic in the United States because of intractable seizures. Kamal had seizures since 2000. In both depression and PTSD, the amygdala may have increased activity (Bryant et al. 2008; Siegel et al. 2007). Conversely, the prefrontal cortex is considered hypoactive (Goldapple et al. 2004; Putnam and McSweeney 2008). The interaction of the prefrontal cortex and the amygdala parallel the ethnopsychological divisions of the *dimaag* and the *man*. The heart--mind is the locus of fear similar to the amygdala. The prefrontal cortex is the center of planning and social appropriate behavior comparable to the brain--mind. In the famous case of Phineaus Gage, it was damage to the prefrontal cortex that led to impaired social behavior and recklessness (Damasio 1994). In Nepali ethnopsychological terms, Gage undoubtedly would have been suffering from a brain--mind dysfunction. Mental health workers providing care for Bhutanese refugees could choose to include a psychoeducation component that gives credence to a neurological basis for the brain--mind and heart--mind division. This may be fruitful for some patients, but more work is required to determine if a biomedical interpretation of Nepali ethnopsychology would impact patient–doctor alliances or treatment adherence behavior. Instead, we feel that a key application of ethnopsychology is for psychotherapy.

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his late teens first starting around the time of his marriage then again in his mid-twenties when his mother had a stroke. Despite treatment with numerous antiepileptic medications in refugee camps, these seizures did not abate. However, they did improve with the amount of time elapsed from major life events: his marriage and his mother’s stroke. In the United States, Kamal’s seizure frequency increased again. He was prescribed myriad antiepileptic medications without improvement. The pattern of Kamal’s seizures raised concerns for conversion disorder, a type of mental disorder in which an individual will display neurological symptoms, but in which no neurological etiology can be identified (Couprie et al. 1995). Pseudoseizures, a common manifestation of conversion disorder, are observable in most populations around the world from high income to low income settings (Bowman and Markand 1996; Guinness 1992).

CBT is a possible treatment for pseudoseizures. In CBT, the first goal would be to highlight the connection among automatic thoughts, feelings, and the seizure behaviors. For example, Kamal’s seizures often were precipitated by major life changes. Kamal revealed that he thought his mother had her stroke because he did not properly care for her and because he had not become a pujari (priest) like his father.

Kamal revealed that not living with his parents in the United States was another sign of his failure as a son. Kamal is the eldest son in his family. Kamal lived with his parents in the refugee camp in Nepal. Often, it is the expectation that the eldest son will look after his elderly parents. However, when the family was resettled not all of the sons were relocated in the same region of the United States, and the elderly parents were resettled with Kamal’s younger brother in a different state from Kamal. Kamal was worried that problems would befall his parents in the United States, and he would not be able to fulfill his responsibility as the eldest son, which entailed caring for their well-being. The thoughts of being a failure as a son typically preceded his seizures. For example, Kamal had one seizure when his father called and said that there was no longer health insurance to pay for his mother’s blood pressure medication. Pseudoseizures are often associated with unspoken dilemmas within families (Griffith et al. 1998).

An essential element of CBT is psychoeducation. Psychoeducation for CBT, as well as other forms of psychotherapy can be explained in terms of Nepali ethnopsychology to facilitate understanding (see Table 1). For Kamal and his family, the explanatory model for Kamal’s seizures was that he had a brain–mind problem that was manifest as epilepsy. Epilepsy typically is considered a brain–mind disease in Nepal and is treated by psychiatrists. This was the starting point for ethnopsychological grounding of CBT. Kamal was asked to identify what could affect the brain–mind. He pointed out that alcohol affects the brain–mind, not getting enough sleep affects the brain–mind, and too many thoughts in his heart–mind affect his brain–mind. Kamal identified worries of being separated from his parents as a major anxiety in his heart–mind that affected his brain–mind.

Eventually, Kamal discovered that his automatic thought, which preceded seizures, was “I am the main person responsible for taking care of my parents. If anything bad happens to them and they do not get help, it will be my fault.” His conditional belief was “as long as I am sick with epilepsy, it is not my responsibility to take care of my parents. If I am sick, then someone else needs to take care of them.” When these
**TABLE 1. Components of Nepali ethnopsychology in therapy modalities**

<table>
<thead>
<tr>
<th>Ethno-psychology Component</th>
<th>Description</th>
<th>Cognitive Behavior Therapy (CBT)</th>
<th>Interpersonal Therapy (IPT)</th>
<th>Dialectical Behavior Therapy (DBT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart-mind (man)</td>
<td>Organ of emotions, memories, and desires</td>
<td>‘Feelings’ in CBT should reference heart-mind processes</td>
<td>Heart-mind processes are examined in the context of social relationships; IPT grief theme relates to the heart-mind</td>
<td>Radical acceptance and change framed in heart-mind and brain-mind conflicts</td>
</tr>
<tr>
<td>Brain-mind (dimaag)</td>
<td>Organ of social responsibility and behavioral control</td>
<td>‘Thoughts’ and ‘appraisals’ in CBT should reference brain-mind processes</td>
<td>Behavioral control through the brain-mind is examined in the context of social relationships</td>
<td>Brain-mind and heart-mind conflicts are reduced; the brain-mind is responsible for regulating ‘opposite actions’ and ‘response prevention’</td>
</tr>
<tr>
<td>Physical body (jiu, saarir)</td>
<td>Physical sense organ, topography of pain</td>
<td>Somatic complaints in CBT may be consequence of heart-mind and brain-mind processes</td>
<td>The connection between physical suffering and relationships is explored through the social world, heart-mind, and physical body</td>
<td>‘Opposite actions’ and ‘response prevention’ are used to prevent self-injury to the body</td>
</tr>
<tr>
<td>Spirit (saato)</td>
<td>Vitality, energy, immunity to illness</td>
<td>Lost vitality in CBT can be associated with strong emotions in heart-mind (anger, fear)</td>
<td>Loss of vitality can be tied to difficulties in interpersonal relationships with both family and ancestral spirits</td>
<td>Preventing soul loss (saato jaane) is addressed through reducing intensity of emotions in heart-mind</td>
</tr>
<tr>
<td>Social status (ijjat)</td>
<td>Personal and family social standing and respect</td>
<td>Social status can be maintained through better insight into thoughts and feelings in CBT</td>
<td>Social status is explored by considering network of relationships; interpersonal deficits related to perceived social status can be challenged</td>
<td>Distress from perceived social status loss (bejjat) is managed through heart-mind emotional acceptance</td>
</tr>
<tr>
<td>Family and community relationships</td>
<td>Social support and social burden</td>
<td>The brain-mind processes related to relationships are explored for their effect on heart-mind processes</td>
<td>IPT themes of interpersonal disputes and role transitions examine social relationships</td>
<td>The group therapy component of DBT is used to discuss and model appropriate social relationships</td>
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</tbody>
</table>

issues were discovered, Kamal examined the ways that he could help his parents even if they were resettled in another state. He also recognized that it was not his fault that his parents were separated from him in the resettlement process. The treatment goal moving forward was to help Kamal reduce the worry in his heart–mind arising from perceived powerless to help his parents. In therapy, Kamal examined the evidence regarding his power to help his parents while they lived with his brother. Kamal identified one solution: to help his mother identify affordable generic medications, which he could send her money to buy. The family, patient, and therapist worked to create an atmosphere in which Kamal’s pseudoseizures could improve by examining the damaging worries in his heart–mind that led to dysfunction of his brain–mind. This treatment goal was framed as minimizing worries in the heart–mind by changing thoughts and behaviors related...
to his perceived powerlessness, which then reduced brain–mind distress that caused pseudoseizures.

In neuroimaging studies of CBT, increased prefrontal cortical activity and decreased amygdala activity have been observed (DeRubeis et al. 2008). Depending on the academic background of the patient or the investment in biomedical explanatory models, a mental health worker could add that CBT treatment is associated with improved brain–mind activity (i.e., the prefrontal cortex) and decreased heart–mind activity (i.e., the amygdala). Interestingly, this resembles the traditional practice of \textit{man baadne}, heart–mind binding, in \textit{dhambi-jhankri} shamanic treatments in Nepal (Kohrt in press).

In some cases, reality testing may not be therapeutic because of real threats to well-being. For many Nepali and Nepali Bhutanese female clients, triggering events are related to interpersonal interactions with their husbands. For example, a triggering event may be giving birth to a girl instead of a boy. The \textit{automatic thought} would be “my husband is going to get a second wife” or “my husband is going to abandon me.” This automatic thought leads to feelings of panic, distress, fear, and hopelessness. The \textit{conditional belief} that underlies this automatic thought is “If I do not produce a son, my husband will leave me,” or, “I am not a real woman until I have been given birth to a son.” These conditional beliefs may be grounded in variants of universal schemas such as “I am helpless” or “I am unlovable.” Unfortunately, the issue of abandonment may be a real threat. Therefore in these cases, alternative therapies such as Interpersonal Therapy may be more appropriate.

\textit{Interpersonal Therapy}

Interpersonal Therapy (IPT) evolved from the work of Harry Stack Sullivan who emphasized the importance of culture in psychiatry and the need to address interpersonal, and not just intrapsychic, phenomenon (Klerman et al. 1984). For Harry Stack Sullivan, the contexts in which relationships form, evolve, and deteriorate were crucial to determine the appropriate treatment. IPT was established as a short-term psychotherapy by Gerald Klerman and colleagues (1984). IPT often occurs over approximately 16 weekly sessions. Regarding cross-cultural applicability, group IPT has shown efficacy in the reduction of depression symptoms among women in Uganda (Bolton et al. 2003, 2007; Verdéli et al. 2003, 2008). IPT produces changes in the limbic system, specifically in the limbic right posterior cingulate and right basal ganglia activation (Martin et al. 2001).

The first trimester of treatment is devoted to the diagnostic assessment and review of current social functioning. Sessions in this section include (1) dealing with depression, giving the syndrome a name, and giving the patient the “sick role,” (2) relating depression to interpersonal context, (3) identifying major problem areas, and (4) explaining the IPT concepts and contract (Klerman et al. 1984). In Nepali, the syndrome being treated by IPT can best be described as \textit{manosamajik samasya} (Kohrt and Harper 2008). This term is used by many NGOs working with trauma survivors and refugees in Nepal. The common translation is “psychosocial problem.” The literal translation is “heart-mind—society problem.” \textit{Manosamajik} highlights the problem neither as intrapsychic nor as exclusively external to the self. Rather, the root of distress is at the intersection of one’s
heart–mind and the experience of social interactions. This captures the ethos of IPT. Therefore, although one could use the psychiatric term *depression*, we feel that framing treatment around *manosamajik samasya* better captures the framing and treatment within IPT. This framing also avoids the stigmatization of a brain–mind problem (Kohrt and Harper 2008). Once the person’s problem has been defined as *manosamajik samasya*, then the treatment plan will highlight both goals for modifying one’s social relations and for changes in one’s emotional appraisal of those relations.

In the first trimester of IPT, the concept of “sick role” is introduced (Klerman et al. 1984). When one treats their psychological distress as a disease, he or she is more likely to take time to recover, modify his or her current behavior to achieve recovery, and prioritize medical care such as psychotherapy or psychopharmacology. Moreover, identifying psychological distress as an illness shifts attention from explanatory models that attribute the distress to personal weakness or inadequacy. We still are struggling with how best to address this with Nepali and Nepali Bhutanese patients. One option is to tell someone that they have a *maanasik rog* (mental sickness). However, this has the potential to greatly stigmatize a patient (Kohrt and Harper 2008). The term *mental illness* is viewed as psychotic or schizophrenic in Nepali ethnopsychology. Concepts such as depression and anxiety are framed differently from psychotic mental illness. Instead of using the label *maanasik rog*, we advocate for emphasizing the goals of the “sick role” framing (e.g., greater investment in self-care, reduction in self-blame, and adherence to treatment) without labeling someone as mentally ill. This is an area that will require greater exploration.

The second trimester of treatment identifies the main problem areas: (1) grief, (2) interpersonal disputes, (3) role transitions, or (4) interpersonal deficits (Klerman et al. 1984). Among refugees, interpersonal disputes and role transitions are common sources of distress (Miller et al. 2002; Porter 2007; Weine et al. 2004). Gender roles may be altered as a woman gets a job and her husband remains at home (Westermeyer et al. 1984). Age-based stratification of roles is inverted as children become parentified because of their greater aptitude with English (Ajdukovic and Ajdukovic 1993). It is not uncommon for a teenage boy or girl to be attending school, working nights and weekends for the family income, and then driving and translating for healthcare and social service visits for their parents. This can lead to interpersonal disputes when parents and children conflict about disciplinary action and behavior expectation. In the final trimester, therapeutic goals are consolidated. IPT has shown comparable efficacy to medication in the treatment of major depression (de Mello et al. 2005; Fournier et al. 2009).

Phulmaya is an elderly woman who presented with problems sleeping, poor concentration, low mood, inability to enjoy activities, feelings of guilt, and pain in her abdomen and scalp. She met criteria for major depressive disorder. Phulmaya is from a low caste Hindu group known as Dalit and historically referred to as “untouchable.” In Nepal, Dalit groups have significantly greater levels of depression and anxiety compared to high caste groups (Kohrt 2009; Kohrt et al. 2009). After multiple sessions, Phulmaya revealed that her heart–mind problems of negative feelings, her brain–mind problems of poor concentration, and her physical pain all began when her adult children, with whom she
lives, converted to Christianity. Her adult children told her that she could longer practice Hindu puja (prayer) in the home and she had to dismantle her small prayer shrine with pictures of Hindu deities. Phulmaya became increasingly distressed about the family’s karma and the consequences that the Christian conversion would have on suffering in this life and the next for her and her family. She was worried that misfortune would befall her and her children. Phulmaya was referred to us because of her depressed mood as well as visualizations of demons when she was going to sleep. Phulmaya explained that it was acceptable for her that her children converted, but that she still wanted to be able to perform puja to pray for them.

Within an IPT framework, the first phase of treatment was to develop a shared therapist and patient understanding of the problem. The ethnopsychological approach to IPT emphasized the connection between the distress in Phulmaya’s heart–mind and her social life, that is, her family relationships, which together resulted in a manosamajik samasya. Phulmaya framed her distress as occurring at that intersection of her feelings and her relationship with her adult children. Phulmaya then traced her symptoms progression to being forced to remove her puja shrine. Once this framing was established, it opened an opportunity to employ components of IPT to address the interpersonal difficulties. Phulmaya developed strategies for negotiating with family regarding continuing to perform puja. Because of Phulmaya’s self-perceived powerlessness in the household, the plan involved enlisting others in the community to communicate the psychosocial issues with her family. Church members were enlisted to speak with the therapist about the impact of the puja prohibition on the Phulmaya’s health. In a meeting facilitated by the therapist, the church members explained to Phulmaya’s adult children that conversion to Christianity was a choice and not forced on everyone in the household. The church members explained to Phulmaya’s adult children that they could pray for Phulmaya. Similarly, Phulmaya could perform puja for her adult children and grandchildren. This allowed each party to engage in the practice that was meaningful for them and allowed them to express their concerns for other family members in a religiously consonant fashion. Moreover, using IPT, Phulmaya focused on her role in the relationships with her adult children. Although improving assertiveness was limited because of the expectations of hierarchy in the household, Phulmaya and the therapist discussed strategies for disclosing what was in her heart–mind. Ultimately, by focusing on Phulmaya’s relationship, rather than individual pathology, we were able to work in collaboration to reduce inter- and intrapersonal dimensions of distress.

Dialectal Behavior Therapy

A third type of manualized psychotherapy that has been tested with randomized control trials is dialectal behavior therapy (DBT; Kliem et al. 2010; Linehan et al. 2006; McMain et al. 2009; Soler et al. 2005). DBT was developed by Marsha Linehan to work with individuals who engage in self-injurious and suicidal behavior (Linehan 1987). Given the high rate of suicide among Nepalis and Nepali Bhutanese, DBT is an important therapy to consider for these patients. Although we have not directly applied DBT to a Nepali patient at this time, we will review the basic tenets and make suggestions for
how Nepali ethnopsychology could be employed, especially in relation to reducing the risk of suicide. Moreover, DBT is ideal for persons with borderline personality disorder (Lynch et al. 2007), which often overlaps significantly with complex posttraumatic stress disorder (PTSD; Eichelman 2010; Southwick et al. 2003).

The goal of DBT is “the reduction of ineffective action tendencies linked with dysregulated emotions” (Lynch et al. 2006:459). The targets are to reduce suicidal behavior, behaviors that interfere with treatment delivery, and other dangerous or destabilizing behaviors (Linehan et al. 2006). DBT does this by improving five functions: increasing behavioral capabilities, improving motivation for skillful behavior, assuring generalization of gains to the natural environment, structuring the treatment environment to reinforce functional behavior, and enhancing therapist capabilities. DBT is intended to be delivered via weekly individual psychotherapy, weekly group sessions, occasional skill trainings, telephone consultations on an “as needed” basis, and weekly therapist team meetings.

DBT was designed with elements of Buddhist and Hindu philosophy such as mindfulness and the connection between radical acceptance and change (Lynch et al. 2006). In DBT, patients are supported as they employ mindfulness to improve their awareness about their own emotional tenor and its association with interpersonal experiences. In radical acceptance, behaviors and feelings are not given a valence of “good” or “bad” but, rather, are to be seen as “just is.” Moreover, after developing increased awareness of one’s emotional and bodily states, patients are taught to engage in “opposite actions” or “response prevention.” A key emotion–behavior cycle to break in DBT is the experience of shame and concomitant shameful behavior such as hiding, withdrawing, or disappearing, of which suicide can be the extreme example.

Within Nepali ethnopsychology, mindfulness is built on the concept of meditation and attentiveness. Dyan garne refers to meditation and dyan dine refers to giving one’s attention, focusing, or concentrating. Dyan dine is a brain–mind function, whereas dyan garne involves the brain–mind but with the ultimate goal of facilitating peace in the heart–mind. Patients can be supported in efforts to attend to their inner states to help facilitate affect stability. DBT also relies on divisions among perception, affect, and behaviors with the goal of separating these so that a person does not see self-harm as an inevitable consequence of negative feelings (Lynch et al. 2006). DBT works to increase awareness about one’s sensations and emotions so that individuals are better able to see associations among the body, the heart–mind, the brain–mind, and the social self. Ultimately, DBT holds promise as an important intervention that can be adapted within Nepali ethnopsychology and can be used to reduce suicide risk.

PART FOUR: CAN ETHNOPSYCHOLOGY USEFULLY INFORM MENTAL HEALTH INTERVENTIONS IN OTHER POPULATIONS?

In Nepali culture, an ethnopsychological perspective has effectively aligned clinical concepts and actions of Western psychotherapies with Nepali understandings of self and emotions so that their therapeutic benefits can be realized with a reduction in stigma.
One can consider whether this approach may be generalizable to other refugee populations with similar benefits.

A fortuitous goodness of fit could appear to exist in Nepali culture between a neuroscience model of regulation of amygdala emotion-processing by the prefrontal cortex and Nepali regulation of heart–mind emotion processing by the brain–mind. In most cultures, however, some form of cognition (e.g., brain–mind) generates pathways toward goals and regulates emotions (e.g., heart–mind; see Damasio 1994; Fox 2003; Keys et al. 2012). Mental health thus requires balance and coordination between brain–mind and heart–mind, and disruptions in this balance result in mental illnesses (c.f. Clifford 1990; Kohrt et al. 2004). As in Nepali culture, stigma often travels most closely with disruptions owing to brain–mind problems because of their greater risk for damaging family relationships and social structures. Perhaps life is so sorrow-laden that a wounded heart is easy to normalize in most cultures.

To the extent that such a regulatory model can be perceived within the ethnopsychology of a culture, a Western model of psychotherapy may be refitted within the categories of the culture. This suggests that an ethnopsychological refitting of a Western psychotherapy should assess the following:

1. How is cognitive regulation of emotion processing formulated within the psychological categories of the local culture?
2. In what ways can dysregulation generate suffering that threatens the individual?
3. In what ways can dysregulation disrupt the functioning of families and extended kin (clan) relationships?
4. In what ways can dysregulation disrupt the function of relationships with the numinous or spirit world?
5. Which of the above forms of disruption are most stigmatized?

This inquiry can be used to guide reformulation of Western psychotherapy concepts and interventions within categories of the local culture. It also can give guidance for what type of psychotherapy might best fit the greater concerns of the culture and whether to prioritize cognitive, emotional, or relational interventions to best reduce stigma.

Decades of psychotherapy outcome research have established that most of the effectiveness of any specific psychotherapy depends on its capabilities for activating the “common factors” of psychotherapy—making good use of a patient’s unique strengths and competencies, mobilizing hope and expectancy of change, and facilitating a robust therapeutic alliance (Frank and Frank 1991; Miller et al. 1997). An ethnopsychological approach holds promise for maximizing these common factors by rendering psychotherapy sensible and usable within the assumptive world and categories of meaning of a local culture.

There are examples where ethnopsychology effectively has been incorporated into psychotherapy for other refugee groups. Hinton and colleagues have detailed various ways that conceptions of the self and conceptions of the body vary across cultures (Hinton and Hinton 2002; Hinton and Otto 2006). Although we have used the term ethnopsychology throughout this article, Hinton and colleagues refer to ethnophysiology as
the cultural model of how the body works including experience and regulation of distress (Hinton and Hinton 2002). Hinton and colleagues have developed versions of CBT that draw on ethnophysiolgies of Cambodian refugees (Hinton and Otto 2006), Vietnamese refugees (Hinton et al. 2006), and Latinas (Hinton et al. 2011). These culturally adapted therapies emphasize the somatic-looping of how the body is experienced, the meanings attributed to sensations, and the cycle of distress exacerbating both somatic sensations and emotional distress (Hinton and Hinton 2002). Culturally adapted CBT is an ideal therapy to interrupt these cycles of distress (Hinton et al. 2009, 2012). In Haiti, we have found that ethnopsychological differences in interpretation among biomedical health workers, Vodou hougan-s (priests), and laypersons leads to avoidance of biomedical practitioners because of their perceived failure to present a coherent ethnopsychological explanation and treatment for mental illness (Keys et al. 2012; Khoury et al. 2012). Ethnopsychology, thus, can be a key element in developing culturally appropriate and compelling psychological treatments.

CONCLUSION

Neuroanthropology provides a framework for considering the cocreation of experience and neural pathways of perception, processing, and behavior (Lende and Downey 2012). The process of enculturation studied in neuroanthropology is recapitulated in the therapeutic process. One product of culture is ethnopsychology—the cultural framing of the self, emotions, and suffering. Ethnopsychology is the outcome of as well as the progenitor of perception, language, and behavior. Understanding ethnopsychology can help achieve therapeutic goals of promotion of hope and expectancy of change. Moreover, using ethnopsychology can aid adaptation of specific schools of psychotherapy, such as CBT, IPT, and DBT. Ethnopsychology can complement other types of adaptation of psychotherapy for Bhutanese, such as adaptations that focus on augmenting community resources and social networks (Kira et al. 2012).

There is a dearth of mental health care in Nepal (Regmi et al. 2004) and among the Nepali diaspora including ethnic Nepali Bhutanese refugees. Despite misconceptions that so-called non-Western psychologies are characterized by holism, Nepali ethnopsychology involves complex divisions of the self. Nepali ethnopsychological terms fit well with the growing body of neuroscience literature on mental illness. The heart–mind and brain–mind divisions capture the division between the amygdala’s and the prefrontal cortex’s roles in psychopathology. Furthermore, drawing on Nepali ethnopsychology will prevent unnecessary stigmatization through use of inappropriate terms for mental disorders (Kohrt and Harper 2008; Kohrt and Hruschka 2010). Nepali ethnopsychology is compatible with three of the major evidence-based psychotherapies: CBT, IPT, and DBT. DBT may be a key in addressing the epidemic of suicide among Bhutanese refugees.

The goal of using neuroanthropology and ethnopsychology is not simply to be a “culturally competent” therapist or researcher for a specific group. Griffith cautions, “A person is not a person if known only as a category” (Griffith 2010:251). Rather these are tools to be used so that identity categories, such as “refugee” or “Bhutanese,” are no
longer the defining feature of the individual. Ultimately, these conceptual frameworks are means to establish a conversation not between cultures but among human beings.

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1. All names of patients are pseudonyms. Cases represent amalgamations of different patients, narratives, and treatment regimens to protect anonymity.

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