Traditional healing practices and perspectives of mental health in Nagaland

Thesis submitted to Martin Luther Christian University, Shillong
For the Degree of Doctor of Philosophy

By

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Under the supervision of
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Declaration

I hereby declare that this thesis entitled Traditional healing practices and perspectives of mental health in Nagaland submitted to Martin Luther Christian University, Shillong for the degree of Doctor of Philosophy is a bonafide effort made on my part under the supervision of Dr PSS Sundar Rao.

This work has not been submitted to this or any other university for the award of any degree or diploma. Any other source of information utilized in the study has been duly acknowledged by me.

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Abstract

Background: The 66th World Health Assembly adopted a comprehensive mental health action plan for 2013-2020 to strengthen effective leadership and governance for mental health by providing comprehensive, integrated and responsive mental health and social care services in community-based settings; implementing strategies for promotion and prevention in mental health; and strengthening information systems. This would help the world's almost 400 million indigenous people who have low standards of health, inadequate clinical care and poor disease prevention services. Most indigenous populations prefer traditional medicine developed over generations before the era of modern medicine. The challenge today is to integrate the best of the different healing traditions to meet the healthcare needs of contemporary society, especially for mental disorders. Nagaland, one of the states of North Eastern India, has a large tribal population, high literacy rates but low health indicators. Thus, research on traditional healing practices in this state will be most useful in framing mental health policies integrating traditional and other systems of healing. The burden of mental illness is likely to be higher in Nagaland and Mizoram, whose population had faced severe stress due to political and other conflicts. Given the scarcity of qualified psychologists and psychiatrists in most poor resource countries especially in indigenous populations, various local practitioners have taken over the role of experts in managing mental illnesses. The outcomes of many of the interventions are unknown. There is an urgent need to therefore identify the burden of mental illness and the role of traditional healing practices in such communities, especially since there is only one mental heath institution in the whole of Nagaland.

Objectives: Three major objectives were formulated for a research project done during 2017 to 2019: (1) To assess the extent of the use of traditional healing practices for mental health among the Naga population and correlate with clinical and demographical, social and cultural factors (2) To examine the help-seeking behaviour of the Naga population in using traditional healing practices for mental health in terms of accessibility, satisfaction and outcomes and (3) To determine the knowledge, attitudes and practices of traditional healers regarding mental disorders. The findings from this study will pave the way for counsellors and mental health professionals to act as an interface in order to bridge the gap between the community, traditional healers and modern psychiatric facilities in the state. In addition, it would benefit health professionals, the Naga community and families at large while promoting and encouraging further discussions and policy making decisions by health professionals in the area of mental health.

Methods: Based on an extensive critical review of published literature, a mixed-methods research approach was adopted using quantitative surveys of households and traditional healers in representative random samples of rural and urban Nagaland as well as a variety of qualitative research techniques such as focus group discussions, in-depth interviews of key informants case studies and an ethnographic study of the State Mental Health Institute at Kohima. For determining the sample size for household surveys, assuming a prevalence of all mental disorders as 20%, and assuming that at least 60% would seek traditional healing at some stage of the disease, with a type 1 error of 5%, power of 80%, and a precision of 20%, the minimum sample size was decided as 700-800 persons, proportionately divided into 500 rural and 300 urban households. In consultation with state and district officials and experts, two rural districts and one urban district were purposively chosen to provide a reasonable geographical and tribal population for this research. A total of 510 rural households and 300 urban households were

finally chosen to represent Nagaland through multistage representative random cluster sampling. All the traditional healers in the selected areas who were treating mental disorders, about 30, were chosen for the Traditional Healers survey. Relevant data were collected through in-depth interviews subjected to pilot studies and tested for reliability and validity. Full confidentiality and thorough explanation of the research topic was conveyed before the start of every interview and informed consent obtained. The permission of the community leaders was also sought for. Ethical clearance for this research was obtained before any data collection from The Martin Luther Christian University. All data were screened, edited entered onto Microsoft Excel sheets and analyzed using SPSS (version 20) software.

Results: Findings from the interview surveys revealed that there were four main modalities of treatment used by the traditional healers either singly or in combination for managing mental disorders. These are Herbal (Ethno-botanical), Animal product-based (Ethno-zoological) Mechanical, mainly massaging and Psycho-spiritual which consisted of a plethora of exotic, supernatural and divining séances. Overall, 383 out of 810 households (47.3%) reported some mental disorder in the past. 256 of 510 rural households (50.2%) as compared to 127 out of 300 urban households (42.3%) reported some mental disorder, the difference statistically significant ($p<0.05$). Overall, most common mental disorders reported were mood disorders (38.4%), 35.9% in the rural and 43.3% in the urban, the difference statistically significant($p<0.05$). Overall nearly 30% consulted a traditional healer 34.8% in the rural and 16.5% in the urban, the difference statistically highly significant ($p<0.0001$). In general, the most common form of traditional healing used was Psycho-spiritual intervention (49.0%). Herbal treatments were statistically significantly higher ($p<0.01$) in the urban as compared to rural (23.8 vs 3.4) while the psycho-spiritual treatments were statistically significantly higher ($p<0.001$) in the rural as compared to urban (60.9 vs 4.8). On the other hand, the mechanical treatments were not statistically significantly different between urban and rural.

Of those with mental health problems who used traditional healing, 58.9% reported that the outcome was good. Only 36.4% in the rural and 30.0% in the urban reported that the outcome was poor, the differences statistically not significant. Excellent or good satisfaction was mentioned by slightly over 50% of rural respondents but only 26% for urban but the differences barely reach statistical significance. Also, nearly half in the rural but only a quarter in the urban said they would recommend traditional healing for mental disorders, largely because of their strong belief that they offer effective treatment and being suitable for some illnesses, if not for all. Again, nearly 60% in the rural but only 24% in the urban felt that traditional healers are still popular for mental health, the difference statistically significant ($p<0.01$) due to their strong faith that they have the diagnostic ability and because they adopt culturally acceptable methods. Only 11% of rural respondents felt that traditional healers require any additional training as compared to 35% in the urban.

The 30 traditional healers treated a total of 74 mental disorders. A third of the mental disorders treated by traditional healers were mood disorders (32.4%) which they described as due to disturbance by spirits of departed relations or ancestor spirits. 18.9% of the cases were schizophrenia and related disorders, all of the traditional healers describing them as 'demon possession' or 'curse' or 'poison'. The most common mental disorder treated being mood disorders was mainly treated through psycho-spiritual from of intervention (70.8%). Majority of the schizophrenia and related disorders and disorders due to psychoactive substance were treated mostly with Psycho-spiritual. Organic mental disorders and mental retardation were treated using mainly manual treatment. Analysis and comparison do not reveal any statistical significance between male and female traditional healers except for female traditional healers who seem to use significantly more psycho-spiritual therapy ($P<0.05$). Differences in treatments given by age or tribe of healers were not statistically significant.

Of the 74 cases treated, 51.4% was reported to have been healed. However, the traditional healers themselves reported that the treatment given was effective only for some people (27.0%), 18.9% of the cases could not be treated and only a small percentage (2.7%) showed a slight improvement in the condition. 33.8% of the cases, however, were referred to an allopathic practitioner. The remaining few cases were referred to either an allopathic doctor, another traditional healer or a Christian prayer centre. Further analysis of referral by traditional healers with mental disorders reveals that majority of the disorders due to psychoactive substance use (84.7%) was referred to allopathic doctors. Almost half of the organic disorders and mental retardation cases were also referred to allopathic doctors. Majority of the traditional healers opined that traditional medicine will grow even more popular in the future but that both allopathy and traditional methods are equally important for treating mental health problems. Of the 30 traditional healers, only 12 was of the opinion that traditional methods and modern methods of treating mental disorders can be linked if allopathic practitioners respects and accepts traditional healing practices.

Conclusions: For a majority of people in Nagaland, traditional methods of healing mental disorders still remain the first point of contact and pursued till the problem is alleviated. There are significant rural urban differences with less urban population resorting to traditional methods. The main modalities of traditional healing are the use of ethno-botanical or herbal concoctions, manual methods such as massaging, performing psycho-spiritual rituals and procedures, and occasionally ethno-zoological remedies. Mood disorders were the predominant mental health problem and in a majority of cases, psycho-spiritual therapies were administered. The outcome of traditional treatments for mental health problems is mostly positive, with more than half of those who used traditional healing reporting that there was a change in their condition. There are significant rural urban differences with regard to

satisfaction of traditional methods for mental health problems, with over 50% of rural respondents more satisfied as compared to only 25% for urban. There are significant rural urban differences with regard to recommendation of traditional healing for mental health problems, with nearly half in the rural but only a quarter in the urban stating they would. The general decline in use of traditional healing in the urban appears to be related to educational background, access to modern psychiatric care, and less access to a traditional healer. While traditional healers are still popular, their number is decreasing and also their capacity to deal with increasing substance abuse, stress disorders and younger clientele. It is concluded that integration of traditional healing with modern allopathic psychiatric practices will significant benefit the Nagaland population and appropriate counselling programs will be necessary. Traditional healers are able to offer effective treatment for only about half of the mental disorders seen. Majority of the traditional healers view traditional methods for mental health as still popular, growing more so in the future but also acknowledged that both western medicine and traditional methods are equally important for mental health care. However, more traditional healers were of the opinion that collaboration between traditional methods with modern methods of treating mental disorders may not be possible, with most feeling disrespected and devalued by allopathic doctors.

Recommendations: Feasible, effective counselling strategies must be developed to educate, provide and guide the people, especially those with mental health problems and their care-givers. Further research is needed on integrating traditional healing of mental health problems with other systems of medicine. Larger, more in-depth quantitative surveys as well as qualitative studies on specific mental disorders may be undertaken. Pharmacokinetic research is required on herbal remedies to document the efficacies to prevent, delay adverse effects of mental health problems of aging such as Alzheimer's. Community based participatory research

has great potential to document further on the role and integration of traditional healing practices to manage mental health problems among the younger ages especially in terms of substance abuse, depression, suicide, etc.

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Chapter 1
Introduction

1.1 Promoting Mental Health in Indigenous populations: A Long-neglected problem

Recently the United Nations and WHO have intensified their efforts in promoting mental health. A comprehensive mental health action plan 2013-2020 was adopted by the 66th World Health Assembly, described by the Director-General, as a landmark achievement focusing international attention on a long-neglected problem rooted firmly in the principles of human rights (WHO, 2019). The action plan aims to strengthen effective leadership and governance for mental health; provide comprehensive, integrated and responsive mental health and social care services in community-based settings; implement strategies for promotion and prevention in mental health; and strengthen information systems, evidence and research for mental health. It calls for a change in the attitudes that perpetuate stigma and discrimination that have isolated people since ancient times, and it calls for an expansion of services in order to promote greater efficiency in the use of resources. The UN General Assembly formulated the Sustainable Development Agenda to transform our world by 2030 by Promoting mental health and well-being, and the prevention and treatment of substance abuse (United Nations General Assembly on 25 September 2015). For translating such resolutions into practice, "Think globally but act locally" is a relevant statement for assessing the status of mental health in indigenous populations such as Nagaland and northeast region of India focusing in particular on the role of traditional healing practices. Hence this research on practices and perspectives on traditional healing in mental health that provides the data for the WHO action plan and guidelines for further research.

The world's almost 400 million Indigenous people have low standards of health. This poor health is associated with poverty, malnutrition, overcrowding, poor hygiene, environmental contamination, and prevalent infections. Inadequate clinical care and health promotion, and poor disease prevention services aggravate this situation. In an excellent article, Gracey & king (2009) comment on the mental health action plan stating the determinants and disease patterns in indigenous populations. Albert & Kharkongor (2010) emphasize the need for building bridges between traditional and modern medicine for well-being through counselling and psychotherapy based on the studies of Khasi and Jaintia people of Northeast India. In a study on Latinos in the faith- based setting, Caplan (2019) describe the intersection of cultural and religious beliefs about mental health and mentions that stigma and cultural and religious values play a significant role in mental health care utilization disparities. Some indigenous groups, as they move from traditional to transitional and modern lifestyles, are rapidly acquiring lifestyle diseases, such as obesity, cardiovascular disease, and type 2 diabetes, and physical, social, and mental disorders linked to misuse of alcohol and of other drugs. Correction of these inequities needs increased awareness, political commitment, and recognition rather than governmental denial and neglect of these serious and complex problems. Nguyen, Holton, Tran & Fisher, (2019) report on the informal mental health interventions for people with severe mental illness in low and lower middle-income countries and recommend training and supportive supervision for informal community care providers as crucial components of effective interventions. In a case study of mental health in Uganda, Africa, a narrative analysis was done to link modern medicine and traditional medicine and identified several areas of convergence (Aboo, Odokonyero & Ovuga, 2019). In a study on developing the alliances to expand traditional indigenous healing practices within Alberta health services in Canada, Drost (2019) conclude that access to both traditional indigenous healing practices and western medicine are needed for all

encompassing holistic health. Indigenous people should be encouraged, trained, and enabled to become increasingly involved in overcoming these challenges. In view of the wide popularity of traditional healing practices globally and particularly in indigenous populations, there is an urgent need to document and evaluate these practices as applied to healing of mental disorders. Dialogue formation between the formal and the informal health workers is crucial in establishing trust and respect between both practitioners and in improving mental health care. Bridges need to be built based on systematic research on the attitudes, knowledge, perceptions and perspectives of all stakeholders using community based participatory research approaches (Israel, Eng, SIchulz & Parker, 2012; Chong, Mythily, Lum, Chan & McGorry, 2005). In a research on barriers and facilitators to community-based participatory mental health care research for racial and ethnic minorities, Delman et al (2019) state that initiating research partnerships with community stakeholders is challenging and does not always lead sustainable community health improvements. These experiences and others based on a critical review of literature will provide a foundation for the present research.

1.2 Traditional Healing practices for mental health: Curative, Preventive, Promotional

Traditional medicine (also known as indigenous or folk medicine) comprises medical aspects of traditional knowledge that developed over generations within various societies before the era of modern medicine. The WHO (2008) defines traditional medicine as "the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness".

Traditional medicine may include formalized aspects of folk medicine, that is to say longstanding remedies passed on and practised by lay people. It is an amorphous concept that comprises a range of long-standing and still evolving practices based on diverse beliefs and theories (Bodeker & Burford, 2008). Folk medicine consists of the healing practices and ideas of body physiology and health preservation known to some in a culture, transmitted informally as general knowledge, and practiced or applied by anyone in the culture having prior experience. Folk medicine may also be referred to as traditional medicine, alternative medicine, indigenous medicine, or natural medicine. These terms are often considered interchangeable.

According to Thomas, 2001 (as cited in Dalal, 2016) folk tradition refers to a set of beliefs, attitudes and actions shared by a cultural group, which also determine worldview and relationships (Thomas, 2001). It explains how a community attempts to develop ecologically valid understanding of human nature; human suffering and remedial measures (Kleinman, 1988). In many anthropological texts (e.g., Mariott, 1955), folk practices are considered within the little tradition, that is, the beliefs and practices of the masses, shamans, spirits and local deities are all part of it.

In some Asian and African countries, up to 80% of the population relies on traditional medicine for their primary health care needs. When adopted outside of its traditional culture, traditional medicine is often called alternative medicine. Practices known as traditional medicines include Ayurveda, Siddha medicine, Unani, ancient Iranian medicine, Iranian (Persian), Islamic medicine, traditional Chinese medicine, traditional Korean medicine, acupuncture, Muti, Ifá, and traditional African medicine. Core disciplines which study traditional medicine include herbalism, ethnomedicine, ethnobotany, and medical anthropology.

Similarly, a h**o**me remedy is a treatment to cure a disease or ailment that employs certain spices, vegetables, or other common items which may or may not have medicinal

properties that treat or cure the disease or ailment in question, as they are typically passed along by lay people. Many are merely used as a result of tradition or habit or because they are effective in inducing the placebo effect

Indigenous medicine is generally transmitted orally through a community, family and individuals until "collected". Within a given culture, elements of indigenous medicine knowledge may be diffusely known by many, or may be gathered and applied by those in a specific role of healer such as a shaman or midwife. Three factors legitimize the role of the healer – their own beliefs, the success of their actions and the beliefs of the community.

All cultures and societies have knowledge best described as folk medicine. Folk medicine often coexists with formalized, education-based, and institutionalized systems of healing such as Western Medicine or Great traditional medicine systems like Ayurvedic, Unani medicine, and Chinese medicine, but is distinguishable from formalized or institutionalized healing systems.

Some examples of strong informal and to some degree institutionalized folk medicine traditions are: Traditional Chinese medicine, traditional Korean medicine, Arabic indigenous medicine (source of Unani medicine, along with ancient Greek medicine), Haitian folk medicine, Uyghur traditional medicine, various African herbal folk remedies, Celtic traditional medicine (in part practiced by the Irish medical families), Japanese Kampō medicine, traditional Aboriginal bush medicine, Georgian folk medicine, and others.

1.3 Healing, Health & Wholeness: Role of Traditional methods

The knowledge of the medicinal value of plants and other substances and their uses go back to the time of the earliest settlers. The vast amount of medical knowledge that has come down

to modern times is the result of long evolution through trial and error and exchange of know-how between diverse communities and regions. The process of exchange and assimilation continues, and today traditional medical practices are obliged to accommodate to the norms of modern biomedicine. However, there is growing awareness among the scientific community and the general public about the intrinsic value of traditional medicine, and as a result Ayurveda, Unani and Siddha have entered the mainstream to compliment biomedicine. The challenge today is to integrate the best of the different healing traditions to meet the healthcare needs of contemporary society

The best practices that can bring success to clients' and patients' whole health is to borrow methods, practices and skills that work well for them from one part of the world to another. This can be done by understanding the role that culture and holistic health practices play in the patients and clients' lives. Culture is a dynamic system of meanings and symbols which shapes every domain of our life. It affects our perceptions of health, illness and well-being, beliefs about causes of diseases, approaches to health promotion, experience and expression of illness, help-seeking and the types of treatment sought (Dalal, 2016).

According to Helms & Cook, 1999 (as cited in Yeh, Hunter, Bahel, Chiang & Arora, 2004), the divergent worldviews of various cultures produce different concepts of mental health, physical well-being, and spirituality. Indigenous healers often share the client's cultural norms and are therefore individuals from whom people seek various forms of assistance, healing, and guidance. From the beginning of human existence, all cultural groups have developed not only their own explanations of abnormal behaviors, but also culture-specific ways of dealing with human problems and distress.

Lee & Armstrong, 1995 (as cited in Yeh et al, 2004) talks about another aspect of healing which, in many cultures, is a reality that is referred to as the "realm of spirits," and it is here that human destiny is often decided. For many helpers in this tradition, the goal is to enter this

realm, in some fashion, on behalf of other people and the helpers then act as conduits of positive energy from this dimension. This energy is then translated into concrete insights or action leading to problem resolution or decision making.

It makes sense to see how working principles of indigenous healing medicine and healing can be integrated into western medical and mental health practices. As Alves and Rosa adequately pointed out: "the formal recognition and respect that major traditional medicinal systems around the world are gaining allied to the extensive practice of traditional medicine in developing countries and the rapidly growing demand for alternative and basic therapeutic means (also in industrialized countries) constitute the international relevancy of research and development in the field". This demand therefore calls for a look at how to marry the excellent practices available in traditional healing practices with those in western practices. Traditional systems have an important role in providing holistic health care (Dalal, 2016).

1.4 Health of Nagaland- Physical and Mental-relationship to environment: Need for this research

Nagaland is one of the states of North Eastern India which is bordered in the East by Myanmar, Assam in the West Manipur in the South and Arunachal Pradesh and partly Assam in the North. Tribal culture and beliefs were predominant amongst the Naga tribes until about the end of the nineteenth century (Longkumer & Borooah, 2013). In view of the strategic location of Nagaland in the North-Eastern part of India, its large tribal population and high literacy rates, the research on traditional healing practices in the state for mental ill-health will be most useful in framing mental health policies integrating traditional and other systems of healing, and in formulating effective mental health systems.

Nagaland is extremely rich in biodiversity with several studies conducted on traditional medicine (Jamir 1997; Jamir & Upadhayay, 1998; Deorani & Sharma, 2007; Sangtam, Jamir, Deb & Jamir, 2012). Numerous ethno botanical plants have been identified which are a source of traditional medicine and traditional methods of healing practices (Jamir, 2006; Jamir, Lanusunep & Narola, 2012; Medhi, Kar & Korthakur, 2013). Other prevailing healing practices include divination, bone setting and zootherapy (Kakati & Doulo, 2002; Tetso, 2008).

Various studies have confirmed that traditional medicine is still popular and usually resorted to as the first step in the treatment of any diseases before seeking other systems of medicine (Saha, Sarker, Kar, Gupta & Sen, 2014). This may be truer in the case of mental ill-health but there is scarce published literature. In a study by Thirthalli et all (2016), it was reported that no studies from India could be identified that investigated systematically the proportion of people with mental illness in the community who sought the services of traditional medicine. The preference for traditional medicine seems more prevalent in the northeast region of India (Govt. of India, 2012). Coincidentally, the health scenario in the northeast India is the poorest and many of the common health indicators are ranked lowest in various northeastern states (Govt. of India,2015). With the emphasis on national health mission and use of ASHA workers, the emphasis seems predominantly for allopathic medicine with only lip service shown for indigenous medicine (Govt. of India, 2015). If the health of the population in northeastern states has to improve, it is urgent that an objective and comprehensive assessment be made on the practice of traditional folk medicines as compared to the allopathic medicine widely promoted in the government primary health system.

The burden of mental illness is likely to be higher in Nagaland and Mizoram, whose population had faced severe stress due to political and other conflicts. Albert & Kharkongor (2010) observe that local health traditions in Meghalaya are widely practiced and used. Each family in each tribe has its own set of ‘home remedies’, passed down by the older generation,

for many common ailments. In illness, whether physical, mental or emotional, they found that Khasis seek out local healers who will diagnose the cause of the illness, which may be located in the patient, the ancestors or in the community.

Longkumer & Borooah (2013) in their study found that most of the participants showed a fair amount of knowledge regarding the causes of mental disorders attributing it to psychosocial and biological factors. Seeking a psychiatrist or a psychologist as a treatment option also reflects their knowledge about mental disorders. However, the researchers also found that a considerable proportion of participants also saw evil spirit possession as the cause of mental disorders and the only way to treat it is through prayer. For Nagas, prayer is an important part of life and irrespective of their level of religiosity; many seek divine intervention through prayer in times of ill health. The researchers found that 10.6 percent of the participants would seek a prayer group along with seeking a mental health practitioner. About a quarter preferred going to a prayer group only. Again, it was found that a small proportion preferred going to a black magician or a traditional healer. In addition, more than a quarter of the respondents could not recognize the case as a mental health problem which shows that there is a lack of knowledge among a large number of the population.

In another research by Zeliang (2014) titled 'Charismatic movements in the Baptist churches in North East India. A Zeliangrong perspective', it was found that among the Zeliangrong Nagas, the Zeliangrong Charismatics also employ exorcism when it is deemed necessary for healing of patients or for prevention of the work of evil spirits in the village. Exorcism refers to the act of driving out evil spirits from people or places by prayer. It was found that some people are believed to be terrorized or possessed by evil spirits (herakesia) and that demon possession can be connected to physical illness. However, in most cases it is believed to cause insanity (kemie). If the patient in question is revealed through one of the

charismatic gifts to be suffering from possession by evil spirits, the charismatic healers employ exorcism.

1.5 Problem Statement for the Research

Mental disorders can be narrowly defined as “evil/ demon” possession requiring supernatural intervention or broadly defined as abnormal or deviant behavior, various psychosis and neurosis, depression, anxiety, stress and similar distresses. Given the scarcity of qualified psychologists and psychiatrists in most poor resource countries especially in indigenous populations, various local practitioners have taken over the role of experts in managing mental illnesses. The outcomes of many of the interventions are unknown. With the advent of Christianity and Buddhism, many ancient religions have revived age-old practices to treat mental illnesses, but there are no systematic studies on these aspects. Indigenous populations generally suffer from the triple problems of poverty, illiteracy and superstition which magnify even simple ailments and common mental disorders. There is an urgent need to therefore identify the burden of mental illness and the role of traditional healing practices in such communities.

Today, in Nagaland, there is only one Mental Hospital in the state capital Kohima now called the State Mental Health Institute headed by one Senior Medical Officer and one Medical Officer (Department of Health and Family Welfare, n.d). In the article, “Talking about mental illness, the first step” (2017), it was reported in Morung express that Nagaland also has only six in-service psychiatrists with some posted as medical officers of government health centers and only two districts are covered under the Mental Health Programme. The scenario being such that in the whole of Nagaland there exists only one institution catering to mental health issues and also a lack of knowledge regarding mental health issues among the Nagas, the

question arises as to how the Naga tribal population goes about addressing these and if traditional treatments are being made used of and how traditional healers play a role in the delivery of mental health care, their accessibility, acceptability and effectiveness.

Published scientific literature on these aspects is scarce. Therefore, it would only be necessary again to document the opinion of the Naga tribal population regarding mental health and also the traditional healing practices for mental health issues.

1.6 Research Questions

(a) Are traditional healing practices for mental health popular among the Naga population?

(b) What is the help-seeking behaviour of the Naga population in using traditional healing practices for mental health in terms of accessibility, satisfaction and outcomes?

(c) What are the knowledge, attitudes and practices among the traditional local healers regarding mental disorders?

1.7 Research Objectives

General: To estimate the use of traditional healing practices for mental disorders among the Naga population and its associations with gender, tribes, urbanization, literacy and other socioeconomic factors as well as type and severity of mental disorder.

Specific:

(a) To assess the extent of the use of traditional healing practices for mental health among the Naga population and correlate with clinical and demographical, social and cultural factors.

(b) To examine the help-seeking behavior of the Naga population in using traditional healing practices for mental health in terms of accessibility, satisfaction and outcomes.

(c) To determine the knowledge, attitudes and practices of traditional healers regarding mental disorders.

1.8 Research Hypotheses:

(a) Traditional healing practices for mental health vary according to region, culture and access to modern psychiatric care.

(b) There has been a significant decline in the practice of traditional healing for mental health especially in the urban population and higher socioeconomic groups.

(c) Traditional healers in mental health have become a small minority and used only by special populations.

(d) Christianity has had no significant impact on the traditional healing for mental health.

1.9 Significance and Scope of the Research

Traditional healers form a major part of the mental health workforce worldwide. Despite this, little systematic examination has been done of their effectiveness in treating mental illness or alleviating psychological distress (Nortje, Oladeji, Gureje & Seedat, 2016). As such, through this study the crucial role that traditional healers play in the delivery of mental health care in Nagaland would be majorly highlighted.

The findings from this study would benefit the Naga community and families at large as well as all health professionals. It would contribute to the little existing body of knowledge regarding mental health in Nagaland.

The findings from this study would help in paving the way for counsellors and mental health professionals to interface in order to bridge the gap between the community, traditional healers and modern psychiatrists in the state.

Finally, the study would also promote and encourage further discussions and policy making decisions by health professionals in the area of mental health.

1.10 Conceptual and theoretical frameworks

Figures 1. I and 1.II displays the theoretical frameworks for this study with an attempt to look at both the traditional healers' and modern psychiatrists' approaches to treating mental disorders. Figure 1.III describes the conceptual framework used in this study.

Figure 1. I: Traditional approach to treating mental disorders

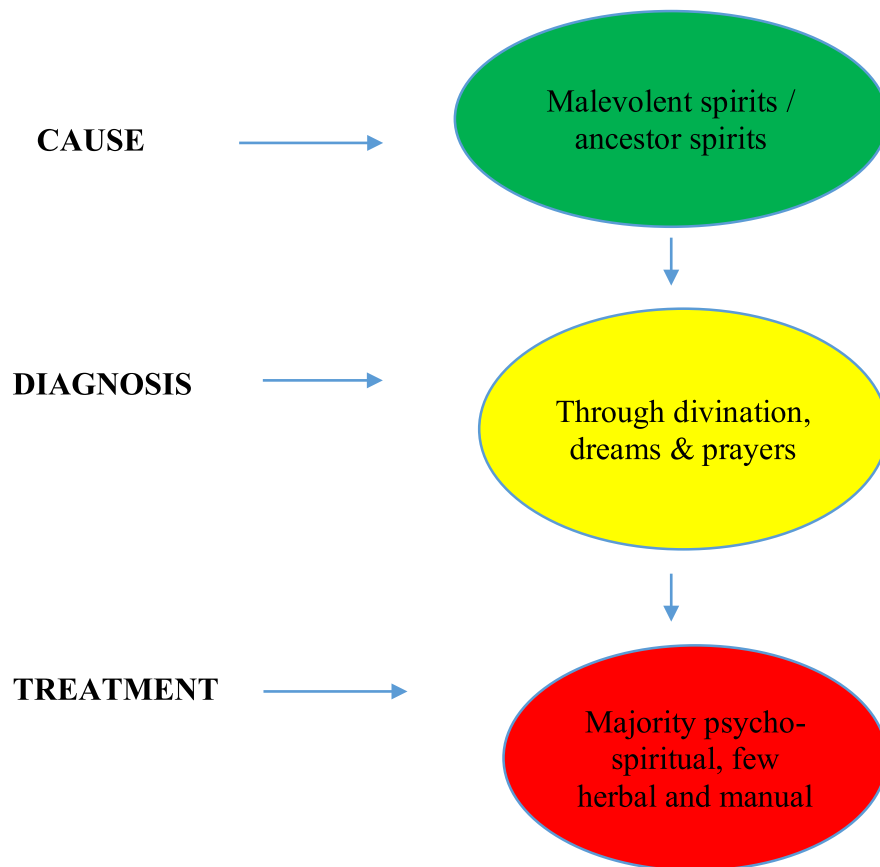


Figure 1. II: Modern approach to treating mental disorders

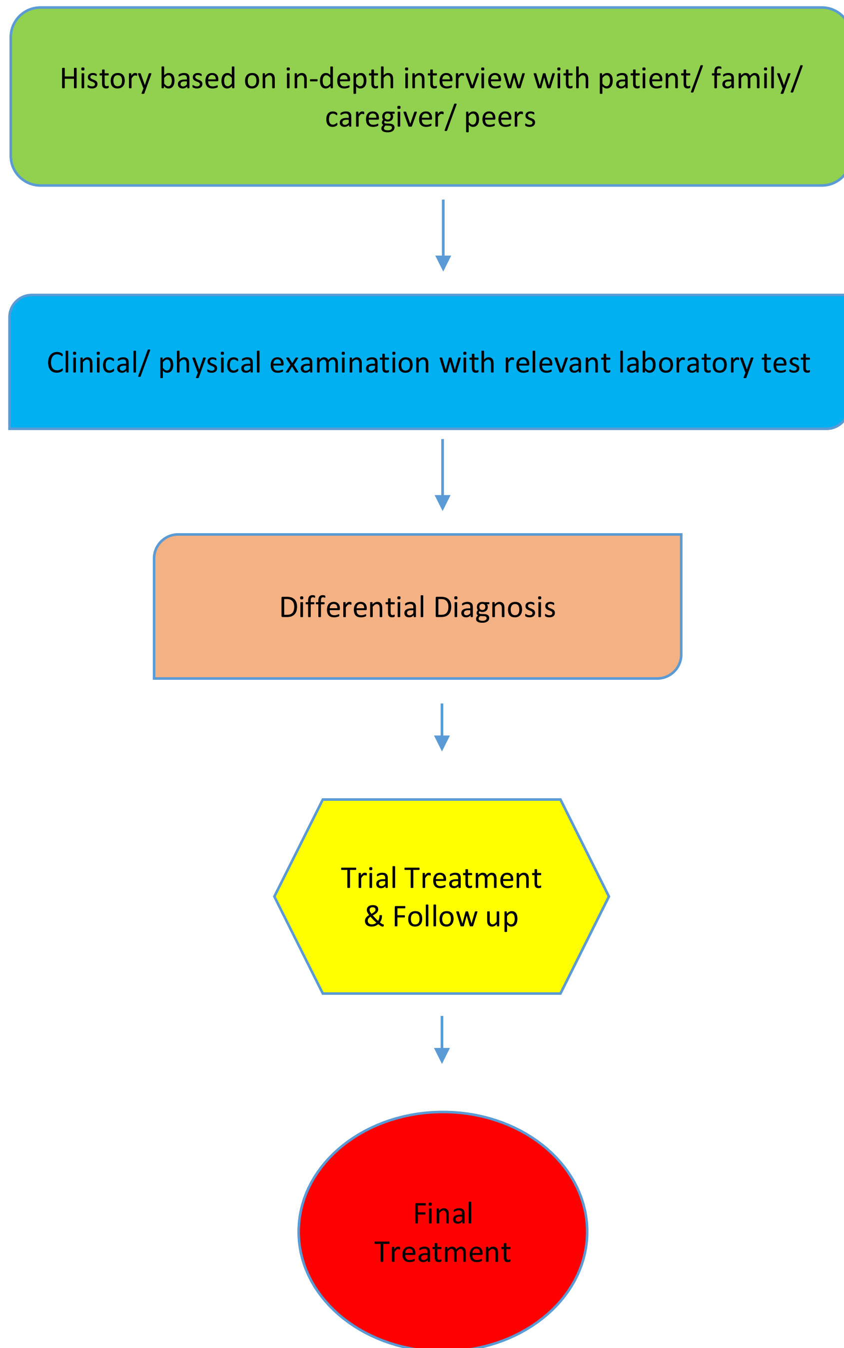
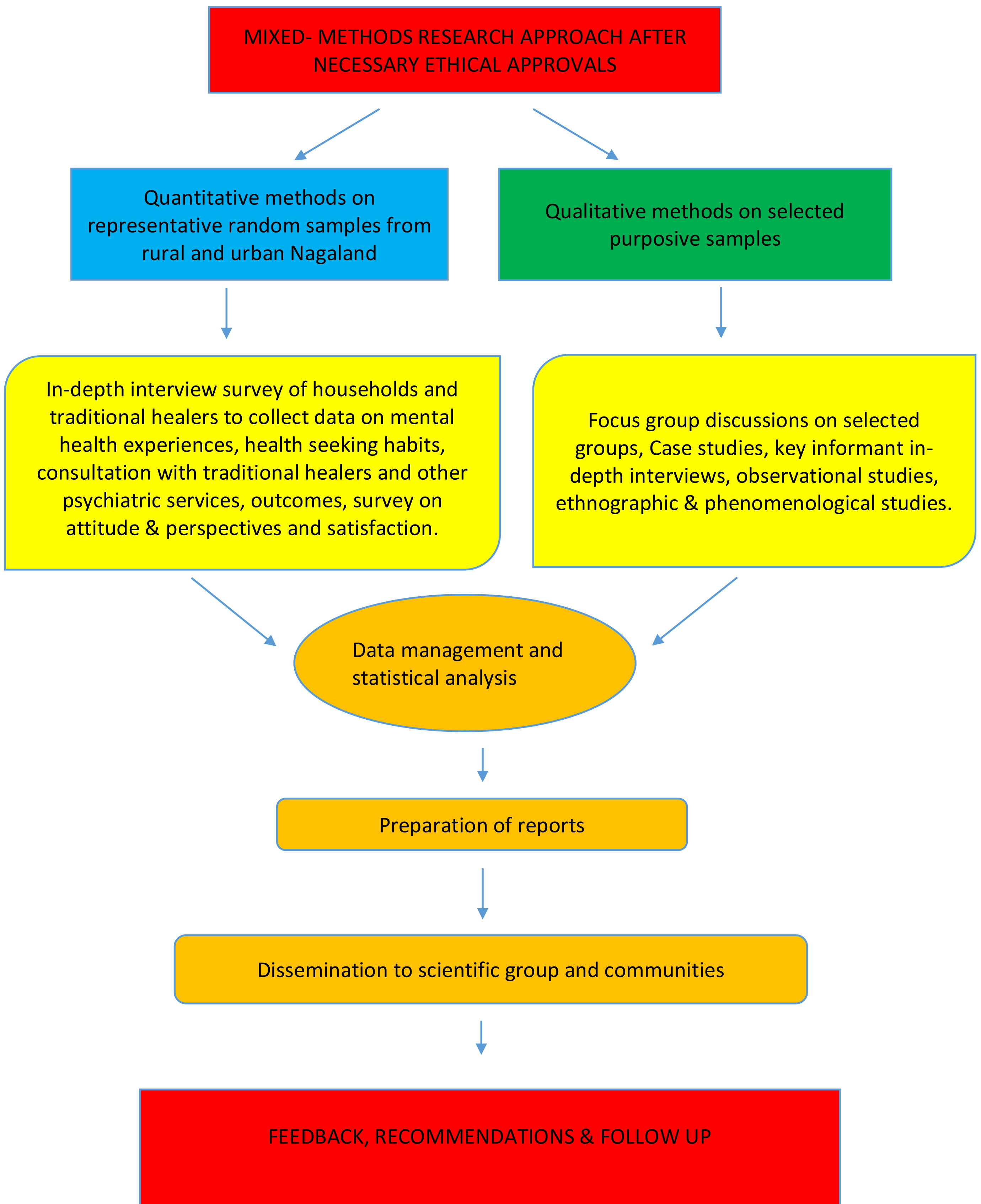


Figure 1.III: Conceptual framework of Research Process



1.11 Operational Definitions

Mental illness:

Mental illness is the term synonymous with mental disorders that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. It includes a wide range of conditions from mild disorders such as anxiety, depression, stress, paranoia, mania, alcoholism, mood disorders, etc to well established diagnosed diseases such as schizophrenia, bipolar disorders, etc. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the definition in the individual, as described above.

Traditional healing:

Ancient and culture bound health care practices, which existed before the evolution of modern scientific medicine (Gupta, Sharma & Sharma, 2014).

Long established ways of recognizing, diagnosing, minimizing and relieving suffering by providing health care using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious backgrounds as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causation of disease and disability in the community.

Perspectives:

A way of regarding traditional healing practices from the positivist view and includes an integrated set of attitudes and beliefs.

Chapter 2

Review of literature

2.1 Introduction

The literature on traditional medicine and traditional healers is quite vast and it is impossible to do justice by reviewing all of them. In view of the topic chosen for research on traditional healing practices in mental health, this chapter is organized under five subheadings: General, International studies, National studies, Northeast Indian studies and global literature by WHO and other international agencies.

Traditional medicine (also known as indigenous or folk medicine) comprises medical aspects of traditional knowledge that developed over generations within various societies before the era of modern medicine. The World Health Organization (2019) defines traditional medicine as "the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness".

In some Asian and African countries, up to 80% of the population relies on traditional medicine for their primary health care needs. When adopted outside of its traditional culture, traditional medicine is often called alternative medicine. Practices known as traditional medicines include Ayurveda, Siddha medicine, Unani, ancient Iranian medicine, Iranian (Persian), Islamic medicine, traditional Chinese medicine, traditional Korean medicine, acupuncture, Muti, Ifá, and traditional African medicine. Core disciplines which study traditional medicine include herbalism, ethnomedicine, ethnobotany, and medical anthropology (WHO, 2008).

The WHO notes, however, that "inappropriate use of traditional medicines or practices can have negative or dangerous effects" and that "further research is needed to ascertain the efficacy and safety" of several of the practices and medicinal plants used by traditional medicine systems. The line between alternative medicine and quackery is a contentious subject. Traditional medicine may include formalized aspects of folk medicine, that is to say longstanding remedies passed on and practised by lay people. Folk medicine consists of the healing practices and ideas of body physiology and health preservation known to some in a culture, transmitted informally as general knowledge, and practiced or applied by anyone in the culture having prior experience(Ansari & Inamdar, 2010). Folk medicine may also be referred to as traditional medicine, alternative medicine, indigenous medicine, or natural medicine. These terms are often considered interchangeable, even though some authors may prefer one or the other because of certain overtones they may wish to highlight. In fact, out of these terms perhaps only *indigenous medicine* and *traditional medicine* have the same meaning as *folk medicine*, while the others should be understood rather in a modern or modernized context (Keith, 1991).

Traditional Healing is the oldest form of structured medicine, that is a medicine that has an underlying set of principles by which it is practiced. It is the medicine from which all later forms of medicine developed, including Chinese medicine, Graeco-Arabic medicine, and of course also modern Western medicine. Traditional Healing was originally an integral part of semi-nomadic and agricultural tribal societies, and although archeological evidence for its existence only dates back to around 14,000 B.C., its origins are believed to lie much further back and probably predate the last Ice-Age.

Unlike other traditional medicines, Traditional Healing has no philosophical base, as its practice is totally founded on healing knowledge that has been accumulated over thousands

of years, and upon the healer's personal experience, which includes his/her awareness of, and sense of unity with the natural world, as well as his/her understanding of the different levels of consciousness within the human psyche. Traditional Healers see the universe as an living intelligence that operates according to natural laws that manifest according to specific rules and correspondences, and exercise their inner conviction that the purpose of life and the nature of disease cannot be understood without a knowledge of these laws and the individual's relationship to the natural world.

Thus Traditional Healers share a profound knowledge and a deep understanding of how natural laws influence living things. It is for this reason that Traditional Healing is often referred to as "wisdom medicine" or "Wizard Medicine" (the word wizard means 'wise man', not 'sorcerer') and Traditional Healers are often referred to as wise or "clever" men or women or as persons of knowledge. It is this knowledge and experience base that provides the similarity between the core principles of Traditional Healing through the ages and in different parts of the world.

There were and of course still are regional differences between the way Traditional Healers apply their knowledge, but this is simply a pragmatic adaptation by the Traditional Healer, because he/she cannot perform their role in a way that is isolated from the cultural perceptions and belief patterns of those whom they treat.

There are "four pillars" of Traditional Healing which according to the Roman historian Piny the Elder (23-79 AD.) were: "Eruditio, Perspicacitas, Beneficentia et Caritas". Roughly translated these mean: "learning, insight, kindness and empathy". These are the basic principles that should guide the Traditional Healer in all his or her actions.

Traditional Healing always deals with natural laws, because all life is subject to these natural laws and ill-health is usually due to an inherent or acquired weakness that has allowed

an abnormal imbalance to occur, either within an organism, or between the organism and its environment. Therefore, Traditional Healers do not only work at correcting any weakness or damage to the life force or psyche that has allowed an illness to "conquer" the individual, but also work to correct the resultant internal imbalances that allow the disease to persist.

Since the advent of 'big government', which in Europe occurred with the Roman invasions and in North America and Australasia with English colonisation, Traditional Healing has at best been misrepresented and suppressed and at worst been persecuted. This is not surprising, as the Traditional Healers' extensive knowledge and their independence, because of their use of freely available natural resources, tends to place them outside of the economic and political control of governments. Governments therefore have, through the ages, tended to view Traditional Healers as a legacy of the past freedoms of tribal life and thus as a threat to their autonomy and power. This is why all governments have striven to fragment and control healing practices. Big government is generally only interested in control and power, and very rarely has had any real or genuine interest in the health of its subjects. This is proven by the fact that governments have, over the ages, been quite happy to sanction and give patronage to medical practices that were more lethal than helpful, as long as these were under their control. For the ability to control a country's medicine gives rulers unsurpassed control over its citizens.

In the past, the fear of reprisals by governments has caused a severe decline in Traditional Healing and has forced most Traditional Healers to do their work very quietly, within a circle of trusted supporters. Nevertheless, there are some areas in the world where governments have had limited impact and Natural Healers have continued to practice, but these are few and are mostly located in Central America, Central Asia and Korea. With the new resurgence of ethnic practices and medicine all over the world however, Traditional Healing is also gradually gaining strength and is making a slow, but sure return, although the number of Traditional Healers worldwide is still not large by any means. Traditional Healing is not

looking for endorsement by any government however. Governments and civilisations exist at best for a limited time. Traditional Healing is both an ancient medicine and the medicine of the future. It is timeless (Traditional Healers Fellowship, 2003).

In this chapter, a selective list of published literature, both international as well as national, that deal with experiences of traditional healing are briefly reviewed first and later, some general articles on traditional healing, dealing with ethno-botanical, ethno-zoological, and psycho-spiritual ritualistic therapies are also briefly reviewed.

2.2 International Studies

The use of psychoactive plants by traditional healers in southern Africa appears to be a neglected area of ethno-botanical research (Sobiecki, 2012). This article explores the healing dynamics involved in the use of popular psychoactive plant preparations known as *ubulawu* in the initiation rituals of Southern Bantu diviners. Research methods include a review of the literature, fieldwork interviews with Southern Bantu diviners, and an analysis of experiential accounts from diverse informants on their use of *ubulawu*. Studies done by Hirst (2005), Sobiecki (2002) and Sobiecki (2008) were referred to in this article. Findings reveal that there is widespread reliance on *ubulawu* as psychoactive spiritual medicines by the indigenous people of southern Africa to communicate with their ancestral spirits—so as to bring luck, and to treat mental disturbances. In the case of the Southern Bantu diviners, *ubulawu* used in a ritual initiation process acts as a mnemonic aid and medicine to familiarize the initiates with enhanced states of awareness and related psychospiritual phenomena such as enhanced intuition and dreams of the ancestral spirits, who teach the initiates how to find and use medicinal plants. The progression of the latter phenomena indicates the steady success of the initiates' own healing integration. Various factors such as psychological attitude and

familiarization, correct plant combinations/synergy and a compatible healer-initiate relationship influence *ubulawu* responsiveness.

In a qualitative study of traditional healing practices, although chronic pain is prevalent among American Indian (AI) populations, the use of traditional healing practices has not been widely investigated (Greensky et al, 2014). The aim of this study was to solicit information from adult AIs with chronic pain regarding use of traditional health practices (THPs) for chronic pain and pain reduction. They referred to various articles by Kim & Kwok (1998), Buchwald, Beals & Manson (2000), Novins, Beals, Moore, Spicer & Manson (2004), Gurley et al (2001), Fortney et al (2012) and Shelley, Sussman, Williams, Segal & Crabtree (2009). The cohort included 21 (10 women and 11men) AI patients with chronic pain. A semi-structured interview guide was developed, and audiotaped interviews were conducted with all patients. The interviews were transcribed, and thematic analysis strategies were used to identify core concepts and categories for coding interview data. A qualitative software analysis program was used to facilitate data coding. A range of THP were described including smudging (burning sage), sweat lodge (ceremonialsauna), sema (ceremonial tobacco), feasting (strengthening process), pipes (ceremonial herb and tobacco), storytelling (nonhierarchical environment for verbal communication), and contact with a traditional healer (elder spiritual leader). The majority of individuals from the Reservation described prior exposure to THP; however, the majority of urban individuals reported limited exposure. Although the majority of individuals endorsed inclusion of THP in ambulatory-based pain treatment programs, recommendations for inclusion of specific practices were not systematically identified. It was concluded that AIs from this tribal community utilize THP, but which specific THPs should be included in an ambulatory-based pain treatment program will require further research. This qualitative study identified several important factors that could influence the use and inclusion of THP into a culturally appropriate inter disciplinary pain treatment program for AI with chronic pain. The

observations from this single tribal community suggest that a wide range of THP should be considered regardless of the individual's familiarity with these practices, but recommendations for inclusion of specific practices will require further research. Additionally, actual participation in THP should be considered optional in that individual beliefs may be a barrier for some patients.

A study was done by Niekerk, Gumbi, Monareng & Thwala (2014) to investigate the perceptions of THPs regarding the importance of occupations such as work, personal care and leisure in the treatment of persons with mental illness and whether THPs use occupation based activities in their treatment; their awareness of occupational therapy and community-based rehabilitation workers (CRWs) in the treatment of mental illness; the perceptions of members of the allopathic medical team and who work with mental health care patients of the role of THPs in mental health and whether referrals occur between the two health care systems. In their study, they referred to studies done by Pelzer (2009), Puckree, Mkhize, Mgobhozi & Lin (2002), Peterson et al (2009) and Ross (2010). A descriptive cross-sectional survey study design with a mixed method was employed. Because no prior occupational therapy research exists in this area, it was decided to conduct a pilot study to which a descriptive design was best suited as it would enable the researchers to describe findings so as to identify further research questions Twenty-five per cent of THPs (n=4) indicated that they were aware of occupational therapy and 62.5% (n=10) that they were aware of community rehabilitation workers. Following the closed ended question of whether the participants were aware of occupational therapists and community rehabilitation workers participants were asked how they thought occupational therapist and community rehabilitation workers helped patients. While 62.5% (n=10) participants indicated that they did not know, one participant indicated that he trains the family to care for the disabled person. A further 25% (n=4) participants said

that occupational therapists and community rehabilitation workers do home visits. One of the participants said that he helped people who do not have care givers. The results of this study also suggest that THPs view occupations as important. Personal hygiene and self-care were rated by 87.5% (n=14) as important to address with patients, whereas 81.25% (n=13) participants viewed addressing leisure as important and 75% (n=12) participants indicated that work and home / family maintenance respectively were important Of the THPs who participated in this study, 81.25% (n=13) referred patients to allopathic practitioners On the open-ended question about the benefit patients would get from referral to clinics and hospitals, the THPs indicated that the benefits mostly related to their access to medication and medical treatment (62.5% (n=10) participants), including sedation of aggressive patients for alleviation of pain. Two participants (12.5%) indicated that allopathic medicine helps with blood transfusions and stopping excessive bleeding. A number of participants felt that there were disadvantages in referring to allopathic practitioners. Three participants (18.75%) indicated that allopathic medicine cannot treat evil spirits and another three participants felt that allopathic practitioners' treatment is not permanent. Two participants (12.5%) reported that allopathic medicine cannot remove bad luck or misfortune and one participant was concerned that there was no referral back to the THP. Two participants reported that allopathic practitioners advise patients not to return for traditional health consultations. The results of this study show interesting, heretofore unexplored points of mutual interest between occupational therapy and traditional healing. No research has considered the THPs' view on occupations and the inclusion of activities in their assessments and understanding of the patient with a mental illness before. This provides an important opportunity for collaboration between occupational therapists and THPs.

Walls, Johnson, Whitbeck & Hoyt (2006) examined factors that influence preferences between traditional cultural and western mental health and substance use associated care among American Indians from the northern Midwest. They have referred to studies done by Barker et al (2004), Manson (2000), Marbella, Harris, Diehr, Ignace & Ignace (1998), mohatt & Varnin (1998), Rhoades & Rhoades (2000) and Whitbeck et al (2002). Mental health: Culture, race, and ethnicity—a supplement to mental health: A report of the surgeon general by the U.S. Department of Health and Human Services (2001) was also referred to as part of this article. Personal interviews were conducted with 865 parents/caretakers of tribally enrolled youth concerning their preferences for traditional/cultural and formal healthcare for mental health or substance abuse problems. Adults strongly preferred traditional informal services to formal medical services. In addition, formal services on reservation were preferred to off reservation services. To better serve the mental health and substance abuse treatment needs of American Indians, traditional informal services should be incorporated into the current medical model.

Limited research has been conducted to explore the factors that support or obstruct collaboration between traditional healers and public sector mental health services. Ae-Ngibise et al conducted a study (2010) was to explore the reasons underpinning the widespread appeal of traditional/faith healers in Ghana. This formed a backdrop for the second objective, to identify what barriers or enabling factors may exist for forming bi-sectoral partnerships. Eighty-one semi-structured interviews and seven focus group discussions were conducted with 120 key stakeholders drawn from five of the ten regions in Ghana. The results were analysed through a framework approach. Respondents indicated many reasons for the appeal of traditional and faith healers, including cultural perceptions of mental disorders, the psychosocial support afforded by such healers, as well as their availability, accessibility and affordability. A number of barriers hindering collaboration, including human rights and safety

concerns, scepticism around the effectiveness of ‘conventional’ treatments, and traditional healer solidarity were identified. Mutual respect and bi-directional conversations surfaced as the key ingredients for successful partnerships. Collaboration is not as easy as commonly assumed, given paradigmatic disjunctures and widespread scepticism between different treatment modalities. Promoting greater understanding, rather than maintaining indifferent distances may lead to more successful co-operation in future.

Machinga (2011) describes the traditional Shona health and healing practices of the Zimbabwean people by exploring the philosophical, clinical, and theological issues surrounding the healing practice. It is through understanding and appreciating the traditional Shona people’s worldview of sickness or disease that one can comprehend the thinking behind the traditional Shona healing practices. In Zimbabwe, people visit the traditional healers, the prophets from “Churches of the Spirit,” hospitals, and clinics for medical treatment. Diseases or sickness are viewed not only as physical or psychological but also as religious issues. Thus, religious beliefs and values play a significant role in the traditional ways of treatment. Rituals, symbolic representations, dreams, and herbal therapy are some methods that have a central place in the traditional Shona healing practice. Along with the physical, social, emotional, and mental nature of human existence, the spiritual, transpersonal, and ecological aspects are highly regarded.

Abiodun (1995) examined the routes taken by patients to mental health care in Nigeria. 238 patients (16 yrs and older) who attended the mental health service over a 1-mo period were interviewed. Results show that 95% patients reported that they had first contacted traditional and religious healers when they became mentally ill. These patients included significantly more males and Muslims and fewer patients with professional occupations. Family members played an important role in the patients' decision about the type of practitioner. It is suggested that use

of psychiatric care in developing countries could be improved by training primary health care workers to give mental health education to the communities they served. The data are intended to be used in developing strategies for integrating mental health care into the primary health care program in Nigeria.

Unconventional medicine is widespread in nearly every culture and often used parallel to professional help. This survey evaluates the use of unconventional methods of psychiatric in-patients with vs. without a background of migration (Assion, Zarouchas, Multamäki, Zolotova & Schröder, 2007). A total of 167 psychiatric in-patients underwent a structured interview. One hundred patients were migrants (group 1) and were compared with 67 German in-patients (group 2). Nearly 50% of all patients reported of at least one unconventional therapy. Both migrants and natives used healing methods parallel to professional help. The migrant group rathered to use folk medical concepts and the native group rathered alternative medicine. Around half of the patients with experience of complementary therapy believed it to be efficacious. The results suggest that nearly half of the psychiatric patients use alternative medicine and a quarter believe in its efficacy. People with a more traditional background tend to use folk medical practices.

In another study by Wane & Sutherland (2010) it was found that traditional healing is an important primary line of health service in Kenya and Grenada. In Grenada, traditional healing systems seem to operate from a multidimensional perspective of illness causation, and address the needs of the population that may not be adequately addressed by the conventional healthcare system. Among the Kenyan and Grenadian people, it was found that psychological distress is often thought of as demon possession the cause of which is attributed to witchcraft practices. Traditional healers accept their clients' conceptualizations of their illnesses and often summon the spirits or deities to relieve them of their ailments. This type of healing often takes

through various rituals in which the healer becomes possessed by the spirit who gives him/her the prescriptions for healing various ailments. Despite much advancement in counseling and multicultural with its particular focus on culture, many African and Caribbean clients remain doubtful of the usefulness of Western therapies (Moodley & West, 2005). This may be due to the failure of Western therapies to include spiritual concepts and traditions immersed into the helping process (Fukuyama & Sevig, 1999).

In Korea, researchers Kim, Kim, Lee & Bahn (2016) in a nationwide population-based study from 2010 to 2012 found that when in need of medical treatment, Korean citizens have a choice of practitioners of western medicine (WM) or Traditional Korean Medicine (TKM). However, the two branches frequently conflict with one another, particularly with regard to mental disorders. The researchers wanted to compare the utilization of WM and TKM, focusing on child/adolescent patients with mental disorders. They analyzed F-code (Mental and behavioral disorders) claims from the Korean Health Insurance Review and Assessment Service, including data from 0-18-year-old patients from 2010 to 2012. Slightly more men than women utilized WM, while TKM use was almost evenly balanced. WM claims increased with advancing age, whereas utilization of TKM was common for the 0-6 age group. It was found that WM takes prevalence over TKM in cases of attention deficit/hyperactivity disorder (ADHD), as well as in psychological problems such as depression and anxiety. On the other hand, patients utilizing TKM was found to be more commonly present with physical health problems including somatoform problems, sleep, and eating disorders.

El-Amin and Ahmed Refat (1997) conducted with the aim of studying the role of traditional (religious) healing in primary care of psychiatric disorders in Sharkia. 196 patients who were attending to a famous sheikh in Sharkia for religious healing were examined. This study covered a period of 3 months, the first month for new patients and the other two for follow up cases of the majority of patients were young age groups, illiterate or low educated,

females more than males. Among all patients, there was a large number of psychiatric patients, because social and religious beliefs have a powerful influence which is stronger than civilization and till now there are inadequate psychiatric services and people fear from stigma of mental illness. On the other hand, religious healers may improve some psychiatric disorders such as dissociation & conversion disorders, adjustment disorders and sexual disorders in males methods used by these healers appear to be related to suggestibility and some sort of cognitive therapy.

A study (Lin, Lee & Yang, 2009) uses a nationwide population-based dataset to explore factors and patterns associated with traditional Chinese medicine (TCM) usage among schizophrenia patients. A retrospective population-based study. Administrative claims data obtained from the Taiwan National Health Insurance Research Database covering the periods 1996-2004 was used to examine patients hospitalized with schizophrenia between 1996 and 2001 (n=34,100) to determine whether they had visited TCM practitioners in 2004 for treatment of schizophrenia. Taiwan. Independent variables included patient's age, gender, comorbid medical disorders, number of visits to clinics, number of hospitalizations, income and the geographical location and urbanization level of patients' residences. Multivariate logistic regressions were performed to determine the association between these factors and visits to TCM practitioners for the treatment of schizophrenia. 3144 of the patients (9.2%) had visited TCM practitioners during 2004. After adjusting for other factors, the odds of such visits by males were found to be 0.825 times those for females, with the odds decreasing with patient's age and urbanization level. The odds of visits to TCM practitioners for patients hospitalized more than once were 3.557 times as high as those for other patients, while those for patients with >or=50 prior visits to other conventional clinics were 54.9 times those with <or=10 prior clinic visits. We conclude that patient's gender, age, geographical location,

urbanization level, severity of illness, number of visits to clinic, income and the presence of diabetes and hypertension all have significant associations with TCM usage.

Another study (Mbwayo, Ndetei, Mutiso & Khasakhala, 2013) aimed to investigate the types of mental illnesses treated by traditional healers, and their methods of identifying and treating mental illnesses in their patients. In urban informal settlements of Kibera, Kangemi and Kawangware in Nairobi, Kenya, we used opportunistic sampling until the required number of traditional healers was reached, trying as much as possible to represent the different communities of Kenya. Focus group discussions were held with traditional healers in each site and later an in-depth interview was conducted with each traditional healer. An in-depth interview with each patient of the traditional healer was conducted and thereafter the MINIPLUS was administered to check the mental illness diagnoses arrived at or missed by the traditional healers. Quantitative analysis was performed using SPSS while focus group discussions and in-depth interviews were analysed for emerging themes. Traditional healers are consulted for mental disorders by members of the community. They are able to recognize some mental disorders, particularly those relating to psychosis. However, they are limited especially for common mental disorders. There is a need to educate healers on how to recognize different types of mental disorders and make referrals when patients are not responding to their treatments.

The experience of epilepsy is profoundly culturally mediated and the meanings attributed to the condition can have a great impact on its social course. This qualitative study (Keikelame & Swartz, 2015) used Kleinman's Explanatory Model framework to explore traditional healers' perspectives on epilepsy in an urban township in Cape Town, South Africa. Several studies were referred to as part of this article by Baskind & Birbeck (2005), Berg

(2003), Campbell et al (2010), Hammond-Tooke (1989), Taylor, Kathomi, Rimba & Newton (2008), Millogo et al (2004), Niehaus et al (2004), Njamnshi et al (2010), thornton (2009), Truter (2007) and Pouchly (2012). The healers who participated in the study were Xhosa-speaking, had experience caring for patients with epilepsy, and had not received any training on epilepsy. Six individual in-depth interviews and one focus group with nine traditional healers were conducted using a semi-structured interview guide. Traditional healers identified several different names referring to epilepsy. They explained epilepsy as a thing inside the body which is recognized by the way it presents itself during an epileptic seizure. According to these healers, epilepsy is difficult to understand because it is not easily detectable. Their biomedical explanations of the cause of epilepsy included, among others, lack of immunizations, child asphyxia, heredity, traumatic birth injuries and dehydration. These healers believed that epilepsy could be caused by *amafufunyana* (evil spirits) and that biomedical doctors could not treat the supernatural causes of epilepsy. However, the healers believed that western medicines, as well as traditional medicines, could be effective in treating the epileptic seizures. Traditional healers were supportive of collaboration with western-trained practitioners and highlighted that the strategy must have formal agreements in view of protection of intellectual property, accountability and respect of their indigenous knowledge. The findings suggest a need for interventions that promote cultural literacy among mental health practitioners. Research is urgently needed to assess the impact of such collaborations between biomedical services and traditional healers on epilepsy treatment and care.

There are four services providing mental health care to the people of Kumasi, Ghana. This study (Appiah-Poku, Laugharne, Mensah, Osei & Burns, 2004) aimed to identify previous help sought by patients presenting to the services for an initial assessment. New patients presenting to each of the four services were asked about distance travelled, previous help

sought and time since symptoms of illness started. Staff also recorded basic demographic details and clinical diagnoses. Of the 322 patients presenting to the four sites, only 6% had seen a traditional healer whereas14% had seen a pastor before presentation. There was a greater delay in presenting to that service if the patient had seen a traditional healer or pastor. Many patients had previously used one of the other mental health units in Kumasi. *Conclusion* It is possible that fewer patients with mental health problems present to traditional healers in modern, urban Africa compared to rural areas. More patients consult with pastors than traditional healers and liaison with these groups may improve mental health care. It is important to maintain liaison between the four services as patients presenting to one clinic may have presented previously to another local clinic.

Few studies have examined the use of alternative therapies among adolescents. This study (Bell et al, 2001) examines the predictors of Native Hawaiian healer preference in the treatment of physical or emotional problems as well as the predictors of healer use. This study is a longitudinal cross-sectional design conducted in five high schools in Hawai'i. Participants: 1,322 high school students selected preference for and/or use of allopathic or alternative practitioners. The main outcome measures: Grade level, gender, ethnicity and cultural identity were used to predict healer preference. Healer preference, socioeconomic status and health status were used to predict healer use. Results: Identification with the Hawaiian culture was the strongest predictor of healer preference for both Hawaiian and non-Hawaiian adolescents. Mental health was also predictive of healer preference for non-Hawaiians. Healer use by Native Hawaiian adolescents was also predicted by Hawaiian cultural identity. Gender, grade level, and socioeconomic variables were not predictive of healer preference or use. It was concluded that cultural identity plays a significant role in the preference and use of alternative practitioners, especially for minority adolescent populations.

A study (Sorketti, Zainal & Habil, 2012) was done to determine the general characteristics of people with mental disorders in traditional healers centres in Sudan in terms of socio demographic profile, common clinical presentations and diagnostic features, and to look at the treatment methods and intervention procedures used in these centres for treating people with mental illness. This is a descriptive cross-sectional study using both quantitative and qualitative research methods. All inpatients with mental illness (405) from 10 selected traditional healers centres in Sudan who gave consent were interviewed, using a specially designed questionnaire and the Mini International Neuropsychiatric Interview (MINI). Most of the visitors to the centres were from central Sudan with a mean age of 31 years, illiterate or with only a primary basic education, male and jobless. The average mean duration of stay in the traditional healer centre was five months and the mean duration of untreated illness before coming to the centre was 13 months. Only 17% reported a history of alcohol abuse and only 11% of drug abuse. The most common prevalent diagnosis was psychotic disorder. It was concluded that this study improves the understanding about what types of people with mental illness are treated at these traditional healer centres and gives recommendations that can help in improving the quality of services in these centres. It can probably be used in building bridges of collaboration between these centres and the available mental health and psychiatric services in Sudan, especially at primary healthcare level.

Early recognition of the signs and symptoms of mental health disorders is important because early intervention is critical to restoring the mental as well as the physical and the social health of an individual. This study (Girmal & Tesfaye, 2011) sought to investigate patterns of treatment seeking behavior and associated factors for mental illness. In their article, they referred to various studies done by Nguyen (2003), Gater et al (1991), Richard, Vesna &Nadja (2005), Bekele, Flisher, Alem & Baheretebeb (2008), Alem, Jacobson & Argaw

(1993) and Deribew & Tamirat (2005). A quantitative, institution-based cross sectional study was conducted among 384 psychiatric patients at Jimma University Specialized Hospital (JUSH) located in Jimma, Ethiopia from March to April 2010. Data was collected using a pretested WHO encounter format by trained psychiatric nurses. Data was analyzed using SPSS v.16.Major depression disorder 186 (48.4%), schizophrenia 55 (14.3%) and other psychotic disorders 47 (12.2%)were the most common diagnoses given to the respondents. The median duration of symptoms of mental illness before contact to modern mental health service was 52.1 weeks. The main sources of information for the help sought by the patients were found to be family 126 (32.8%) and other patients 75 (19.5%). Over a third of the patients 135 (35.2%), came directly to JUSH. Half of the patients sought traditional treatment from either a religious healer 116 (30.2%) or an herbalist 77 (20.1%) before they came to the hospital. The most common explanations given for the cause of the mental illness were spiritual possession 198 (51.6%) and evil eye 61 (15.9%), whereas 73(19.0%) of the respondents said they did not know the cause of mental illnesses. Nearly all of the respondents 379(98.7%) believed that mental illness can be cured with modern treatment. Individuals who presented with abdominal pain and headache were more likely to seek care earlier. Being in the age group 31-40 years had significant statistical association with delayed treatment seeking behavior. There is significant delay in modern psychiatric treatment seeking in the majority of the cases. Traditional healers were the first place where help was sought for mental illness in this population. Most of the respondents claimed that mental illnesses were caused by supernatural factors. In contrast to their thoughts about the causes of mental illnesses however, most of the respondents believed that mental illnesses could be cured with biomedical treatment. Interventions targeted at improving public awareness about the causes and treatment of mental illness could reduce the delay in treatment seeking and improve treatment outcomes.

Mental health facilities in Uganda remain underutilized, despite efforts to decentralize the services (Nsereko et al, 2011). One of the possible explanations for this is the help-seeking behaviours of people with mental health problems. Unfortunately, little is known about the factors that influence the help-seeking behaviors. Delays in seeking proper treatment are known to compromise the outcome of the care. They referred to studies by Okello (2007), Bebbington et al (2007), Teuton, Dowrick & Bentall (2007), Ofori-Atta & Linden (1995), Cocks & Moller (2002), Sodi (1996) and Summerton (2006). To examine the help-seeking behaviours of individuals with mental health problems, and the factors that may influence such behaviours in Uganda, sixty-two interviews and six focus groups were conducted with stakeholders drawn from national and district levels. Thematic analysis of the data was conducted using a framework analysis approach. The findings revealed that in some Ugandan communities, help is mostly sought from traditional healers initially, whereas western form of care is usually considered as a last resort. The factors found to influence help seeking behaviour within the community include: beliefs about the causes of mental illness, the nature of service delivery, accessibility and cost, stigma. It was concluded that increasing the uptake of mental health services requires dedicating more human and financial resources to conventional mental health services. Better understanding of socio-cultural factors that may influence accessibility engagement and collaboration with traditional healers and conventional practitioners is also urgently required.

In recent times there have been debates among health professionals on the desirability of integrating traditional health practices into orthodox medicine (Chukwuemeka, 2009). This thinking was influenced by the resistance of some ailments to the orthodox healing methods as well as the proven efficacy of traditional healing processes in the treatment of some ailments. In Nigeria, the ambience of psychiatric victims or madmen at every corner and under bridges

has raised some concerns on the actual role of psychiatric hospitals and their efficiency and effectiveness in contemporary times. The need for new ways of handling psychiatric cases led to new interest in traditional healing processes which have been shown to be effective in the management of ailments. Consequently, traditional practitioners have availed themselves the opportunity of this debate to call for recognition as partners in the provision of effective and affordable health care. This paper explored the traditional psychiatric healing processes in Igboland, Nigeria. It analyzed the various concepts, processes, perspectives and dimensions of traditional psychiatric healing in Igbo land and argued for the integration of this aspect of psychiatry into modern system of psychological or psychiatric intervention and general health care

Since time immemorial, people from East Africa, and beyond, depended on traditional healers for treatment of all types of disorders, including those related to mental health (Ndetei, 2006). Even today, the use of traditional healers is common, despite the introduction of modern drugs. Alternative medicine is growing fast all over the world. It is estimated that traditional practitioners manage at least 80% of the healthcare needs of rural inhabitants in East Africa. Research statistics from Kenya and Uganda suggest that 25–40% of all people seeking medical care at primary health level have problems purely related to mental health and another 25–40% have a combination of both mental health problems and physical problems (Ndetei & Muhanji, 1979). It can therefore be expected that at least half of all patients who go to see traditional healers have mental health problems. Data from general hospitals in Kenya suggest that 30–40%of patients admitted to those facilities have a mental health problem which is not recognised as such by the medical professionals working there. It is also common knowledge that many patients would use both modern medicines (as offered in general hospitals) and traditional healers. So, whichever way one looks at it, traditional healers have as much share,

if not a much bigger share, of all the patients seeking medical help at any particular time. This was recognised in Kenya by Dr Otsyula, who reported in 1973that patients went to hospital only to look for the cure of their illness, whereas they went to see traditional doctors for both the cure and also to find out the cause of their illness. Further, several studies have suggested that many cultures have names for various mental health disorders, implying that they have long recognised them (Otsyula, 1973). The types of management prescribed by these traditional healers (often concurrently) fall into several main groups. These include the use of herbal preparations (pharmacotherapy)and several types of psychotherapy. At this point, it is important to differentiate between traditional medicine and witchcraft, although overlaps can be seen, especially in theories of causation. Traditional healers have theories that recognise genetic, social, psychological and environmental factors in the causation and maintenance of illness. They also embrace spiritual causation, usually ancestral. Witchcraft focuses on evil designs, usually on or by close relatives, associates or competitors, and its prescriptions are usually designed to bring pain and suffering or even death to assumed or alleged enemies, based on jealousy, the need to obtain wealth, fame, popularity and so on. This is usually done through agents known as witches. Witches are generally shunned and are often thrown out of their own communities. Witch-doctors are the people who hunt for and bring to book the witches (Otsyula, 1973). Pharmacotherapy The range of herbs used is broad and such herbs are widely available. They are still under study using modern pharmacological assays. An example of a plant with medicinal properties *Rauwolfia*, which is rich in reserpine. This plant is found as an ornamental plant in many parts of Kenya and Tanzania, especially around the Mt Kilimanjaro area, where it also grows in the wild. It is known for the treatment of 'madness', by which is meant psychosis, regardless of the cause or type. There is a story of Chief Adetona from Nigeria who travelled to the UK in 1925 with *Rauwolfia* extracts to treat a Nigerian who had become psychotic there. This was long before any known psychotropic was available in

the West (Prince, 1960). Psychotherapy The practice of psychotherapy and behavioural therapy is so very much advanced in traditional practice in East Africa that these therapies as practised in the West are not a match. This is illustrated by a statement by Rappoport & Dent (1979) on family therapy in Tanzania. They remarked 'nothing we had seen in a Western clinic could compete with the deep power of this ritual'. In the early 1980s, the present author had the opportunity to sit in on a clinic of a traditional healer deep in a rural area in Kenya. This healer specialised in the treatment of sexual dysfunctions using herbs and psychotherapy. The herbs must have acted very much like Viagra, for they helped men to achieve and sustain erection. But most impressive was the psychotherapeutic and behavioural approach, involving couple therapy. Without ever having heard of the Masters and Johnson technique, and himself never having travelled far from his home, and also being totally illiterate, this traditional healer prescribed almost to the letter that technique for sexual dysfunction. Asked how he learnt about it, He said he had done so from his father, who had learnt from his own father and so on. There were no textbooks. They learnt simply through pupillage. Family therapy groups and group therapy are prescribed as a form of psychotherapy by many traditional healers. Of course, they do not call it psychotherapy, but in practice it is psychotherapy as we psychiatrists understand it today. The operational procedures are much the same as those practiced in the West. In the process of these types of psychotherapy, individual psychodynamics are explored. Compare this with Freud's psychodynamic procedures at the end of1800s and early 1900s and ask yourself who really invented psychotherapy and when. Spiritual therapy -Spiritual therapy attempts to bring peace and harmony between the living and the spiritual world, especially spirits of the ancestors, which are believed to live on after death and continue to influence events in the living world. Without going into the merits and demerits of their beliefs about the ancestors, what really matters are the effects of the perceived harmony, which, translated into today's thinking, amounts to stress reduction. The effect of reduced stress specially in relation

to immunological response, is not in any doubt, even by today's science. Although psychiatrists may not accept an explanation that does not make sense in terms of modern science, the explanation is not the issue here: what matters are the perceived effects by those who practise spiritual therapy. George Brown and Tirril Harris from London used the word *meaning* to explain this phenomenon when they wrote about contextual threat (Brown & Harris, 1978). Surgical- A classic example of a traditional surgical intervention is craniotomy as practised by the Kisii and Turkana peoples of Kenya, for the treatment of psychosis related to diseases thought to be located inside the skull. This is, however, not practised today. What are still very much practised are small cuts on various parts of the body to relieve pain or for the insertion of medicines. The researchers conclude that traditional healers see and manage most of the mental health problems in East Africa. Our understanding of the pharmacology of the herbs they use is limited, but this is not so with psychotherapy. Indeed, the West has a lot to learn from traditional healers in East Africa. The challenge is to psychiatrists trained on the Western model. Are they willing to learn from the traditional healers? Are they willing to work with them? They can say no to this only to the detriment of the patients they seek to heal, and more significantly to the detriment of science, which they seek to embrace. An even greater challenge is whether they can work together so that they each benefit from what is good from the other.

Facing severe mental health disparities rooted in a complex history of cultural oppression, members of many urban American Indian (AI) communities are reaching out for indigenous traditional healing to augment their use of standard Western mental health services (Hartmann & Gone, 2012). Because detailed descriptions of approaches for making traditional healing available for urban AI communities do not exist in the literature, this community-based project convened 4 focus groups consisting of 26 members of a mid-western urban AI community to better understand traditional healing practices of interest and how they might be

integrated into the mental health and substance abuse treatment services in an Urban Indian Health Organization (UIHO). Studies done by Beals, Manson, Whitesell, Spicer, Novins & Mitchell (2005) and Heilbron & Guttman (2000) were referred to in their study. Qualitative content analysis of focus group transcripts revealed that ceremonial participation, traditional education, culture keepers, and community cohesion were thought to be key components of a successful traditional healing program. Potential incorporation of these components into an urban environment, however, yielded 4 marked tensions: traditional healing protocols versus the realities of impoverished urban living, multi tribal representation in traditional healing services versus relational consistency with the culture keepers who would provide them, enthusiasm for traditional healing versus uncertainty about who is trustworthy, and the integrity of traditional healing versus the appeal of alternative medicine. Although these tensions would likely arise in most urban AI clinical contexts, the way in which each is resolved will likely depend on tailored community needs, conditions, and mental health objectives. Despite repeated calls for improved health services for American Indian (AI) populations over the last half-century (e.g. Indian Health Care Improvement Act, 1976; U.S. Commission on Civil Rights, 2004), little progress has been made toward ameliorating the significant health disparities faced by these communities (Beals, Manson, et al., 2005).Inequalities have been documented for many AI communities and involve various forms of physical health, mental health, and substance abuse (Castor et al., 2006; Goins, Spencer, Roubideaux, & Manson, 2005; Gone & Trimble, 2012; Indian Health Service, 2009; U.S.

A study by Adewuya & Makanjuola (2009) aimed to assess the southwestern Nigerian public's preferences for the treatment of mental illness in that region. They referred to studies by Ayorinde, Gureje & Rahman (2004), Riedel-Heller, Matschinger & Anger-meyer (2005) and Adelekan, Makanjuola & Ndom (2001). Adults (N=2,078) selected from three Nigerian

communities completed questionnaires on socio demographic details and on their perceptions regarding causes of, stereotypes of, and treatment options for mental illness. The preferred treatment option was spiritual healers, endorsed by 41% of respondents. Thirty percent endorsed traditional healers, and 29% endorsed hospital and Western medicine. Correlates of preference for spiritual and traditional healers included female gender, never having provided care for persons with mental illness, endorsement of supernatural causation of mental illness, and lower education. It was concluded that the south western Nigerian public preferred alternatives to Western medicine for the treatment of mental illness. Efforts to improve professional mental health services in Nigeria must consider and address beliefs and preferences of the public in regard to mental health treatment.

A quantitative survey among psychiatric patients in Finnmark and Nord-Troms, Norway was done (Sexton & Sorlie, 2008) to learn more about the extent of, and factors related to the use of traditional and complementary healing modalities among Sámi psychiatric patients. A total of 186 Sámi and Norwegian patients responded to the survey, a response rate of 48%. Of these, 43 had a strong Sámi cultural affiliation. Use of traditional and complementary treatment modalities was significantly higher within the Sámi group. Factors related to use differed between Sámi and Norwegian groups. Sámi users were found to give greater importance to religion and spirituality in dealing with illness than Sámi patients who had not used these treatments. They were also found to be less satisfied with central aspects of their psychiatric treatment. They found several differences in factors related to the use of traditional and complementary treatments between Sámi and Norwegian psychiatric patient groups. Sámi users were found to give greater importance to religion and spirituality and were less satisfied with the public psychiatric services than Sámi patients who had not used traditional or complementary treatments. The study implies that finding ways to include

different aspects of traditional healing within the health services to the Sámi community should be given consideration.

In another study done in Jamaica, James & Peltzer (2012) investigated traditional and alternative therapy for mental illness in Jamaica - the patients' conceptions and practitioners' attitudes. They found that among psychiatric patients more than a third expressed the belief that the overall cause of their mental illness was as a result of supernatural factors. In general, the majority of patients felt that their perception of their problems did not concur with the western practitioner, which in turn caused distress for these patients. In case for those who also sought traditional medicine, they were more inclined to feel pleased about their interaction and the treatment they received. Results from western trained practitioners found that although they acknowledged that traditional medicine plays a major role in the treatment of mental illness among psychiatric patients the treatment was not advantageous. For the most part when all three traditional approaches were examined alternative medicine seemed more favorable than traditional healing and traditional herbal treatment. The researchers assert that there is a need to develop models of collaboration that promote a workable relationship between the two healing systems in treating mental illness.

A study (Kabir, Iliyasu, Abubakar & Aliyu, 2010) was designed to examine the knowledge, attitude and beliefs about causes, manifestations and treatment of mental illness among adults in a rural community in northern Nigeria. Methods**:** A cross sectional study design was used. A pre-tested, semi-structured questionnaire was administered to 250 adults residing in Karfi village, northern Nigeria. The most common symptoms proffered by respondents as manifestations of mental illness included aggression/destructiveness (22.0%), loquaciousness (21.2%), eccentric behavior (16.1%) and wandering (13.3%). Drug misuse including alcohol, cannabis, and other street drugs was identified in 34.3% of the responses as

a major cause of mental illness, followed by divine wrath/God's will (19%), and magic/spirit possession (18.0%). About 46% of respondents preferred orthodox medical care for the mentally sick while 34% were more inclined to spiritual healing. Almost half of the respondents harbored negative feelings towards the mentally ill. Literate respondents were seven times more likely to exhibit positive feelings towards the mentally ill as compared to non-literate subjects (OR = 7.6, 95% confidence interval = 3.8–15.1). The study demonstrates the need for community educational programs in Nigeria aimed at demystifying mental illness. A better understanding of mental disorders among the public would allay fear and mistrust about mentally ill persons in the community as well as lessen stigmatization towards such persons.

In many traditional belief systems in Africa, including South Africa, mental health problems may be attributed to the influence of ancestors or to bewitchment. Traditional healers are viewed as having the expertise to address these causes. However, there is limited information on their explanatory models and consequent treatment practices. The present study (Sorsdahl, Flisher, Wilson & Stein, 2010) examines traditional healers' explanatory models (EMs) and treatment practices for psychotic and non-psychotic mental illnesses. For this article, they referred to studies done by Shankar, Saravanan & Jacob (2006), Patel (1995) and Robertson (2006). Four focus group discussions (8 healers in each group) and 18 in-depth interviews were conducted. Four vignettes were presented (schizophrenia, depression, panic and somatization) and traditional healers' views on the nature of the problem, cause, consequence, treatment and patient expectations were elicited. Results: Traditional healers held multiple explanatory models for psychotic and non-psychotic disorders. Psychotic illnesses appear to be the main exemplar of mental illness and were treated with traditional medicine, while nonpsychotic illnesses were not viewed as a mental illness at all. Additionally, traditional healers do not only use herbs and substances solely from "traditional" sources but rather have

incorporated into their treatment practices modern ingredients that are potentially toxic. It was concluded that Interventions aimed at increasing the mental health literacy of traditional healers are essential. In addition, investigations of the effectiveness of traditional healer treatment for psychiatric disorders should be conducted.

There are few population-level insights into the use of traditional healers and other forms of alternative care for the treatment of common mental disorders in sub-Saharan Africa (Sorsdahl, Stein, Grimsrud, Seedat, Flisher, Williams & Myer, 2009) We examined the extent to which alternative practitioners are consulted, and predictors of traditional healer visits. Studies done by Abiodun (1995), Edwards, Grobbelaar, Sibaya, Nene, Kunene & Magwaza (1983), Ensink & Robertson (1999) were referred as part of this article. A national survey was conducted with 3651 adults South African between 2002 and 2004 using the World Health Organization Composite International Diagnostic Interview (CIDI) to generate diagnoses. A minority of participants with a lifetime DSM-IV diagnosis obtained treatment from Western (29%) or alternative (20%practitioners. Traditional healers were consulted by 9% of the respondents and 11% consulted a religious or spiritual advisor. Use of traditional healers in the full sample was predicted by older age, black race, unemployment, lower education and having an anxiety or a substance use disorder. Alternative practitioners, including traditional healers and religious advisors, appear to play an important role in the delivery of mental health care in South Africa.

Buddhist-derived “mindfulness” practices are currently enjoying popularity amongst both the lay population and health professionals in the West, especially in the treatment of psychiatric conditions such as depression. This popularity leads to questions regarding how people in diverse Buddhist communities might conceptualise psychiatric illness and healing.

This paper (Deane, 2014) explores perspectives on psychiatric illness within a Tibetan Buddhist community in North India, focusing on the role of "emotions" in causation and treatment which was frequently discussed by informants. Comparisons between biomedical perspectives on emotional "disturbance" as a symptom of psychiatric illness and Tibetan conceptions of emotions as causal or contributory factors in a number of psychiatric illnesses are discussed. Three case studies are described to illustrate some of these common perspectives, examine how they are reflected in health-seeking behavior, and consider comparisons between the two systems.

Postpartum Depression (PPD) affects more than one in ten women and is associated with adverse consequences for mother, child and family. Integrating mental health care into maternal health care platforms is proposed as a means of improving access to effective care and reducing the 'treatment gap' in low- and middle-income countries. This study (Azalel, Fekadu & Hanlon,) aimed to determine the proportion of women with PPD who sought help form a health facility and the associated factors. For their study, several studies were referred done by Surkan, Kennedy, Hurley & Black (2011), Baron, Field, Kafaar & Honikman (2014), Twomey, Prince, Cieza, Baldwin & Prina (2015), Bilszta, Ericksen, Buist & Milgrom (2011), Abrams, Dornig, & Curran (2009), Dennis & Chung-Lee (2006), Dejma et al (2008), Vega, Kolody & Aguilar-Gaxiola (2001) and Gulliver, Griffiths, Christensen & Brewer (2012). Method used was a community based, cross-sectional survey was conducted in southern Ethiopia. A total of 3147 women who were between one and 12 months postpartum were screened for depressive symptoms in their home using a culturally validated version of the Patient Health Questionnaire (PHQ-9). Women scoring five or more (indicating potential depressive disorder) (n = 385) were interviewed regarding help-seeking behavior. Multiple logistic regression was used to identify factors associated independently with help-seeking

from health services. Only 4.2 % of women (n = 16) with high PPD symptoms had obtained mental health care and only 12.7 % of women (n = 49) had been in contact with any health service since the onset of their symptoms. In the multivariable analysis, urban residence, adjusted odds ratio (aOR): 4.39 (95 % confidence interval (CI) 1.23, 15.68); strong social support, aOR: 2.44 (95 % CI 1.30, 4.56); perceived physical cause, aOR: 6.61 (95 % CI 1.76, 24.80); perceived higherseverity aOR: 2.28 (95 % CI 1.41, 5.47); perceived need for treatment aOR: 1.46 (95 % CI 1.57, 18.99); PHQ score, aOR: 1.14(95 % CI 1.04, 1.25); and disability, aOR: 1.06 (95 % CI 1.01, 1.15) were associated significantly with help-seeking from health services. More than half of the women with high levels of PPD symptoms (n = 231; 60.0 %) attributed their symptoms to a psychosocial cause and 269 (69.9 %) perceived a need for treatment. Equal proportions endorsed biomedical treatment and traditional or religious healing as the appropriate intervention. It was concluded that in the absence of an accessible maternal mental health service the treatment gap was very high. There isa need to create public awareness about PPD, its causes and consequences, and the need for help seeking. However, symptom attributions and help-seeking preferences indicate potential acceptability of interventions located in maternal health care services within primary care.

Epilepsy is a serious neurological disorder associated with a high level of psychiatric comorbidity. Suicidality is a recognised complication of epilepsy. As part of developing an integrated service for people with epilepsy (PWE) and priority psychiatric disorders within primary care, a cross-sectional study (Tsigebrhan, Hanlon, Medhin & Fekadul, 2017) was conducted in a rural district in Ethiopia to investigate patterns of help-seeking, suicidality and the association with duration of untreated epilepsy (DUE) among PWE. They referred to various studies such as those done by mbuba, Ngug, Newton & Carter (2008), Nwani et al (2013), Seo et al (2015), Shibre et al (2008) and Shibre et al (2001). Cases were identified

through community key informants and diagnosis was confirmed by trained primary care clinicians. Severity of epilepsy, depression and suicidality were assessed using standardised methods. Multivariable regression analysis was used to test the hypothesis that suicidality was associated with DUE. The majority of PWE sought help from both religious and biomedical healing centres. The lifetime treatment gap for biomedical care was 26.9%, with a 12month treatment gap of 56.7%. Close to one-third (29.9%) of participants reported using traditional and cultural healing practices. Nearly one-third (30.2%) of participants reported suicidality (suicidal ideation, plan or attempt) in the previous 1 year. The median (IQR) DUE was 24 months (4–72). There was no association between DUE and suicidality. In the multivariable model, being married [odds ratio (OR) 2.81, 95%CI 1.22, 6.46], increased depressive symptoms (OR 1.17, 95% CI 1.10, 1.26) and perceived poorer wealth relative to others (OR 2.67, 95% CI 1.07, 6.68) were associated independently with suicidality. Conclusion: In this study, PWE sought help from both biomedical and religious healing centres. Suicidality and depression have a high prevalence in PWE in this setting. Integrated mental and neurological health care within primary care is needed for improved holistic management of epilepsy.

The process to seek for care by patients who experience episodes of mental disorders may determine how and where they receive the needed treatment. This study (Ibrahim et al, 2016) aimed to understand the pathways that people with mental disorders traversed for psychiatric services, particularly where these individuals will first seek treatment and the factors that influence such pathways to mental health care. Methods: A cross-sectional study conducted at Pantang psychiatric hospital in Accra, Ghana involving 107 patients of ages 18 and older and their family members. The study adapted the World Health Organization's (WHO) pathway

encounter form to collect information about patients' pathway contacts for psychiatric care. Chi Square test was done to determine patients' first point of contact and any association between the independent variables (clinical diagnosis and socio-demographic factors) and first pathway contact. Multiple regression analyses were also done to estimate the odds of patients' first pathway contact. Results showed that overall, nearly 48 % of patients initially contacted non-psychiatric treatment centers (faith-based, traditional healers and general medical practitioners) as their first point of contact for treatment of mental disorders. A little more than half of the patients went directly to the formal public psychiatric facility as their first point of contact for care of their mental disorders. Patients' occupation was significantly associated with their first point of contact for psychiatric care ($\chi 2 = 6.91$; $p < 0.033$). Those with secondary education were less likely to initially seek care from the formal public psychiatric hospital compared to those with no formal education (uOR = 0.86; 95 % CI 0.18–4.08). Conclusion: Patients used different pathways to seek psychiatric care, namely direct pathway to a psychiatric hospital or through transition from informal non-psychiatric service providers. Since nearly half of patients do not initially seek mental health care directly at the formal psychiatric facility, it is important for the government of Ghana to increase funding to the mental health authorities in Ghana as a matter of priority so that more individuals can be identified and integrated into mainstream psychiatric treatment and general health facilities where there are trained Community Mental Health Officers (CMHO) and Clinical Psychiatric Officers (CPO) to provide early intervention and treatment.

In Nepal (Pradhan, Sharma, Malla & Sharma, 2013) a large number of mentally ill patients prefer to visit non-medical practitioners such as faith healers because of the stigma attached to mental illness and/or belief that mental illness are caused by supernatural powers. Faith healers

are more convenient to be approached first because of ease of availability and prevalent cultural belief and persuasion. They referred to studies done by Campion & Bhugra (1997), Ravishankar, Saravanan & Jacob (2006) and Nagpal, Mishra, Chadda, Sood & Gard (2011). The current study aims to find the help seeking behavior of patients suffering from mental illness and whom they approach first once affected, either psychiatrists or faith healers. A cross sectional study was conducted among patients admitted in the psychiatric ward of Kathmandu Medical College Teaching Hospital during 1st January to 30th July 2012. All patients admitted in the ward during that period were informed about the purpose of the study and a written informed consent was taken. In case of psychotic patients, the consent was obtained from nearby relatives. Among 54 patients enrolled in the study, significant number of psychotic patients (n=15) visited faith healers in comparison to only 4 non-psychotic patients. Number of females (n=12) visiting faith healers in comparison to males(n=7) was higher. Patients having belief in black magic were more likely to visit faith healers than those who were non believers. In contrary to the popular belief, patients approaching the faith healers spent more money (>$20) in the treatment than who approached psychiatrists (<$20). The study shows that most of the patients suffering from mental illness prefer to approach faith healers first because of the prevailing trust on faith healers, because they are locally available and because of a prevailing belief in supernatural causation of mental illness.

As mental health systems are still developing in many Asian countries, knowledge of the pathways to mental health care (MHC) in this region would be very important. A study (Hashimoto et al, 2010) was therefore done to clarify the pathways to MHC in 5 Asian countries. Several studies done by Linden, Gothe & Ormel (2003), Rhi et al (1995), , Fujisawa et al (2008), Gater et al (2005) and Yazquez-Barquero et al (1993) were referred for this article. Method: A total of 50 new subjects attending each institution were interviewed. Pathway

diagrams, the patterns and duration of care seeking, and the previous treatment were compared. Results: Four major pathways were direct access, referrals from private practitioners, referrals from general hospitals, and referrals from native or religious healers. General practitioners did not play a pivotal role in any of the areas, whereas native or religious healers had an important place in all areas except for Yokohama, Japan. Family members had a significant impact on the decision to seek MHC. Conclusions: Studies of pathways to MHC in Asian countries are feasible and can provide data of interest in the organization of care.

Hickey, Pryjmachuk & Waterman (2016) notes that rapid growth and development in recent decades has seen mental health and mental illness emerge as priority health concerns for the Gulf Cooperation Council (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates). As a result, mental health services in the region are being redefined and expanded. However, there is a paucity of local research to guide ongoing service development. They referred studies done by Salem, Saleh, Yousef & Sabri (2009), Al-Subaie (1994) and Kirmayer (2001). Local research is important because service users' experience of mental illness and mental health services are linked to their sociocultural context. In order for service development to be most effective, there is a need for increased understanding of the people who use these services. This article aims to review and synthesize mental health research from the Gulf Cooperation Council. It also seeks to identify gaps in the literature and suggest directions for future research. A scoping framework was used to conduct this review. To identify studies, database searches were undertaken, regional journals were hand-searched, and reference lists of included articles were examined. Empirical studies undertaken in the Gulf Cooperation Council that reported mental health service users' experience of mental illness were included. Framework analysis was used to synthesize results. Fifty-five studies met inclusion criteria and the following themes were identified: service preferences, illness

(symptomology, perceived cause, impact), and recovery (traditional healing, family support, religion). Gaps included contradictory findings related to the supportive role of the Arabic extended family and religion, under-representation of women in study samples, and limited attention on illness management outside of the hospital setting. From this review, it is clear that the sociocultural context in the region is linked to service users' experience of mental illness. Future research that aims to fill the identified gaps and develop and test culturally appropriate interventions will aid practice and policy development in the region.

A study in Sierra Leone (Yoder, Tol, Reis & Jong, 2016) complements the growing amount of research on the psychosocial impact of war on children by examining local perceptions of child mental health, formal and informal care systems, help seeking behaviour and stigma. Studies done by Ventevogel, Jordans, Reis & de Jong (2013), Kleinman (1980) and Belfer (2008) were referred as part of this article. The study combined: (1) a nationwide survey of mental health care providers, with (2) exploratory qualitative research among service users and providers and other stakeholders concerned with child and adolescent mental health, with a particular emphasis on local explanations and stigma. Formal mental health care services are extremely limited resulting in an estimated treatment gap of over 99.8 %. Local explanations of child mental health problems in Sierra Leone are commonly spiritual or supernatural in nature, and associated with help-seeking from traditional healers or religious institutions. There is a considerable amount of stigma related to mental disorders, which affects children, their caregivers and service providers, and may lead to discrimination and abuse. It was concluded that Child and Adolescent Mental Health (CAMH) care development in Sierra Leone should cater to the long-term structural effects of war-violence and an Ebola epidemic. Priorities for development include: (1) the strengthening of legal structures and the development of relevant policies that strengthen the health system andspecifically include

children and adolescents, (2) a clearer local distinction between children with psychiatric, neurological, developmental or psychosocial problems and subsequent channelling into appropriate services (3) supplementary CAMH training for a range of professionals working with children across various sectors, (4) specialist training in CAMH, (5) integration of CAMH care into primary health care, education and the social welfare system, (6) further research on local explanations of child mental disorders and the effect they have on the well-being of the child, and a careful consideration of the role of religious healers as care providers. Prevalence rates obtained from community studies in other resource-poor settings vary from 8 to 16 %. Based on this we can expect the number of children with mental health problems in Sierra Leone in 2011 to have been 237,200 to 474,400. This reveals an estimated treatment gap of 99.8–99.9 %. This is higher than the estimated 99.5 % treatment gap for the entire population. Traditional Healers mostly reported treatment of children with problems related to witchcraft or 'demonic' powers. Diagnoses are being made using special, God given capacities, observation of behaviour or bodily symptoms, and divination techniques using cowry shells, mirrors, leaves, etc. Treatment may include: secret ceremonies to pull the children from the underworld (the realm of demons and witches); herbal concoctions to drink, wash or rub on faces/bodies; establishing rules/regulations that need to be respected (e.g. not taking a bath at certain hours, as there are more demons around at that time of the day); sacrifices to pacify the demons; washing with a locally made soap or "Lasmami" (written Arabic text washed from a slate) as well as advice to parents and children. Problems are identified by Christian Healing Ministry workers through counselling and listening, observation of behaviour, fasting, prayer and divine revelation. Help is mostly offered in the form of counselling, prayer and fasting (for which parents and children can be encouraged or are requested to join), "deliverance" (being released from evil forces such as demons) and Bible-teaching. One church offered residential treatment, sometimes for children as young as 9 years old. Another church said to sometimes

give financial assistance to parents or children. They also help with family reintegration. While allopathic medication was used for physical ailments, the child was taken to traditional and religious healers for treatment of mental health problems. The financial implications of this help-seeking behavior appeared to put a significant strain on families. This is during the feedback meeting several participants expressed doubts about the accuracy of our findings on the role of traditional healers in child mental health care. It was felt that the research presented a picture of traditional healers which was too positive. Participants expressed concern over the abuse they believed to be going on: high financial or material demands, chaining, beating, and keeping children under inhumane conditions. It was said that some children do not survive the "treatment". We must also be aware that pastors and traditional healers in Sierra Leone greatly outnumber health professionals, which makes informal care much more accessible. At the time of our interviews, the Traditional Healers Union reported a country-wide membership of over 30 thousand. It may be argued that the calculated treatment gap of 99.8–99.9 % is another example of iatrocentric reasoning by Western researchers, as it excludes the care given by traditional healers and religious institutions. However, as mentioned earlier, participants in our feedback meeting felt that the role of traditional healers was portrayed as too positive in our presentation of findings. Also, it could be argued that—although more widely available—informal care is not necessarily more affordable considering the high prices that can be charged for treatment. While religious leaders and traditional healers are an important group both as recipients and transmitters of child mental health messages, their role as care providers should be critically and sensitively assessed and determined.

A systematic review was conducted (Burns & Tomita, 2015) to evaluate the proportion of patients attending formal health services after making first contact for treatment of mental disorders with traditional or religious healers or other informal and formal care providers

within published research in Africa. Electronic databases were searched for the period from January 1990 to February 2014. Quality assessment of included studies was conducted the SAQOR tool. In resource-limited contexts in low- and middle-income countries (LMICs), a considerable proportion of individuals seeking care for mental disorders consult traditional and religious healers in their pathway to mental health care. Reports from Africa suggest that early involvement of healers may result in delays in the care pathway; a potential barrier to early identification and intervention. Fourteen papers were identified with data on category of first care provider. Utilizing random effects modelling with inverse variance method, the pooled proportion of participants making first contact for treatment of mental disorders with two broadly categorised providers (informal and formal) was 48.1 % (95 % CI 36.4–60.0 %) and 49.2 % (95 % CI 38.0–60.4 %), respectively. The pooled proportion of participants making first contact with specific providers was: traditional healers (17.0 %, 95 % CI 10.9–24.1 %); religious healers (26.2 %, 95 % CI 18.1–35.1 %); general health services (24.3 %, 95 % CI 16.9–32.5 %); and mental health services (13.0(13.0 %, 95 % CI 5.1–23.5 %). Substantial regional variation in patterns of first provider choice was evident. Within this context, people seeking help for mental disorders in LMICs rely heavily on alternative or informal sources of care. There is good evidence that in these countries, a considerable proportion of individuals seek help from traditional and religious healers for a range of health problems, including mental disorders. Critics argue that the proportion commonly quoted in the literature of 80 % of the population may be greatly exaggerated. While studies show that satisfaction with care administered by healers is high in many cases for individuals with mental disorders, the evidence indicates that delays in accessing formal mental health services are common where they feature in the pathway to care.

As stated in the introduction, an important consideration in relation to pathways to care is whether choice of initial care provider impacts on delays in accessing treatment. Within the

African context, where a substantial proportion of individuals with mental health problems choose traditional and religious healers as their initial provider, addressing this issue is critical to the development of appropriate public mental health strategies. Reducing delays in accessing services and providing early intervention are key strategies in preventing morbidity associated with severe mental disorders such as schizophrenia . Several studies in the current review addressed this issue, albeit with different approaches and variable methods, which hinders attempts to compare and contrast findings. Specifically, four studies examined the association between consulting traditional or religious healers as first provider and experiencing relative delays in accessing mental health services. All were conducted in populations with first-episodes of mental disorders, mainly first-episode psychosis and reported longer delays in accessing mental health services where traditional or religious healers were the initial care providers. This raises the question of how formal health providers, planners and policy makers should engage with informal providers, such as traditional and religious healers within LMIC contexts, in relation to improving pathways to care for people with mental disorders. While the biomedical agenda is to hasten individuals with mental health symptoms and disorders into formal mental health care, it is a fact that within resource-limited contexts the services needed to enable this to take place are not available. As a result, the formal health services often fail to meet the needs of individuals and communities.

A cross-sectional, interview survey of the beliefs, knowledge, attitudes and practice towards mental illness of 29 traditional healers in the Pallisa district of Uganda was carried out (Boardman & Oluka, 1999). Many of the healers had experienced emotional problems that had been treated by other healers. Almost all had a family member who was also a traditional healer. They treated a wide range of conditions and all dealt with mental illness. Most believed that mental disorders were caused by supernatural processes. Many recognised the role of

environmental agents. Their diagnosis and management of mental illness was eclectic. The healers were either traditional herbalists or spirit diviners or a mixture of both. Almost all referred patients to the district hospitals and were willing to work with government health services. The results of the survey suggest the presence of fertile ground on which to build cooperation between traditional healers and medical services. Such cooperation may harness primary care resources more effectively. Sequential or simultaneous models of collaboration (or combinations of both) may be considered. Further work on specific treatments, their outcomes and the evaluation of collaborative models is needed.

In many countries, traditional healers play an important role in the treatment of mental health problems and these healers maybe an important resource in the provision of primary mental health services (Young, 1983; World Health Organization, 1990: Winston et al1995). Uganda is no exception to this (Boardman& Ovuga, 1997). This paper reports on a survey of such traditional healers in one area of Uganda.It has long been recognised that traditional healing practices exist side-by-side with modern medical practice (Lambo, 1956; Orley, 1970; Ademuwagun, 1976; Imperato, 1976). A significant proportion of people seek care from traditional and spiritual healers whom they consult for a range of medical problems. A Nigerian study noted that spiritual healers, traditional healers and general practitioners were the first to be contacted by 13%, 19% and 47% of patients respectively (Gureje et al, 1995). Those dissatisfied with the results of orthodox medicine often take themselves to traditional healers (Patel *et al 1997a) and a significant proportion of these* have psychiatric disorders (Patel et al 1997b). Few studies have surveyed the practice of traditional healers in relation to mental illness. Odejide et al (1977) examined the characteristics and practices of 53 traditional healers in Ibadan, Nigeria and noted that while they engaged in some undesirable practices, they held

a broad concept of psychopathology and provided an important force in the treatment of psychiatric disorders.

A systematic review and meta-analysis was conducted to examine the efficacy of Tai Chi as an adjunctive treatment for schizophrenia using randomized controlled trial (RCT) data (Zheng et al, 2016) Tai Chi as a form of moderate aerobic exercise originating in China, could promote balance and healing of the mind-body. Furthermore, Tai Chi has been used as an adjunctive treatment for patients with schizophrenia. However, no meta-analysis or systematic review on adjunctive Tai Chi for patients with schizophrenia has yet been reported. Several studies on tai chi were referred as part of this article such as those by Wang, Bannuru, Ramel, Kupelnick, Scott & Schmid (2010), Wang et al (2014), Wang, Chan, Ho, Tsang, Chan & Ng (2013) and Lin, Lee, Tong, Lee & Chen (2014). Two evaluators independently and systematically searched both English- and Chinese-language databases for RCTs of Tai Chi for schizophrenia patients, selected studies, extracted data, conducted quality assessment and data synthesis. Statistical analyses were performed using the Review Manager (version 5.3). The Cochrane Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) was used to assess the strength of the evidence. In 6 RCTs conducted in mainland China and Hong Kong, there were 483 participants including 215 subjects in the intervention group and 268 subjects in the control group. The trials lasted 16.0 (6.2) weeks. Compared to control group, we found significant differences regarding improvement of negative symptoms assessed by the Positive and Negative Syndrome Scale (PANSS) negative symptom sub-score (2 trials) and Scale for the Assessment of Negative Symptoms (SANS) (3 trials) over the study period in the intervention group (5 trials with 6 treatment arms, n=451, SMD: -0.87 (95%CI: -1.51, -0.24), p=0.007; $I2$=90%).Furthermore, there is no significant difference regarding improvement of positive symptoms assessed by the PANSS positive symptom sub-score (2

trials) and Scale for the Assessment of Positive Symptoms (SAPS) (2trials) over the study period (4 trials with 5 treatment arms, n=391, SMD: -0.09 (95%CI: -0.44, 0.26), p=0.60;$I2$=65%). All included RCTs did not report side effects. Based on the GRADE, the strength of the evidence for primary outcome was 'very low'. The researchers conclude that the data available on the effectiveness of adjunctive Tai Chi in patients with schizophrenia who are receiving antipsychotic is insufficient to arrive at a definitive conclusion about its efficacy. Furthermore, follow-up time in the available studies was relatively short, and all studies did not use blinded assessment of outcome measures. High-quality randomized trials are needed to inform clinical recommendations.

Suicide and mental disorders are a growing public health issue in Bhutan, due in part to a rapidly transitioning society (Dorji et al, 2017). Although population-level data on mental disorders are scant, health-facility morbidity reports indicate that, from 2011 to 2015, there was an increase in the total number of documented cases of mental health disorders, from 2878 cases to 7004, of which 45% and 31% were anxiety and depression respectively. Suicide attempts are associated with depression and other mental disorders. The burden of suicide has been recognized by the Royal Government of Bhutan and, as a result, it introduced the country's first ever national suicide-prevention plan in 2015. In the country's history of 60 years of allopathic medicine, Bhutan only has four psychiatrists. In addition, the country lacks any psychiatric social workers or mental health counsellors with comprehensive training. As a result, routine clinical mentoring of primary health-care services in management of mental disorders is compromised. The quality of mental health services is therefore low and relatively basic. Treatment and rehabilitation centres for misuse of drugs and alcohol are provided through joint efforts of government and civil society, and their coverage is very low. In addition, back-up from the health services is not optimum, owing to low capacity of the health-

service providers. Myths and lack of awareness about mental disorders abound, as the concept of mental health is relatively new in Bhutan.4 Stigma and discrimination related to mental health are universal challenges,10 and are prevalent in Bhutan, such that most people with mental disorders and depression receive no treatment or delay seeking care. The 3-year action plan takes a holistic approach to making suicide-prevention services a top social priority, through strengthening suicide prevention policies, promoting socially protective measures, mitigating risk factors and reaching out to individuals who are at risk of suicide or affected by incidents of suicide. This article documents Bhutan's policy and governance for addressing depression and suicide within the context of its national suicide-prevention strategy, examines progress and highlights lessons for future directions in suicide prevention. Since the endorsement of the 3-year action plan by the prime minister's cabinet, the implementation of suicide prevention measures has been accelerated through a high-level national steering committee. Activities include suicide-prevention actions by sectors such as health, education, monastic communities and police; building capacity of gatekeepers; and improving the suicide information system to inform policies and decision-making.

The effectiveness of interventions for people with severe mental illness delivered by informal community care providers in low and lower middle-income countries is not known. Nguyen et al (2019) conducted a systematic review of the impact of community-based interventions implemented by the informal sector for people with severe mental illness in these settings. Five electronic databases (MEDLINE, EMBASE, PsycINFO, CINAHL, and Cochrane Central Register of Controlled Trials) were searched for English-language publications using both keywords and MeSH terms. All study designs were included. The result was that five papers, reporting data from five studies conducted in four low and lower middle-income countries in 2017, met the inclusion criteria for the review. Of the five included studies,

three had a before and after design, one was a randomized controlled trial, and one a qualitative investigation. Most interventions with a low-moderate quality of evidence used informal community care providers to deliver either self-help groups, traditional healing treatments, and/or a rehabilitation program. The investigators reported data about improvements in the outcomes of intervention participants (psychosocial functioning, psychotic symptoms, and social inclusion) and positive impacts on their families (family's knowledge and skills of mental illness management, caregiving burden, social exclusion/stigma against people with severe mental illness, and financial burden). Cost-effectiveness of the intervention (in one study) found that it had a higher financial cost but greater effectiveness than the usual standard of care. They concluded that although only a small number of studies were identified, the review provides promising evidence of the professionally developed interventions for people with severe mental illness, delivered by the informal community workforce in low and lower middle-income settings. Training and supportive supervision for informal community care providers are crucial components of effective interventions.

Traditional Medicine Practices (TMP) which are premised on indigenous knowledge and experiences within a local context of the culture and environment, are common place in low income countries. In Africa and in Uganda specifically, nearly 80% of the Ugandan population relies on TMP for the care of their mental health but they also use Modern Medicine. There are areas of departure between Traditional and Modern Medical practices in Africa that have been cited. What has attracted less research attention, are the areas of convergence. This paper (Delman et al, 2019) aims to critically examine the link between Modern Medicine and Traditional Healing Practices in Africa, citing Uganda as case example. A Narrative literature review with critical element assessment was undertaken to identify documented points of departure, areas of common practice, and ways in which the two models

can co-exist and work together through a carefully thought out integration. Result showed that points of departure between Modern Medicine and Traditional Medicine Practices are philosophical underpinnings of both practices, training of practitioners, and methods and ethics of work. Common areas of practice include human rights perspective, descriptions of mental illnesses, clinical diagnostic practice, particularly severer forms, intellectual property rights, and cross prescriptions. Exhibiting cultural humility and responsibility on the side of the Modern Medicine Practitioners is one of the ways to work together with TMPs. The researchers conclude that points of departure are more documented and explicit and overshadow areas of common practice while the links between the two are mainly implicit but sadly unrecognized. Mental disorders are disorders of the brain and in neuroscience; the brain is culturally and socially constructed. Sociocultural issues therefore cannot be divorced from disorders of the brain and their management. For better patient outcome and patient-centered approach of care, it is necessary to acknowledge and enhance the links in teaching, clinical and policy level and carry out research on how the links could be improved.

2.3 Studies from India

The healing power of temples in India is described in a study (Raguram, Venkateshwaran, Ramakrishna & Weiss, 2002). The use of complementary medicine and the traditional medicine of other cultures has been increasing in Europe and North America. Although less well documented, the use of complementary medicines and consultations with traditional healers is widely acknowledged in low income countries, such as India. Here too the limited availability of health services motivates the use of a wide range of alternative systems of care for various ailments, including mental illnesses. The role of traditional healers

in mental health care in rural India (Kapur, 1979) was referred as part of this article. Other noteworthy studies referred in this article includes studies done by Ernst (2000), Pakaslahti (1998), Raghu (1999), Kapur (1975) and musyimi, Mutiso, Loeffen, Krumeich & Ndetei (2018). In addition to herbal and other traditional medicines, healers and healing temples are seen as providing curative and restorative benefits. In India many people troubled by emotional distress or more serious mental illnesses go to Hindu, Muslim, Christian, and other religious centres. The healing power identified with these institutions may reside in the site itself, rather than in the religious leader or any medicines provided at the site. Studies of these healing sites have focused primarily on ethnographic accounts. Research has not systematically examined the psychiatric status of the people coming for help at these religious centres or the clinical impact of healing. It has focused primarily on possession and non-psychotic disorders, rather than serious psychotic illnesses. Yet people with serious psychotic illnesses do visit such healing temples in India, and understanding the role of these institutions may help with planning for community mental health services in underserved rural areas. We describe here the work of a Hindu heal-ing temple in South India known as a source of help for people with serious mental disorders. We also tried to measure the clinical effectiveness of religious healing at this site.

The study was conducted at the temple of Muthusamy in the village of Velayuthampalayampudur, Dindugal District, Tamil Nadu. Set in the foothills of the Palanirange of the Western Ghats, this temple, built over 60years ago, has become increasingly popular as a place of healing, especially for people with serious psychiat-ric problems. It was built on the outskirts of the village in the middle of a graveyard, over the tomb of Muthuswamy, a man who lived in the village a century ago. Our research was carried out over three months from June to August 2000. Everyone who came for help and stayed in the temple was studied. The purpose and nature of the study was explained to the subjects and the family caregivers

who stayed with them, and informed consent was obtained from both. During this period one of the authors (AV) stayed in the temple and carried out an in depth ethnographic inquiry into the historical background of the temple, the various popular ideas about the origin of the temple, and the process of healing that occurs. He elicited the patients' illness experience and the caregivers' views on the causes with a locally adapted semi structured cultural epidemiological interview, known as “emic.” The term emic, after which these interviews are named, refers to the “internal” views of health and illness according to patients and the local population, in contrast to the “etic” or “external” views of doctors and epidemiologists. This research shows that a brief stay at one healing temple in South India improved objective measures of clinical psychopathology.

In recent times, the pathway of care by psychiatric patients has been studied across the world. However, there are limited studies from India, restricted to reputed hospitals and research centers. Therefore, a study was planned, to understand the pathway of care adopted by psychiatric patients in central India (Lahariya, Singhal, Sumeet & Ashok, 2010). For their study, they referred to various studies done by Dasgupta & Dasgupta (2009), Shamasundar (2008), Banerjee & Banerjee (1995) and Naqvi & Khan (2006). The present study was conducted to study the socio-demographic profile of psychiatric patients attending the Gwalior Mansik Arogyashala (GMA), a psychiatric specialty hospital in central India; to understand the pathways of care adopted by the patients attending this facility, and to explore the interrelationship between the pathways of care and the socio-demographic variables. In recent times, the pathway of care by psychiatric patients has been studied across the world. However, there are limited studies from India, restricted to reputed hospitals and research centers. Therefore, this study was planned, to understand the pathway of care adopted by psychiatric patients in central India. The present study was conducted to study the socio-

demographic profile of psychiatric patients attending the Gwalior Mansik Arogyashala (GMA), a psychiatric specialty hospital in central India; to understand the pathways of care adopted by the patients attending this facility, and to explore the interrelationship between the pathways of care and the socio-demographic variables.

In a recent research done in Gujarat by Schoonover et al. (2014), the researchers aimed to determine the perspective of patients, their families, and healthy community members toward faith healing for mental illness, including the type of interventions received perceptions of its efficacy, and overall satisfaction with the process. They also sought to explore the range of care received in the community and investigate possibilities for enhancing mental health treatment in rural Gujarat. They interviewed 49 individuals in July 2013 at Dhiraj General Hospital and in 8 villages surrounding Vadodara. These subjects in the study were separated into 5 groups as follows: Group 1 included psychiatric patients who sought treatment from both doctors and traditional healers, group 2 were patients who sought treatment from doctors only, group 3 includes patients who sought treatment from a traditional healer only, group 4 was comprised of subjects with mental illness who had not sought treatment, and group 5 included healthy community members who did not know anyone with mental illness. Qualitative analysis was performed on the completed data set using grounded theory methodology. The subjects' narratives were qualitatively analyzed to reveal trends in the causes attributed to mental illness, the interventions performed by traditional healers and doctors, patient preferences for treatment type (traditional healer vs doctor), and attitudes toward traditional healing according to provenance and assigned group. Three investigators coded data and read the interview transcripts to look for themes using the grounded theory method. Data were reviewed to discover themes within each of the 5 subgroups as well as for the entire study population. Through the study, they found that subjects were largely dissatisfied with their experiences of traditional healers and would recommend a doctor over a healer. Many also felt

that healers were not effective for mental illness or are dishonest and should not be used. However, the researchers note that because healers are such integral parts of their communities and so commonly sought out, collaboration between faith healers and medical practitioners would hold significant promise as a means to benefit patients.

Traditional and complementary systems of medicine include a broad range of practices, which are commonly embedded in cultural milieus and reflect community beliefs, experiences, religion, and spirituality (Gureje et al.,2015). Gureje et al contends that the evidence from around the world suggests that a traditional or complementary system of medicine is used by a large number of people with mental illness. They found that the practitioners of traditional medicine in low-income and middle-income countries fill a major gap in mental health service delivery. Although some overlap exists in the diagnostic approaches of traditional and complementary systems of medicine and conventional biomedicine, some major differences exist, largely in the understanding of the nature and cause of mental disorders. Treatments used by providers of traditional and complementary systems of medicine, especially traditional and faith healers in low-income and middle-income countries, might sometimes fail to meet widespread understandings of human rights and humane care. Nevertheless, the researchers assert that collaborative engagement between traditional and complementary systems of medicine and conventional biomedicine might be possible in the care of people with mental illness.

A hospital based study (Shekar, Anitha & Reddy, 2011) was conducted at Institute of Mental Health, Hyderabad on patients visiting outpatient department using a semi structured questionnaire This study was planned to understand the factors which lead the patients to faith healers and to assess the percentage of patients switching over to faith healers from medical professionals. Psychiatric services in India are limited. Studies on help seeking behavior of

psychiatric patients by Chadda, Agarwal, Singh & Raheja (2001), Dhadphale et al (1991) and Mishra, Nagpal, Chaddha & Sood (2011) were referred as part of this article As a result, a variety of people including faith healers, unqualified medical professionals etc, form first line of contact for patients with mental illness. Also, faith in the medical model of psychiatric illness may be shattered during course of treatment owing to chronicity of illness. The data was analysed using Microsoft excel version. Only the prevalence was estimated. Among 98 people who were included in the study, males predominated. The socio demographic factors which had impact on patients approaching faith healer were; age less than 35 years, literacy, and family income. Urban or rural background did not have much impact on patients contacting faith healers. Patients consulting non psychiatric medical professionals have higher switch compared to those consulting psychiatrists. Conclusion: There is a need to increase awareness regarding psychiatry among non-psychiatrists, with an effective referral system in place. Awareness programmes also should be targeted to general population.

India and China face the same challenge of having too few trained psychiatric personnel to manage effectively the substantial burden of mental illness within their population. At the same time, both countries have many practitioners of traditional, complementary, and alternative medicine who are a potential resource for delivery of mental health care. In this paper (Thirthalli et al, 2016), part of *The Lancet* and *Lancet Psychiatry*'s Series about the China–India Mental Health Alliance, they describe and compare types of traditional, complementary, and alternative medicine in India and China. Further, we provide a systematic overview of evidence assessing the effectiveness of these alternative approaches for mental illness and discuss challenges in research. Several studies done by Patet et al (2016), Priya & Shweta (2010), Trivedi & Sethi (1979), Sax (2014), Kou & Chen (2012), Isaac (2011) and Jacob (2011) were referred to. We suggest how practitioners of traditional, complementary,

and alternative medicine and mental health professionals might forge collaborative relationships to provide more accessible, affordable, and acceptable mental health care in India and China. A substantial proportion of individuals with mental illness use traditional, complementary, and alternative medicine, either exclusively or with biomedicine, for reasons ranging from faith and cultural congruence to accessibility, cost, and belief that these approaches are safe. Systematic reviews of the effectiveness of traditional, complementary, and alternative medicine find several approaches to be promising for treatment of mental illness, but most clinical trials included in these systematic reviews have methodological limitations. Contemporary methods to establish efficacy and safety—typically through randomised controlled trials—need to be complemented by other means. The community of practice built on collaborative relationships between practitioners of traditional, complementary, and alternative medicine and providers of mental health care holds promise in bridging the treatment gap in mental health care in India and China.

2.4 Studies from North-East India

A study (Zhasa, Hazarika & Tripathi, 2015) was carried out to explore indigenous knowledge on utilization of available plant biodiversity which have been utilized for treatment and cure of human ailment by eight Naga tribes i.e. Angami, Zeliang, Ao, Lotha, Sangtam, Konyak, Chakhesang, Rengma, and Khiamniungam in 20 villages of 9 districts of Nagaland during 2005-2010. Studies by Jamir & Rao (1990), Changkija (1999), Jamir, Jungdan & Deb (2008), Jamir, Lanusunep & Jamir (2010), Imchen & Jamir (2011), Lanusunep & Konyak (2011) were referred to in this article. Selected villages and households were surveyed and interviewed by using the structured schedule (questionnaires) for medicinal plant resources, their uses and information about their relationships with indigenous people. Information about

traditional practices adopted for the medicinal resources was also gathered from the 'Local Medicine Men/Local Healers', Goanburha (Village Head Man), village elders etc. About 241 plant species belong to 142 families were recorded for traditional medicine used by eight Naga tribes. Highest number of utilization of medicinal plants were reported from cold regions (22.61 %) i.e. from high altitude areas of the state, followed by warm areas (25.73 %). Extraction of traditional medicines was highest in case of plant leaf (106 plant species) followed by roots (58 plant species), fruits (45 plant species), whole plant (36 plant species), bark (30 plant species) and the seeds (27 plant species) while the least used part were flowers and pods (21 plant species). About 33 plant species were recorded to use for treating dysentery, followed by 20 plant species for treatment of cough and control fever each. Fifteen plant species recorded for treatment of diarrhoea and 12 plant species were recorded to use for treat asthma. It was also observed that some endangered plant species such as Rhus semialata Murr, Aquilaria malaccensis Lam, and Cephalotaxus griffithii Hook.f., are utilized the people of Nagaland for medicinal purpose.

The paper (Lanusunep, Amri, Jamir, Longkumer & Jamir, 2018) deals with the first hand investigation of 51 species of herbal medicinal plants used by Ao-Naga tribes of Mokokchung district in Nagaland for treatment of various diseases and ailments. The paper includes the plants' scientific name, local name and diseases treated by the plants reported from the district. They also referred to several studies by Jamir, Lanusunep, Seb & Soyhunlo (2016), Rongsensashi, Renchumi, Changkija & Limasenla (2013) and Sumitra & Jamir (2009). Mokokchung district is the homeland of the Ao-Nagas in the state of Nagaland, India. The major rivers of Mokokchung district are Milak, Dikhu, Tzürang, etc. and the main agricultural products are rice, maize, orange, tomato and passion fruit. Topographically, the area is mainly mountainous except some areas bordering the Assam valley. Majority of the population in the

district is concentrated in villages situated at hill-tops surrounded by natural forests. Thus, naturally, the Ao-Nagas have close proximity with nature as that helped them to practice traditional medicine since for generations to treat and cure their various ailments (Mills 1921).The people of Ao-Nagas prefers to dwell mostly in hill-tops and slopes which are preferably surrounded by dense natural forests. The traditional knowledge on medicinal plants is generally confined with the local medicine men (Kobiraz). However, some secrets of these knowledge can be obtained from them through close contacts and interaction (Jamir 1997).

In the present investigation (Pfoze, Kehie, Kayang & Mao, 2014), literature survey on ethnobotanical plants published by different workers was conducted to records data on ethnobotanical uses of plants by the indigenous Naga tribal community. A total of 37 published papers covering about 13 different tribes of the Naga were investigated. Analysis of the taxonomic diversity recorded a total of 628 species belonging to 398 genera and 146 families. Of this, about 73.88% (464) of the species are used as ethno medicine, 27.23% (171) as edible plants, 13.69% (86) as edible fruits, 5.73% (36) as dyes, 4.30%(27) as fish poison, 1.60% (10) as fermented food and beverage, 1.75% (11) as fodder and pasture grass and about7.96% (50) for other uses. Further analysis of the species from different taxonomic groups showed that about95.06% belongs to angiosperms (78.18% dicots and 16.88% monocots) and the remaining 4.94% are from gymnosperm, pteridophytes and edible mushrooms. Moreover, 176 species have been listed to have more than one category of used.

This study is an attempt to present the most comprehensive and detailed list of ethno botanical plants of the Nagas of Northeast India. The present paper (Shankar & Devalla, 2012) deals with the details of studies on conservation of traditional healing practices of tribal people of Nagaland, one of the states of North Eastern India which is bordered in the East by Myanmar,

Assam in the West, Manipur in the South, and Arunachal Pradesh and partly Assam in the North. It lies between 93.5 to 94.70 N longitude and 25.5 to 27.5 E latitude. The state as a whole is a hilly tract and occupying an area of 16,527 sq. km. The state consists of seven districts and 16 tribes and their sub-tribes. The state is rich in biodiversity as a source of medicinal plants as well as the traditional method of healing practices and health management. Traditional practices in Nagaland are practiced by some of the herbalists who use the practice of treatment through single drug or in compound formulation. Due to modernization of the society these practices are gradually getting reduced which needs to be conserved through promoting of the traditional healers by taking them in practice through scientific organizations after passing through various scientific validation practices.

The present study (Longkumer & Borooah, 2013) surveyed knowledge and attitudes toward mental disorders among Nagas. As part f this article, they referred to various studies done by Wolff, Pathare, Craig & Leff (1996), Ineland, Jacobsson, Renberg & Sjolander (2008), Jorm (2000), Angermeyer & Dietrich (2006) and Economou, Richardson, Gramandani, Stalikas & Stefanis (2003). The sample comprised of 500 adults above 21 years of age and included both males (n = 226) and females (n =272). The distribution of the 500 participants according to their educational qualification was – up to MiddleSchool (n = 136); up to High School (n = 164); Graduate and above (n = 198). A case vignette of schizophrenia was used and participants were asked to respond to a questionnaire based on the vignette. Percentage frequencies of responses were worked out for every item on the questionnaire for analysis. A great majority could recognize a mental health problem in the case vignette but used more general terms such as psychological problem/ mental problem/ mental illness. Majority attributed the problem to psychosocial factors and chose a psychiatrist/psychologist over other options. However, a considerable number of participants reported evil spirit possession as the

cause of mental disorders and preferred seeking for divine intervention as a treatment mode. Chi-square test was applied to see the relationship of educational level with attitudes toward mental disorders. Results showed significant differences in attitudes when compared by educational level.

Ethnobotany is an important branch of research that deals with medicines derived from plants and use of different plant parts in the treatment of various disease and ailments, based on indigenous pharmacopoeia, folklore, and herbal charms. An extensive study (Bhuyan, Meyiwapangla & Laskar, 2014) on Traditional practice of medicinal plants by 4 major tribes of Nagaland was conducted in different localities from districts of the state. The tribes undertaken for study were Ao, Angami, Lotha, Sema, residing in Nagaland. The survey was conducted by interviewing Local healers, village elders, and farmers. A total of 50 informants from 20 villages were interviewed which includes 9 local herbalists, 11 traditional healers, 8 mid-wives, 6 bonesetters, 10 village elders, and 6 farmers. The study comprises 257 species of ethno-medicinal plants belonging to 85 families. The conservation efforts are needed for plantation and protection of these plants with maximum participation of local people.

Jamir & Lal (2005) in their paper describes the traditional method of treating various kinds of ailments using different vertebrates and invertebrates and/or their products by different Naga tribes. Since different Naga tribes have their own distinct language and vernacular of a particular animal differs from one tribe to other. Efforts have been made to identify different animals of medicinal value used by Naga tribes and decode their names in common English language along with their local and zoological names as far as possible. A study on ethnozoological practices among Naga tribes done by Kakati & Doulo (2002) was referred as part of this article. A list of twenty- six animal species

and their products, nature of ailments and mode of treatments has been presented. Efforts have been to make known the animal based remedial measures practiced by and large by the Naga tribes. Though traditional in nature, most of the treatments have been reported to provide miraculous healing in various kinds of ailments.

The study (Pandey, Mavinkurve, & Garg, 2013) was undertaken by questionnaire, interview and the video documentation method with prior consent of the Traditional Health Practitioners. India is one of the few mega biodiversity countries with a rich diversity of flora and fauna, as well as a home for traditional health practices, remedies and therapies. Traditional medicine has been used for thousands of years with great contributions made by practitioners to human health, particularly as primary health care providers at the community level. Most of the populations especially in the rural areas depend on the oral knowledge of the Traditional Health Practices (THPs), remedies and therapies to meet their primary health needs. However, in view of the oral transmission of this folk knowledge over several generations, it is getting rapidly eroded. For their article, they referred to studies done by Barbhuiya (2009) and Hazarika (2011). In order to prevent the erosion of THPs and to promote the safe and efficacious remedies used by the Traditional Health Practitioners a pilot study on Local Health Practices was undertaken with selected traditional health practitioners from 4 villages of Jorhat district, Assam. In support of the documented THPs plant Herbarium Specimens were collected for authentication and promotion of the safe and efficacious Local Health Practices. Analysis of the survey showed revitalization is important and contributes for primary health care.

Sobhani, Pal, Bhattacharjee, Mitra & Aguan (2017) screened Indigenous Medicinal Plants of Northeast India for Their Anti-Alzheimer's Properties Alzheimer's disease, the most

common form of dementia, is a progressive neurologic disorder of the brain that leads to the irreversible loss of neurons. AD impairs cognitive and memory functions, communication, personality, behavior, and ability to function properly. The average duration of survival of AD patients after the onset of dementia is 5 to 9.3 years.1,2 Because of the absence of a permanent cure, AD has become a major health problem, although there are some treatments that may slow down its advances.3 It is estimated that there are 35.6 million people living with dementia worldwide and will increase to 65.7 million by 2030, whereby much of the increase will be in developing countries.4 Neurofibrillary tangles, Amyloid plaques and loss of cholinergic neurons are three pathological findings commonly observed in the cerebral cortex of Alzheimer's disease cases.5-8 Based on the findings that there exist a correlation between cholinergic system abnormalities and intellectual impairment, "cholinergic hypothesis" has been put forward in the functioning of memory.Alzheimer's disease (AD) is a progressive neurologic disease of the brain that affects intellectual abilities, reasoning and memory. Acetylcholine (ACh) is involved in the maintenance of cognitive process. Pathologically, ACh production is compromised in the brains of AD affected people. Presence of acetylcholinesterase (AChE) in the synaptic cleft, which hydrolyzes ACh, further decreases the ACh-levels, and thereby, additionally compromises cognition. The tribal people of North East India have been using indigenous plants as traditional medicine for brain disorders. We assayed whether the plants used in the traditional tribal knowledge for the treatment of brain disorders might contain better AChE-inhibitors. They collected 10 traditional medicinal plants from Northeast India. A total of 39 plant extracts were prepared using three solvent systems. The Acetylcholinesterase (AChE) activity was measured with Ellman method. The experiment was done in triplicate for each level of inhibitor. The activity was measured at 412 nm wavelength using Plate Reader. The standard student t-test was used to show significant difference in IC50 values between extracts. The result are reported based on Km, Vmax, IC50 (μg/μl), percentage

inhibition and inhibition pattern. Two extracts had competitive inhibition, 11 extracts had mixed inhibition, 2 extracts had non-competitive inhibition, 11 extracts had uncompetitive inhibition and 4 extracts did not provide any proper pattern. The IC50 for these plant extracts were at the range of 0.51-12.4 µg/µl. Notably, Cinnamomum camphora (leaf: chloroform), Litsea glutinosa (stem; chloroform), and Litsea glutinosa (stem; methanol) showed IC50 values of 0.51, 0.53 & 0.81 µg/µl, respectively.

Ramashankar, Deb & Sharma (2015) in their studies in Northeastern region of the India comprising states of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura reported that they still follow the age old traditional healing systems based on Ayurveda, Unani and other allied practices. Each state is having its own dialect, plant and animal resources for meeting out the requirement of community including health facilities. They all adapt herbs, animal parts, *mantras* for keeping them healthy. During various studies it was observed that the traditional healers in this region belong to different categories like herbalist, diviners and birth attendants etc. (Jamir, 1989; Jamir, 1990; Jamir, 1991; Jamir, 1997; Kharkongor & Joseph, 1997; Kumar, 2002) Their method of treatment, ethics and significance of traditional healing practices are discussed in this paper. At the moment, scientific validation and recognition of traditional healing medicines are urgently required for revitalizing this loosing traditional knowledge. Traditional healers neither always perform the same functions, nor do they all fall into the same category. Each of them has their own field of expertise. Even the techniques employed differ considerably. Every healer has its own methods of diagnosis and its own particular medicine. By interviewing it was found that there are different types of traditional healers on the basis of their expertise in north east India. The major types are as follows- Herbalists: Herbalists are common in every states of north east India. They are ordinary people who have acquired an extensive knowledge or technique but do not, typically, possess occult powers. They are expected to diagnose and prescribe medicines for everyday

ailments and illnesses, to prevent and to alleviate misfortune or evil, to provide protection against witchcraft and misfortune, and to bring prosperity and happiness. In the healing practices of herbalists, empirical knowledge plays an important role, as they are able to diagnose certain illnesses with certainty and to prescribe healing herbs for those illnesses. In general, magical techniques also have a decisive role to play, because virtually all medicines can contain ingredients that are endowed with magical powers. They feel that common people wouldn't be able to become a good herbalist; it needs some spiritual power also. Diviners: They were observed in the remote village of Assam and Arunachal Pradesh. Diviners are the most important intermediaries between humans and the supernatural. Unlike herbalists, no one can become a diviner by personal choice. The ancestors call them (more usually a woman) and they regard themselves as servants of the ancestors. Diviners concentrate on diagnosing the unexplainable. They analyse the causes of specific events and interpret the messages of the ancestors. They use divination objects and they explain the unknown by means of their particular mediumistic powers. Their vocation is mainly that of divination, but they often also provide the medication for the specific case they have diagnosed. Traditional birth attendants: Traditional birth attendants often serve the communities located in isolated and remote areas where they are consulted as a matter of necessity due to the unavailability of Western health care services. However, they also render their services in urban/semi-urban communities, which despite their exposure to Western health care services may still prefer traditional birth attendants. Although number of traditional birth attendants in north east India or any state is not readily available, but they are part and parcel of the very large human resource component in the traditional sector, and it can be safely deduced that this category of health provider continues to play an important role. Other: Veterinary, bone setter, acupuncturist, breathing treatment, etc. are also practiced in this region. But the detail about the method of treatment is not yet explored. After taking interview of different traditional healer of north east India, it was

observed that the traditional healers have some principles in their system of healing practices. Traditional healers can realize the mind-body relationship. According to them the natural harmony of the body can only be restored by an integrated and holistic approach. They use natural methods of treatment, because these were the resources that have nurtured since time immemorial. Traditional healers used to be taught by other traditional healers with many years experience from generation to generation and some of them have god gifted power of this knowledge. Traditional healers have strong ethical principles that they extend to all life. They believe that it is their duty to promote and save life from suffering. They also believe that Nature's laws must be obeyed in order to avoid decline and ultimate disaster. Traditional healers do not only work at correcting the internal imbalances through which disease can manifests in an individual, but also work at re-establishing an individual's harmony with their environment and their relationship with the natural cycles to which all life is subject. Traditional healing practice views the universe as operating according to natural laws that manifest according to specific rules and correspondences.

Albert & Kharkongor (2010) observe that local health traditions in Meghalaya are widely practiced and used. Each family in each tribe has its own set of 'home remedies', passed down by the older generation, for many common ailments. In illness, whether physical, mental or emotional, they found that Khasis seek out local healers who will diagnose the cause of the illness, which may be located in the patient, the ancestors or in the community.

12.5 Other Studies

A few general related articles are also included in this review. The first is by Telles, Pathak, Singh & Balkrishna (2014) on Research on Traditional Medicine: What Has Been

Done, the Difficulties, and Possible Solutions. Traditional medicine (TM) is being used more frequently all over the world. However most often these are choices made by the patient. Integrating TM into mainstream health care would require research to understand the efficacy, safety, and mechanism of action of TM systems. This paper describes research done on TM and difficulties encountered in researching TM, especially when an attempt is made to conform to the model for conventional medicine. The research articles were PubMed searched and categorizedas experimental, quasi experimental, reviews, descriptive, historical, interviews, case histories, and abstract not available. The last part of the report provides suggestions to make research on TM more acceptable and useful, with the ultimate goal of integrating TM into mainstream healthcare with sufficient knowledge about the efficacy, safety, and mechanism of action of TM systems.

According to the World Health Organization atlas (2002),"traditional medicine (TM)" refers to health practices, approaches, knowledge, and beliefs incorporating plant, animal, and mineral based medicines, spiritual therapies, and manual techniques applied individually or in combination to treat, diagnose, and prevent illnesses or maintain wellbeing. It is worth noting that the description of TM given by the WHO in 2002 may have altered in some respects since then. Traditional, Complementary and Alternative Medicine Policy and Public Health Perspectives (Bodeker & Burford, 2007) has been referred to as part of this article.

TM can be considered to belong to three main categories (Payyappallimana, 2010). These are (i) codified medical systems, (ii) folk medicine, and (iii) allied forms of health knowledge Codified medical systems include great traditions which have evolved over 3-4 millennia and include Ayurveda, Siddha, and Unani in the Indian subcontinent and traditional Chinese medicine and acupuncture in China. These medical traditions have a unique understanding of physiology, pathogenesis, pharmacology, and pharmaceuticals which are different from Western bio-medicine Perhaps because of this systematic approach these

medical systems have been professionalized within the last millennia. Folk medicine is those traditional knowledge systems which are more often orally transmitted, have been generated by communities over centuries, and use components of the ecosystem which are locally available and accessible Folk medicine has not been formalized and is diverse and adaptable based on changing contexts. There are several similarities in the folk/indigenous medicine of widely differing, geographically distinct communities. Allied forms of health knowledge include techniques which are related to wellbeing though they are not purely medical systems, such as yoga, tai-chi, qi-gong, and different meditations and breathing techniques.

Differences between Conventional and Traditional Systems of Medicine

Characteristic	Conventional medicine (CM)	Traditional medicine (TM)
Mode of treatment	Primarily through medicine or surgery with additional information about precautions and side effects.	Includes poly, herbal and mineral preparations, surgery, and guidelines encompassing the whole lifestyle (diet, mental attitude, physical activity and even spiritual beliefs.
Standardization	Well standardized so that it can be comprehended all over the world.	Remains unstandardized. There are differences within a healing method; hence detailed descriptions are essential.
Training of the practitioners	A well-defined system has been developed in each country	There are differences in training program with respect to their content and duration.
Quality of medicines	The medicines undergo rigorous testing and have to meet predetermined standards for safety which are set in each country.	Some of the codified medical systems, such as Ayurveda, do undergo testing for quality control and component analysis. However, this is not rigorous and also it is not uniform within a country.
Involvement of the healer	The patient has to be cooperative in the diagnosis, treatment, and follow up. Most	The patient actively participates in TM healing systems during the diagnosis, treatment, and follow up. While

	often this involves taking specified medicines at specified times.	some TM methods such as massage require passive cooperation of the patient, others, such as yoga practiced as therapy, require the patient's active participation.
Safety	The safety of CM is based on rigorous drug trials which go through several levels, from trials on experimental animals to final trials after approval on human subjects.	A few systems such as Ayurveda and TCM have had rigorous trials. However, most TM preparations are not scrutinized with rigor.
Adverse effects	Adverse effects for all medicines and surgical procedures are reported and made available to the medical community globally.	Adverse effects of TM systems are often not systematically documental or reported.This is an area in which considerable work remains to be done so that TM systems can have adequate legitimacy and be used widely.
Efficacy and dosage	CM has details of the efficacy of the medicines and surgical procedures. Also, the dosages have been worked out taking into account factors such as age, body weight, and liver and kidney functions.	TMsystems often decide the type and quantum of treatment based on individual factors. In some cases trying to apply the CM model to TM may reduce the usefulness of the TM system. Nonetheless there has to be a definite description of the factors which could determine TM efficacy and dosage.
Mechanisms of action	The mechanisms of action of many CM methods of treatment are known.	Many TMare effective in healing but little is known about their mechanism of action. Research in this area is often made difficult by the fact that TM systems include subtle concepts such as "spiritual wellbeing," "energy medicine," and others which are not described in conventional medicine.

Practicing evidence based medicine will identify and apply the most efficacious interventions with ideas and concepts to think positively to maximise the chances of individuals, groups and communities to attain and sustain, long happy and fulfilled lives (Pal, Mohanta, Sarker, Rustagi & Ghosh, 2015). Traditional medicine is the oldest primary care with 400 million practitioners across the globe. Many consider traditional medicine to be unsystematic and not based on science, with voluminous apprehensions. Yet, due to reasons better known to them as care-seekers daily patronize traditional healers by accepting them as ‘Friend, Philosopher and Guide’. Otherwise in absence of 'receivers of treatment' these traditional healers would not have survived over years with respect from the community. They are true professionals. Our so-called academic understanding is nothing in front of their generations old practical knowledge stored in their senior members. From the pragmatic and empiricist medicine of 5000 BC, today medicine has put off the robe of ego for the ultimate benefit of mankind amidst profiteering groups. We have to use both individual clinical expertise and the best available evidence for the benefit of mankind. From the age old concept of ‘Doctor’ as ‘healer, preacher and teacher’, we have currently reached the era of evidence based medicine- ‘What is the evidence that what you have just advised, works’. Practicing evidence based medicine will identify and apply the most efficacious interventions with ideas and concepts to think positively to maximise the chances of individuals, groups and communities to attain and sustain, long happy and fulfilled lives. The empiricist traditional healers are truly practicing 'Evidenced Based Medicine' in their own limited way. We have to pass through painstaking process to help them learn how to improve. The empiricist traditional healers are truly practicing 'Evidenced Based Medicine' in their own limited way. We have to pass through painstaking process to help them learn how to improve. Practicing evidence based medicine will identify and apply the

most efficacious interventions with ideas and concepts to think positively to maximise the chances of individuals, groups and communities to attain and sustain, long happy and fulfilled lives. The empiricist traditional healers are truly practicing 'Evidenced Based Medicine' in their own limited way. We have to pass through painstaking process to help them learn how to improve. Traditional medicine is the oldest primary care with 400 million practitioners across the globe. Many consider traditional medicine to be unsystematic and not based on science, with voluminous apprehensions. Yet, due to reasons better known to them as care-seekers daily patronize traditional healers by accepting them as 'Friend, Philosopher and Guide'. Otherwise in absence of 'receivers of treatment' these traditional healers would not have survived over years with respect from the community. They are true professionals. Our so-called academic understanding is nothing in front of their generations old practical knowledge stored in their senior members. From the pragmatic and empiricist medicine of 5000 BC, today medicine has put off the robe of ego for the ultimate benefit of mankind amidst profiteering groups. We have to use both individual clinical expertise and the best available evidence for the benefit of mankind. From the age old concept of 'Doctor' as 'healer, preacher and teacher', we have currently reached the era of evidence based medicine- 'What is the evidence that what you have just advised, works'.

The WHO Traditional Medicine Strategy 2014-2023 will help health care leaders to develop solutions that contribute to a broader vision of improved health and patient autonomy. The strategy has two key goals: to support Member States in harnessing the potential contribution of T&CM to health, wellness and people centred health care and to promote the safe and effective use of T&CM through the regulation of products, practices and practitioners. These goals will be reached by implementing three strategic objectives: 1) building the knowledge base and formulating national policies; 2) strengthening safety, quality and

effectiveness through regulation; and, 3) promoting universal health coverage by integrating T&CM services and self-health care into national health systems.

Rinaldi & Shetty (2015) reviews the facts and figures and challenges of mixing modern and traditional medicine. For millennia, people have healed with herbal or animal-derived remedies, using knowledge handed down through generations. In Africa, Asia, Latin America and the Middle East, 70-95 per cent of the population still use traditional medicine (TM) for primary healthcare. In their paper, they refer to the study by Robinson & Zhang (2011) about some 100 million people who are believed to use traditional, complementary or herbal medicine in the European Union (EU) alone — as high as 90 per cent of the population in some countries. The industry is worth big money. In 2012, global sales of Chinese herbal medicine reached US$83 billion, up more than 20 per cent from 2011 (WHO, 2013). The global market for all herbal supplements and remedies could reach US$115 billion by 2020, with Europe the largest and the Asia-Pacific the fastest growing markets. The demand is driven by women as the main consumers of dietary supplements, by growing emphasis on healthy living and concerns over the side-effects of mainstream drugs. Across the globe, researchers, policymakers, pharmaceutical companies and traditional healers are joining forces to bring TM into the twenty first century. In some ways, it is already here. Nearly a quarter of all modern medicines come from natural products, many of which were first used in traditional remedies. They refer to Prasad & Tyagi (2015) who mentions that 121 prescription drugs used worldwide against cancer, 90 are derived from plants.

Key differences between traditional and modern medicine

	Traditional medicine	**Modern medicine**

Knowledge protection	Open access but social or legal restrictions may govern who can use certain knowledge, under what conditions and with what benefit for knowledge holders	Closed, patent-protected
Formulation	Ad hoc during consultation with the patient	Predetermined and, once approved in clinical trials, formulas cannot be changed unless retested
Regulation	Usually loose. In some cases, with restrictions on use or dissemination. Rules and standardisation are being introduced but vary between countries	Extremely tight
Testing	No formal testing: understanding of effectiveness is handed down through generations	Rigorous trials that happen in different phases (first testing for safety, then efficacy) mean bringing a drug to market costs billions of dollars
Dosage	Unfixed: the amount of medicine given might be roughly similar, but the amount of active ingredient (which is what dosage really is) can vary hugely	Standardised medicines given in fixed doses that vary with age or weight, or disease severity

Consultation	Lengthy, and the patient is asked a wider range of questions than just about their symptoms	Consultations in both primary and secondary care tend to be brief and focused, especially as national health systems come under financial strain
Training	Lengthy training over many years but knowledge is often passed one-to-one through families, and practitioners are often born into a family of healers	Lengthy and often vocational: health professionals go through formal training in schools and universities
DEFINITIONS		
Allopathic medicine	The modern, mainstream system of medical practice in Western countries. It targets disease with remedies that treat or suppress symptoms or the condition itself. It tends to produce effects different from those produced by the disease under treatment.	
Complementary/alternative medicine	The terms complementary and alternative medicine are sometimes used interchangeably with the term traditional medicine. They refer to the healthcare practices that are not part of a country's own tradition and are not integrated into the dominant healthcare system.	

Herbal medicines	These include herbs, herbal materials, preparations and products that contain plant materials or combinations of plants as active ingredients. Herbalism is the practice of making or prescribing plant-based herbal remedies for medical conditions and is considered a form of alternative medicine.
Integrative medicine	The term refers to the blending of conventional and natural/complementary medicines and/or therapies along with lifestyle interventions in a holistic approach, taking into account the physical, psychological, social and spiritual wellbeing of the person.
Traditional medicine	The overall body of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether they can be explained or not. These might be used to maintain health as well as prevent, diagnose, improve or treat physical and mental illness.

Chapter 3

Methodology

3.1 Introduction

The setting for this research is Nagaland state and in this chapter will be described the sampling process to represent the state, the methodology adopted for collection of relevant data pertaining to the three objectives and related questions, the data management and statistical techniques adopted for drawing valid conclusions. Both quantitative and appropriate qualitative research methods were used and described. This research was carried out during 2017 to 2019.

3.2 Sampling of Nagaland state

Nagaland is one of the "seven sisters" of the North-East India and attained its autonomy in 1972 along with the other states. One of the smaller hill states of India, Nagaland is known for its myriad tribes with their rich culture and traditions. The State has a distinct character both in terms of its social composition as well as in its developmental history. If India is a country that boasts of "unity in diversity", then the North-East is its most visible embodiment. Among the North-Eastern states, Nagaland stands out as a land of diverse tribes, systems of governance, cultures, sheer colour and variety. As its 16 major tribes hold their festivals each calendar month of the year, Nagaland is often referred to as the "land of festivals". Nagaland represents sociological and anthropological gold mines because it is still scientifically unexplored. Though Nagaland has been confronted with special constraints and challenges in the areas of politics, economics, geographical terrain, and development, especially of

infrastructure, the "social capital" and resilience of the Naga village communities are not only giving hope but also beginning to help overcome the other difficulties.

Indeed, in spite of its many constraints and challenges, Nagaland has continued to chart new developmental paths for itself and has shown a unique model for the country. The Village Councils, other Village Development Boards, and the recently introduced Communitisation of Public Institutions and Services Act, 2002, in areas like education, health, power, etc., which have already been acknowledged as successful.

Nagaland state has a total area of 16,579sq. kms and an enumerated population of 19,80,602 according to All India National Census (2011). Kohima is the state capital but Dimapur is the largest urban area. Geographically there are 9 predominantly rural districts and 2 urban districts. The M: F sex ratio is 909:1000 and the literacy rate 80.1%. English is the official language and the population predominantly Christian.

The state boundaries of Nagaland are Myanmar and Arunachal Pradesh on the East, Assam on the West, Assam and Arunachal Pradesh on the North and Manipur in the South. The map of Nagaland is presented in Figure 3. I.

Figure 3.I: Map of Nagaland

Source: Maps of India

For determining the sample size, assuming a prevalence of all mental disorders as 20%, and assuming that at least 60% would seek traditional healing at some stage of the disease, with a type 1 error of 5%, power of 80%, and a precision of 20%, the minimum sample size to be studied was decided as 700-800 persons. This was proportionately divided as around 500 rural and 300 urban.

In consultation with state and district officials and experts, the following districts were purposively chosen to provide a reasonable geographical and tribal population for this research (1) One urban district Dimapur and (2) Two rural districts Mokokchung in the north-west and

Kiphire in the south-east. In both areas, multi-stage representative random cluster samples of households were selected, villages in the rural districts and wards in the urban.

As per 2011 Indian National Census, the district of Mokokchung is predominantly inhabited by people belonging to Ao tribe, who constitute more than nine-tenth of the total population in the district. The district of Kiphire is inhabited by different Naga tribes speaking different dialects and languages. The important tribes inhabiting the districts are Sangtam, Sumi, Yimchungre, Makware and Chirr.

The district of Dimapur is the most populous district of Nagaland with a population of 3,78,811. It has a diverse mix of people from all over India. Besides the dominant Naga tribe who comprises about 50% of the city's population, other prominent groups include Bengalis, Assamese, Nepalese, Biharis, Marwaris, Punjabis and also Tamils and Keralites.

Further details of the sampling process are now given:

In Mokokchung district, which has nine blocks out, one block Mangkolemba was randomly selected and out of which a random sample of two villages Khar and Chungtiayimsen, geographically widespread were selected. From each village, a systematic random sampling of 70 and 40 households respectively were selected for the study, thus providing 110 rural households.

In Kiphire district, which has eight blocks, three blocks were purposively chosen to provide a reasonable sample of the three major tribes found in the district. From the first two blocks Amahator and Sitimi (inhabited by Sangtam and Sema tribes respectively) a stratified random sampling of three villages each were selected. From the third block Pungro (inhabited by Yimjunger tribe), a stratified random sampling of two villages each were selected. Then from each of these villages, a systematic random sampling of 50 households were selected for

the study, thus providing 400 rural households. A total of 510 rural households were thus chosen to represent rural Nagaland.

The Urban area of Dimapur district includes Dimapur Sadar, Chumukedima, Medziphema & four other census towns.

Of these, Dimapur Sadar with 23 wards and an approximate number of 27,000 households (2011 Indian national census) and Chumukedima with 11 wards with an approximate number of 5129 households were selected as representative of urban Nagaland. A multi-stage representative random sample of urban households were chosen.

One ward from Dimapur Sardar was selected from each zone through random sampling. The selected wards for the study were ward no.10 from the north zone, ward no.23 from the south zone, ward no.5 from the east zone and ward no. 12 from the west zone.

From each ward, a systematic random sampling of 50 households were selected for the study, thus providing 200 households in Dimapur Sardar.

Likewise, the 11 wards in Chumukedima were geographically divided as north zone and south zone. From each zone, one ward was randomly selected: Ward no.11 (North) and Ward no.8 (South). A systematic random sampling of 50 households were then selected from each of these two wards to provide 100 urban households.

A total of 300 households were chosen to represent urban Nagaland.

Thus, a representative random sample of 810 households were chosen to represent Nagaland.

3.3 Data collection methods

Keeping in view the objectives of this research, the quantitative research was conducted primarily through in-depth interviews of households and traditional healers. Separate interview

schedules were developed for the purpose of eliciting information from both the households and traditional healers. The qualitative research done will be described later.

The researcher first met the village heads and ward chairmen to introduce the project and established good rapport and got their permission to carry out the study with the residents of their respective villages and wards. The researcher assured them of full confidentiality of the responses elicited. These initial meetings also enabled the researcher to get suggestions and relevant information related to the set objectives. Through the help of the village heads, some village guides were designated to help the researcher in approaching the households and the traditional healers. The village guides introduced the researcher to the households and helped in building good rapport and also in explaining about the reason for the visit. The researcher being a complete stranger to them, most of them were wary of the visit and hence the presence of the village guides greatly helped in dispelling any sort of suspiciousness. The in-depth household survey was first conducted in Mokokchung district from October- November 2017, followed by Dimapur district from March-May 2018 and finally in Kiphire district from June-Aug 2018. After a good rapport was established, the researcher then explained to them about the research study making sure that they understood what the researcher was trying to study and how important their participation and honest responses meant for the study. The respondents were then assured of complete confidentiality of their responses. Interviews were conducted with the heads of the households, whoever was available at the time and willing to respond. Most of the respondents were very willing and openly shared the personal details of their families and their experiences. However, despite constant assurances of confidentiality, some respondents were very hesitant and unwilling to open about any mental health problems and also the use of traditional healing. The research topic, being of a very sensitive nature and the stigma associated with mental disorders, proved to be quite a challenge. Apart from mental disorders, there was a general sense of hesitancy (especially in the urban area) in opening up

about the use of traditional healing, which seems to have its own stigma with the advent of Christianity in Nagaland. There was fear of being mocked at for seeking help from a traditional healer who are commonly believed to work through the medium of other spirits which are different from that of Christianity. Thus, the stigma and also fear, suspicion and distrust of the researcher proved to be major challenges in the process of collecting the data for the study. Although the entire process of the field work was extremely time consuming and challenging, it was a matter of great satisfaction to record the ready participation and encouragement of most of the respondents for the study. Most importantly, the discussions with the households also enabled the researcher to sensitize them on mental health problems and the current mental health services and facilities available in the state.

The same procedure of data collection was applied to the traditional healers' interviews. For the meeting, the households and other family members who knew them personally helped in contacting and introducing the researcher to the traditional healers. Most of the traditional healers, especially in the rural areas, had to be contacted twice and sometimes even thrice since they were out in the fields or at a patient's house. Hence, the researcher could meet them only during early mornings or late evenings. Full confidentiality and thorough explanation of the research topic was conveyed before the start of every interview. All the healers were interviewed in- depth which took approximately two hours. The traditional healers were very cooperative and willingly shared about their practices and perspectives, allowing the researcher to even observe the treatment process with some patients. They were also extremely encouraging of the study and some in the remote rural areas stated that it was their first experience of being interviewed.

3.3.1 Description of tools used in quantitative surveys

Household interview schedule:

The household Interview schedule was developed in such a way to ensure that the households were made comfortable by discussing firstly about utilization of traditional medicine for any general health problem. Then, it gathered information on their knowledge of mental disorders and specifically any mental health problems in their family during the past one to five years and use of traditional healing practices for it, overall satisfaction of traditional healing and outcome and also the households' demographics.

The interview schedule was divided into four parts based on the research objectives:

1. The first part was developed to gather information on attitudes to and utilization of traditional medicine during the past one year for general health problems, age and sex of the patient, treatment given, if it was effective, if supplemented by any other therapy and if they would seek traditional medicine for the same problem and why.
2. The second part made enquiries on knowledge of any mental disorders and if they think they were common in Nagaland.
3. The third part was developed to gather information on any mental health problems in the family during the past one to five years, age and sex, when it started, their perception of the underlying cause, if they sought help from a traditional healer, treatment given and the outcome.
4. The fourth part made enquiries on the overall satisfaction of traditional healers for both general and mental health, if they would recommend other people to seek traditional healing for mental health problems, if traditional healing was still popular for both general and mental health, reasons for it, if traditional healers needed additional training and also any traditional remedies kept at home.

In order to examine similarities and carry out sub-analyses according to the objectives, Information was collected on a variety of demographic variables including age, gender, tribe, religion, occupation, marital status, number of family members living with him/her, number of children living with him/her and type of family.

Traditional healer interview schedule:

The traditional healer's interview schedule was developed keeping in mind the third research objective and divided into four parts to gather information on the healers' demographics, practice, knowledge and attitude. The specifics of each part is given as below:

1. The first part focused on the traditional healer's practice in treating mental health problems: mental health problems treated, age and sex of the patients, approximate number of patients received per year, how treated, duration of the treatment, effectiveness, any referrals made, if they maintain any record, if they charge their patients and if they follow up on their patients.
2. The second part made enquiries on their knowledge and attitudes on traditional healing for mental health problems: the common mental disorders in the area, if traditional healing was popular and if effective, if the use of traditional healing was declining and their views on if traditional healing was better compared to allopathy.
3. The third part made enquiries on their perspective of traditional healing for mental health: if they require any professional help to improve their practice, their thoughts on the future prospects of traditional healing for mental health and if traditional methods and modern methods of treating mental health problems can be linked.

Information was collected on a variety of demographic variables including age, sex, tribe, religion, village/ward of normal residence, village for practice if different from above, education, occupation if any other than local practitioner, if traditional healing is a family practice, any training received and practicing since when.

3.3.2 Pilot study

I nterview schedules for in-depth interviews of both the households and traditional healers were subjected to pilot studies for validation of the tools and feasibility and also to ensure that the tools were non-threatening The pilot studies were conducted in Shillong (urban) and Pynursla and Nongspung villages (rural) under East Khasi hills, Meghalaya. A total of twenty- eight households and nine traditional healers were interviewed in depth. The pilot studies very importantly enabled the researcher to edit and refine the wording in the tools to make it more understandable and extract data specifically to meet the objectives within a reasonable time limit.

3.3.3 Validity of the tools

The tools used in this research study were subjected to numerous editing and refining. Some words in both the interview schedules were modified to make it more understandable, avoided the use of any ambiguous terms and few items were rearranged to give a proper flow to the questions being asked. After much refining, it was made to ensure that the tools measure the set objectives. Apart from the tools, the researcher also made personal observations during the interview process to confirm what the respondents were saying.

The proforma was vetted by experts and community leaders and subjected to pilot studies before use as stated earlier. The medium of communication used were the local dialect Nagamese in the rural areas and also English in urban areas. In some of the rural areas where the researcher had to converse with the tribal dialects and was not familiar with it , volunteers helped in communicating to the respondents. Voice recorders were also used, after obtaining informed consent, while interviewing key informants, during the Focus Group Discussions and for the case studies to eliminate any error and for the purpose of transcribing the interviews. All recorded files were duly deleted thereafter.

3.4 Quantitative Data management

Since the interview schedules and other data gathering tools were made computerizable, data entry onto Microsoft Excel sheets were easy and less time consuming. Since the lay person's diagnosis of the illness was usually symptomatic and voluminous, efforts were made to condense them into a standard internationally acceptable format, and after discussion with experts, the ICD 10 classification for mental disorders was used. The traditional methods of healing included herbal preparations, manual or mechanical methods of therapy such as massaging, varieties of divinations and exorcism, use of rituals using zoo-therapy, trances, etc., and required grouping into broad categories. Questions dealing with outcomes or effectiveness, recommendations or popularity and other perspectives tended to be subjective but had to be summarised before entry on the excel sheets. On completion of the entry of all necessary data, the same were edited and cleaned before transfer to SPSS software. Data which could not be reduced to tabulated form are presented by way of narratives.

Two separate excel sheets were maintained for the household and traditional healers' survey, as well as by geographic area of the study to facilitate consolidation into rural and urban Nagaland. The codings are shown in the Annexures.

3.5 Quantitative Data analysis

Keeping in view the research objectives, data was analyzed using the Statistical Package for Social Sciences (SPSS). Both descriptive and inferential statistics were calculated to determine the statistical significances of differences and associations observed.

Similarity of respondents based on socio-demographic factors between the rural and urban samples were tested using the Chi-square test and Analyses of Variance. Differences in percentages or averages were tested using the Normal and t-distributions. 95% confidence intervals were determined for all estimates.

Simple descriptive analyses were used to summarize the socio-demographic and clinical characteristics of the study respondents. General and mental health morbidity and type of treatment given were all calculated as percentages. Cross tabulations were used to analyze the number of households who sought help from a traditional healer by type of illness, type of healing methods and its association with age, gender, tribe, urbanization, literacy and other demographic variables.

Satisfaction, outcome, accessibility, recommendation and popularity of traditional healing were all summarized using a variety of descriptive statistics.

Similar procedure was applied for the analysis of traditional healers' survey. Where appropriate for better presentation, the tables were diagrammatically represented through histograms, pie-charts and other figures.

3.6 Qualitative Research Methodology

A variety of qualitative research techniques were used in this research.

3.6.1 Focus Group Discussions

It was decided to conduct several FGDs among representative population which included men, women, younger, older, rural and urban samples. Hayward, Simpson & Wood, 2004 states that focus group discussion is a technique where a researcher assembles a group of individuals to discuss a specific topic, aiming to draw from the complex personal experiences, beliefs, perceptions and attitudes of the participants through a moderated interaction (as cited in Nyumba, Wilson, Derrick & Mukherjee, 2018). About 7-10 participants were identified through snowballing technique who were knowledgeable and experienced in the traditional healing practices for mental health. Those identified were contacted, the project explained and their cooperation sought. After obtaining their consent, they were invited to hold their group discussion at a convenient date, time and place. One person was nominated to be the chairperson and one more as a rapporteur / secretary. The project was explained first and the methodology for the FGD elaborated to be more as a discussion and not as an interview. A trial discussion was held before the actual discussion. Each FGDs was held for about 30 minutes and based on the verbal statements, the narratives were thematically summarized and consensus arrived at. The steps and procedures followed for the FGDS were according to the methodology outlined by Kreuger (2002). These procedures were systematically followed for all the three FGDs.

3.6.2 Key Informant in-depth interviews.

Three key informants knowledgeable in traditional healing practices for mental health in Nagaland were identified and contacted. The project was thoroughly explained and their consent obtained. Each key informant was asked a number of open ended questions focusing

primarily on the research objectives of how popular traditional healing for mental health was in Nagaland, the help seeking habits of the Naga population and knowledge of traditional healers in treating mental disorders. Each interview lasted for almost 45 minutes.

3.6.3 Case Studies

The purpose of a case study is to understand the characteristics that define a particular bounded system, and perhaps to describe an event or process occurring within that system (Vanderstoep & Johnston, 2009). For this study, three case studies were selected as part of the qualitative research. Each case study was chosen to throw light on the use of traditional healing for three different mental disorders, help seeking pathways, and the outcome. These particular case studies would address and give a better understanding of the research questions of how popular traditional healing is, satisfaction and outcome. An important strength of case studies is the ability to undertake an investigation into a phenomenon in its context (Rowley, 2002). Two of the case studies were selected from the household survey for which more in-depth questioning was done. The third case study was done on site during the visit at the apex Mental Health institute in Kohima. The cases were also chosen based on typicality and on the criterion of uniqueness (Vanderstoep & Johnston, 2009). The respondents were briefed thoroughly about the research project and their consent obtained before the start of each interview.

3.6.4 Ethnographic study: State Mental Health Institute, Kohima

According to Wolcott (1999), the ethnographic perspective has been described as a unique “way of seeing” (as cited in Vanderstoep & Johnston, 2009). The Mental Health Institute in the state capital kohima is the only apex mental hospital in the whole of Nagaland. Prior consent was sought before visiting the Institute from one of the medical officers. Next,

necessary permission to interact with the staff and patients was obtained from the Medical Superintendent, the head of the Institute. After explaining the project and obtaining their consent, a number of OPD patients were questioned regarding their help seeking behaviour and use of traditional healing before visiting the hospital. The psychiatrist on his daily rounds of the in-patients also allowed for interaction with few of the patients. The annual reports and statistics were gathered and summarized to give a perspective on the referred cases of mental disorders. almost all the patients had sought some traditional healer before coming to the hospital. Daily visits to the hospital were made for five days to make observations and interact with the staff and patients.

3.7 Ethical considerations

Prior to pilot studies and actual fieldwork, University ethical clearance was obtained on approval of the proposal. It was granted by the University Research Ethics Committee dated 18th of August, 2017 with the UREC number given as VI/1 (8)/UREC/EA/272/2015-3669 (vide Annexure).

Given the sensitive nature of the research topic, informed consent from all the respondents was obtained in the written form before the start of every interview. It included information regarding the purpose of the study and a confidentiality statement emphasizing that the identity of the respondent would remain anonymous and that the responses would be used only for the purpose of the study. It also contained a statement wherein they had the freedom to withdraw at any point if they wish and that there would be no obligations for discontinuing. On submission of the final thesis, the findings would be reported to the community in a suitable manner from which the data has been collected and then submitted to the Secretary, Doctoral Committee before the public defense.

Chapter 4

Materials

4.1Introduction

In this chapter the major characteristics of the study population of both the quantitative and qualitative surveys are described.

4.2 Quantitative: Household survey

Taking into consideration the minimum sample size which was calculated as 700-800, 510 in rural and 300 in urban were selected for this study. House-to-house visits were conducted wherein only adult respondents (more than 15 years of age) were included in this study who were interviewed in-depth which took approximately 45 minutes per household. All information pertaining to use of traditional healing for general health problems, mental health problems, outcome, satisfaction and socio-demographic characteristics were collected using the interview schedule developed for the households. Utmost care was taken to assure every household of full confidentiality in order to encourage open and candid responses and opinions.

The socio-demographic information collected from the rural and urban samples were compared and are described as below.

4.2.1 The distribution of respondents by age in the rural and urban samples are shown in Table 4.1.

Table 4.1: Distribution of respondents by age and area

Age (years)	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Below 30	154	30.2	108	36.0	262	32.2
30-49	229	44.9	128	42.7	357	44.1
50 & above	127	24.9	64	21.3	191	23.5
Total	510	100.0	300	100.0	810	100.0

In both the rural and urban areas, half of the respondents were middle aged (44.9%, 42.7%), 30.2% in rural and 36.0% in urban were young adults and 24.9% in rural and 21.3% in urban were elderly.

4.2.2 The distribution of respondents by gender in the rural and urban samples is displayed in Table 4.2.

Table 4.2: Distribution of respondents by gender and area

Gender	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Male	241	47.3	84	28.0	325	40.1
Female	269	52.7	216	72.0	485	59.9
Total	510	100.0	300	100.0	810	100.0

Of the 810 households, 59.9% of the respondents were females as compared to 40.1 % of male respondents. In the rural area, gender-wise distribution of respondents was not very significantly different. Whereas in the urban block, female respondents were significantly more than the male respondents.

4.2.3 The distribution of respondents by tribe in the rural and urban samples are displayed in Table 4.3.

Table 4.3: Distribution of respondents by tribe and area

Tribe	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Ao	110	21.6	120	40.0	230	28.4
Angami	0	0.0	32	10.7	32	4.0
Sumi	150	29.4	44	14.7	194	24.0
Lotha	0	0.0	27	9.0	27	3.3
Chakesang	0	0.0	14	4.7	14	1.7
Zeliang	0	0.0	5	1.7	5	0.6
Chang	0	0.0	1	0.3	1	0.1
Yimjunger	100	19.6	4	1.3	104	12.8
Konyak	0	0.0	3	1.0	3	0.4
Phom	0	0.0	2	0.7	2	0.2
Khiamniungan	0	0.0	3	1.0	3	0.4
Rengma	0	0.0	7	2.3	7	0.9
Sangtam	150	29.4	25	8.3	175	21.6
Others	0	0.0	13	4.3	13	1.6
Total	510	100.0	300	100.0	810	100.0

In the rural area, the households comprised of four tribes: Ao (21.6%), Sumi (29.4%), Yimjunger (19.6%) and Sangtam (29.4%). On the contrary, in the urban block the households belonged to different tribal groups, majority belonging to Ao tribe (40.0%).

4.2.4 The distribution of respondents is shown by religion in the rural and urban samples in Table 4.4.

Table 4.4: Distribution of respondents by religion and area

Religion	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Christian	510	100.0	288	96.0	798	98.5
Hindu	0	0.0	2	0.7	2	0.2
Muslim	0	0.0	9	3.0	9	1.1
Other	0	0.0	1	0.3	1	0.1
Total	510	100.0	300	100.0	810	100.0

Almost all the respondents were Christians in both the rural (100.0%) and urban areas (96.0%) except for a few belonging to Hindu, Muslim and other religion in the urban area.

4.2.5 The distribution of respondents by educational level in the rural and urban samples are presented in Table 4.5.

Table 4.5: Distribution of respondents by educational level and area

Educational level	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Illiterate	160	31.4	2	0.7	162	20.0
<5	170	33.3	17	5.7	187	23.1
5-9	130	25.5	41	13.7	171	21.1
10-12	50	9.8	146	48.7	196	24.2
Grad >	0	0.0	94	31.3	94	11.6
Total	510	100.0	300	100.0	810	100.0

In the rural area, most of the respondents (31.4%) had no formal education, 33.3% had studied up to primary school, 25.5% had studied up to middle school and the few remaining (9.8%) up to high school. Whereas, in the urban block, only few (0.7%) were illiterates with no formal education with the majority of the respondents having formal education.

4.2.6 The distribution of respondents by occupation in the rural and urban samples are displayed in Table 4.6.

Table 4.6: Distribution of respondents by occupation and area

Occupation	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Unemployed/student/homemaker	260	51.0	136	45.5	396	48.9
Casual labourer	19	3.7	3	1.0	22	2.7
Agricultural labourer	150	29.4	2	0.7	152	18.8
Small industry/baker/repair	2	0.4	2	0.7	4	0.5
Clerical/white collar/teacher/ lawyer	27	5.3	62	20.7	89	11.0
Communications/IT/Technical	0	0.0	1	0.3	1	0.1
Defence/police/transport	3	0.6	2	0.7	5	0.6
Private business	10	2.0	18	6.0	28	3.5
Others	39	7.6	74	24.7	113	14.0
Total	510	100.0	300	100.0	810	100.0

Most of the respondents were either unemployed, homemakers and students in both the rural (51.0%) and urban areas (45.5%). However, in the rural area a large number of respondents (29.4%) were also agricultural labourers whereas in the urban area 20.7 % had white collar jobs, were teachers and lawyers.

4.2.7 The distribution of respondents by marital status in the rural and urban samples are shown in Table 4.7.

Table 4.7: Distribution of respondents by marital status and area

Marital status	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Never married	125	24.5	119	39.7	244	30.1
Married	362	70.9	160	53.3	522	64.4
Widowed	14	2.7	17	5.7	31	3.8
Divorced/ separated	9	1.8	4	1.3	13	1.6
Total	510	100.0	300	100.0	810	100.0

Majority of the respondents in both the areas were married (20.9%, 53.3%). Only few were widowed in both the rural and urban areas (2.7%, 5.7%) and the remaining either divorced/separated (1.8%, 1.3%).

4.2.8 The distribution of respondents by type of family in the rural and urban samples is presented in Table 4.8.

Table 4.8: Distribution of respondents by type of family and area

Type of	Rural		Urban		Total	
family	No.	%	No.	%	No.	%
Nuclear	458	89.8	288	96.0	746	92.1
Joint	52	10.2	12	4.0	64	7.9
Total	510	100.0	300	100.0	810	100.0

In both the rural and urban areas, almost all households (96.0%, 89.8%) belonged to nuclear type of families. Only few belonged to joint families (10.2%, 4.0%).

4. 3 Quantitative: Traditional healers Survey

For this study, only traditional healers who specifically treated mental disorders were required in order to determine their practice, knowledge and attitude. Efforts were made to locate and make appointments with traditional healers in all the three districts through the help of the households, village heads and village guides. A total of 70 traditional healers were identified. However, some were either not available, had relocated or were out of station. Of the remaining who were available at the time of visit, only 30 reported to have treated mental health problems. The rest stated that they treated only general health problems. All 30 traditional healers were interviewed in-depth using the interview schedule developed specifically for them. All the traditional healers, except for one, were extremely cooperative and willingly participated in the study and most readily shared their knowledge, views and opinions. Only one healer was extremely rude and uncooperative and seemed to have been slightly intoxicated at the time of the visit. The interviews with each traditional healer took approximately 2 hours. Rapport building was an important part of the interview to ensure that they were made comfortable and understood what the study was about. Informed consent was obtained before the start of each interview and anonymity and confidentiality was duly emphasized. All information pertaining to their treatment of various mental disorders, knowledge and attitudes on traditional healing for mental disorders and perspectives on future prospects on traditional healing for mental health were meticulously collected. Important demographic characteristics of each traditional healer was also collected.

The socio-demographic information collected from the traditional healers in rural and urban samples were compared and are presented as below.

4.3.1 A larger number of the traditional healers were males as compared to females as shown in Table 4.9.

Table 4.9: Gender of traditional healers

Gender	No.	%
Male	17	56.7
Female	13	43.3
Total	30	100.0

4.3.2 Majority of the traditional healers were elderly aged 50 years and above as displayed in Table 4.10.

Table 4.10: Age of traditional healers

Age (years)	No.	%
30-49	8	27.0
50 & above	22	73.0
Total	30	100.0

4.3.3 The traditional healers are shown by tribe in Table 4.11.

Table 4.11: Tribe of the traditional healers

Tribe	No.	%
Ao	19	63.3
Angami	1	3.3
Sumi	1	3.3
Chakesang	1	3.3
Yimjunger	4	13.3
Khiamniungan	1	3.3
Sangtam	3	10.0
Total	30	100.0

Majority of the traditional healers belonged to Ao tribe and the rest to other tribes.

All the traditional healers were also Christians.

4.3.4 Most of the traditional healers had some formal education with varying educational levels as shown in Table 4.12.

Table 4.12: Educational level of the traditional healers

Educational level	No.	%
Illiterate	5	16.7
Below 5	8	26.6
5-9	11	36.7
10-12	5	16.7
Grad & above	1	3.3
Total	30	100.0

Only one of them was a graduate while 5 had no formal education.

All except for one traditional healer stayed with their family.

4.3.5 Other occupation besides being a local practitioner are shown in Table 4.13

Table 4.13: Occupation besides being a local practitioner

Occupation	No.	%
Agricultural labourer	12	40.0
Carpenter	1	3.3
Retired Army personnel	1	3.3
Retired Govt. servant	7	23.3
Teacher	2	6.7
None	7	23.3
Total	30	100.0

Majority of the respondents are engaged in agriculture to supplement their source of livelihood. Only two of the traditional healers had no other occupation.

4.3.6 The number of years of practice of the traditional healers are displayed in Table 4.14

Table 4.14: No. of years of practice of traditional healers

No. of years of practice	No.	%
Below 10	1	3.3
10-29	13	43.3
30-59	10	33.3
60 and over	6	20
Total	30	100.0

Of the 30 traditional healers, fourteen traditional healers had been practicing for 30 years and below, while sixteen traditional healers had been practicing for more than 30 years.

4.3.7 Majority of the traditional healers mentioned that it was a family practice and that the healing power had been passed on from their ancestors as presented in Table 4.15.

Table 4.15: Traditional healing as a family practice

Is traditional healing a family practice	No.	%
Yes	16	53.3
No	14	46.7
Total	30	100.0

None of the traditional healers had received any formal training and stated that they received their healing power from God. For some, it had been passed on from generation from generation.

4.4 Qualitative: Focus Group Discussions

The first focus group discussion in Mokokchung (rural) comprised of 8 participants- 4 men and 4 women. All participants belonged to Ao tribe, were Christians and aged 50 and above. All were married, three were graduates and five were matriculates.

The second focus group discussion in Dimapur (urban) among the working youth comprised of 7 participants- four males and three females. Three belonged to Sema tribe & four belonged to Ao tribe. All were Christians, of the age group 28 to 35 years of age and all graduates & above.

The third focus group discussion among the students in Dimapur (urban) comprised of 7 participants- four males and three females. Two belonged to Sangtam tribe, two belonged to Rengma tribe, two belonged to Yimchunger tribe & one belonged to Phom tribe. All were Christians, of the age group 17 to 21 years of age. All were matriculates.

4.5 Qualitative: key Informant In-depth Interviews

Key informants consisted of a senior medical officer (specialized in psychotherapy and counselling) posted in the State Mental Health Institute, a Church pastor and an elderly traditional healer.

4.6 Qualitative: Selected Patients' Case Reports

The three case reports consist of a 23-year-old male belonging to Rengma tribe in Longleng district suffering from Cannabis Use Disorder, a married 40-year-old female nurse belonging to Sangtam tribe in kiphire district suffering from severe depression and a 27-year-old female belonging to Ao tribe in Mokokchung district diagnosed with Schizophrenia.

4.7 Qualitative: Ethnographic study: State Mental Health Institute, Kohima

The sample consisted of senior administrative staff such as the Medical Superintendent and the psychiatrists.

Chapter 5

Findings

5.1 Introduction:

The findings are presented first based on the two Quantitative surveys, the Household interview surveys and the Traditional Healer interview surveys, and then the Observations from a variety of Qualitative Research studies. The first section describes the findings from the Household interview surveys on traditional healing practices, outcomes and perspectives comparing the rural and urban samples in general and then according to specific variables as mentioned in the objectives, such as gender, tribe, etc. The second section contains the findings from the Survey of Traditional healers correlating them with the responses from the households. The third section presents the observations and results from the qualitative research methods

5.2 Quantitative Surveys:

The findings from the household interview surveys and traditional healers interview surveys based on the research objectives are presented under the quantitative surveys.

5.2.1 Household Interview Survey

5.2.1.1 Traditional healing practices:

Four main modalities of treatment were used by the traditional healers either singularly or in combination for managing mental disorders. These are Herbal (Ethno-botanical), Animal

product-based (Ethno-zoological) Mechanical and Psycho-spiritual. Examples of these 4 methods are shown in Tables 5.1, 5.2, 5.3 and 5.4.

Table 5.1: Common ethno-botanical (herbal) treatments

Description of ethno-botanical products used
Ao moli/ mozü (translated as Ao medicine) consists of a mixture of various herbs which has been sundried and pounded into a powder form.
Thangbu (rhus simialata, murr/nutgall tree), the fruit of which is sun-dried, pounded into a powder form.
Tsungrempang moli/ mozü (Cyclea peltata, Hook.f and Thunb), leaves crushed and consumed or used as a herbal bath.
Crushed neem leaves applied on the body
Nangpera (Ocimum basilicum/Basil) leaves consumed.
Mustard oil, garlic and tulsi leaves
Mustard oil, crushed ginger & garlic

Table 5.2: Common ethno-zoological (animal product-based) treatments

Description of ethno-zoological products used
Applying a mixture of burnt chicken feathers and sugar on the chest.

Applying the fat of python.
Massage using fats of tiger and snake.
Massaging with honey.
Massaging using local eggs.
Applying local egg yolk.
Consuming the gall bladder of bears.
One to two fresh crabs crushed and mixed with boiled water, filtering it and consuming it.
Massaging using excreta of porcupine.

Table 5.3: Manual treatments

Description of manual techniques
Massaging the nerves and joints for various body aches.
For females, gently massaging the navel area where the womb is located for one month.
Poking a needle onto the entire back area & biting onto the stomach area to suck out the impurities.
For stomach ailments, the traditional healer presses and gently rubs the navel of the patient and diagnoses the problem and massages it.
Rolling a local egg with a banana leaf and making a small opening on the top part of the egg. This is pressed on certain body parts to extract 'dirt', 'poison', 'curse' which reveals itself in the form of small flies. The healer then burns it immediately in the fireplace.
For stomach ailments, placing a small piece of rolled paper smeared with mustard oil on the navel and burning the top portion. Immediately a cup is placed on it after which the belly contracts.

Table 5.4: Psycho-spiritual treatments

Description of psycho-spiritual treatment
Before sleeping at night the healer *Amongrüh* (diviner) prays for the sick person and in his/her dream travels to the Land of the Dead, called *Asühlang,* in search of the person's soul which is believed to have been taken away by the spirits of departed relations or ancestor spirits. On the way to *Asühlang*, the healer chants the person's name and sings. The healer gives some offering in the form of rice and money to the spirits pleading with them to release the soul of the person. This continues for three consecutive nights.
Arasentsür/ Rachenlar (diviner) instructs to sprinkle water around the bed and place a bowl of water under the bed before sleeping and to observe *Anempong/Kimho* for three days – to refrain from eating meat and not letting in visitors inside the house.
The healer diagnoses the illness as due to disturbance by the dead grandfather's spirit which has turned to a tiger. Instructed to offer a rooster to appease the tiger spirit.
Amongrüh prays and rubs a mixture of crushed orange and lemon leaves all over the body of the patient and travels to Asühlang in search of the person's soul.
Prays to the spirit and instructs to keep a currency note under the pillow while sleeping.
Sacrificing and offering a rooster, rice and chilies as demanded by the spirit of the departed relations.

Arasentsür instructs to immediately sprinkle water on the door and place a bowl of water under the bed, then to utter to the spirit of the departed relations saying that there is a big ocean which separates them.

Arasentsür instructs to place the deceased person's shawl under the pillow while sleeping and to sprinkle water around the bed for three nights and uttering to the spirit saying there is a big ocean which separates them

Arasentsür instructs to sprinkle mustard seeds outside the house, burn some and throw away the rest; then to sprinkle water around the bed and refrain from eating meat for three consecutive days.

Arasentsür blows on a piece of dried beef invoking the spirits of the animal to leave, which the person had hunted in the forest.

Arasenstür instructs to keep a bone of a wild cow that the person has killed under the pillow while sleeping for three consecutive nights.

Arasentsür burns the person's clothes, rubs *nangpera* (Ocimum basilicum/Basil) all over the body, bathes the person daily with warm water and places a bowl of water near the bed every night.

Arasentsür diagnosed the illness as due to '*Lepsa*'- belief that if one passes by a place where people have fought, the bad luck passes onto them. Directed to blow saliva on a stone and throw it far away before sleeping.

Arasentsur gave a bottle of wood struck by lighting which was soaked in water & asked to take bath with it for three days.

A small branch of a peach tree is split into six similar pieces with the use of a *dao*, a traditional machete. The healer flings pairs of it on the floor and by the direction in which it falls, the healer diagnoses the ailment and gives the instruction for treatment.

Family members of the sick person are instructed to take a rooster to the forest or field and offer it to the malevolent spirits in exchange for the release of the soul of the person. While offering the rooster, they call out the name of the person six times. They then take back any stone or stick they find in the area of the offering and keep it under the bed of the sick person.

Putting pieces of straws of hay and pebbles – six each for men and five each for women- in a cup of water and place it under the bed before bedtime and cry out loudly to the spirit saying that big trees and huge mountains now separates them and that they now reside in two different worlds. On the fourth morning, the cup of water along with the hay and pebbles are thrown in the direction of the sunset.

5.2.1.2 Prevalence of mental disorders:

Overall, 383 out of 810 households (47.3%; 95% Confidence Interval:43.9 - 50.7) reported some mental disorder in the past. 256 of 510 rural households (50.2%) as compared to 127 out of 300 urban households (42.3%) reported some mental disorder, the difference statistically significant (p<.05).

The mental disorders reported by the rural and urban samples using ICD-10 coding are presented in Table 5.5

Table 5.5: Mental disorders reported in rural and urban households

Mental Disorders	Rural No. %	Urban No. %	Total No. %	Rural-Urban difference p
Organic mental disorders	38 (14.8)	6 (4.7)	44 (11.5)	<0.001
Disorders due to psychoactive substance use	37 (14.5)	9 (7.1)	46 (12.0)	<0.001
Schizophrenia and related disorders	16 (6.2)	2 (1.6)	18 (4.7)	<0..01
Mood [affective] disorders	92 (35.9)	55 (43.3)	147(38.4)	<.0.05
Neurotic, stress-related and somatoform disorders	41(16.0)	47 (37.0)	88 (23.0)	.0.001
Disorders of adult personality and behavior	13 (5.1)	4 (3.1)	17 (4.4)	NS
Behavioral syndromes	2 (0.8)	1 (0.8)	3 (0.8)	NS
Mental retardation	16 (6.2)	1 (0.8)	17 (4.4)	<0.01
Disorders of childhood and adolescence	1 (0.4)	2 (1.6)	3 (0.8)	NS
Total	256 (100.0)	127(100.0)	383(100.0)	

Figure 5.I: Overall prevalence of mental disorders

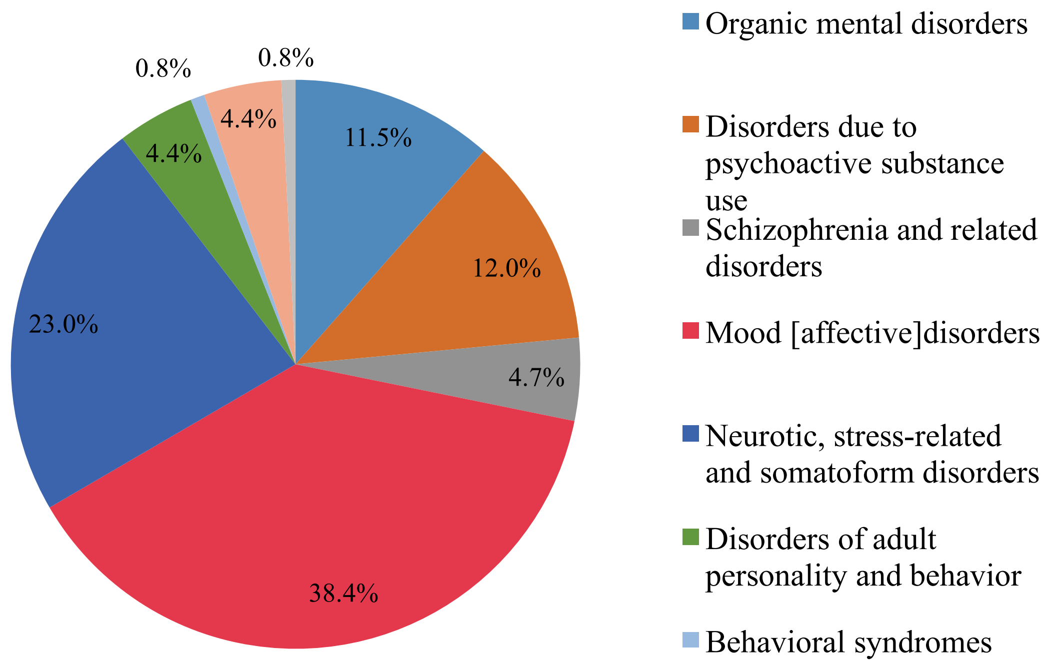
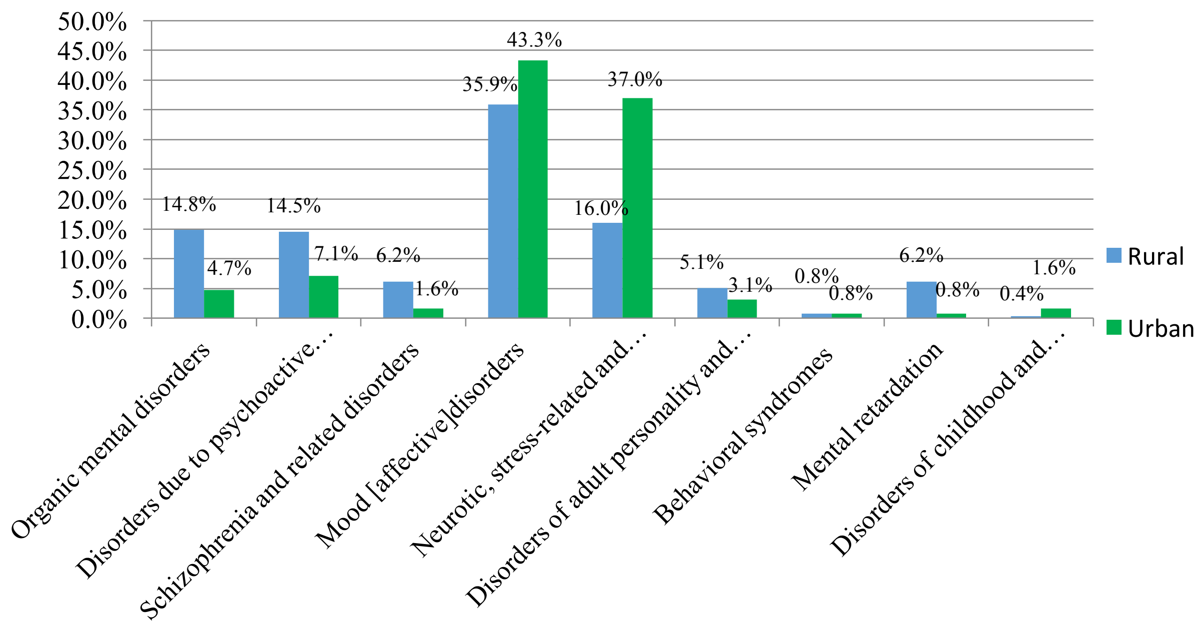


Figure 5.II: Mental disorders reported in rural and urban households



Overall, 38.4% reported mood disorders, 35.9% in the rural and 43.3% in the urban, the difference statistically significant($p<0.05$).

In the rural area, nearly 15% also reported organic disorders, as compared to only 4.7% in the urban ($p <0.001$.). On the other hand, nearly 40% reported neurotic, stress-related and somatoform disorders in the urban as compared to only 16% in the rural. ($p<0.001$.) Nearly 15% in the rural reported mental and behavioral disorders due to psychoactive substance use, mostly alcohol use, as compared to 7.1 % in the urban ($p<0.01$.). In summary, as seen from the above table, organic mental disorders were significantly higher in rural area as compared to urban, while neurotic, stress-related and somatoform disorders were significantly higher in urban as compared to rural.

5.2.1.3 Consulting traditional healer:

The number of households who sought help from a traditional healer for mental disorders is displayed in Table 5.6

Table 5.6: No. of households who consulted a traditional healer in rural and urban samples

Consulted traditional healer	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Yes	89	34.8	21	16.5	110	28.8
No	167	65.2	106	83.5	273	71.2
Total	256	100.0	127	100.0	383	100.0

Figure 5.III: Consultation of traditional healers

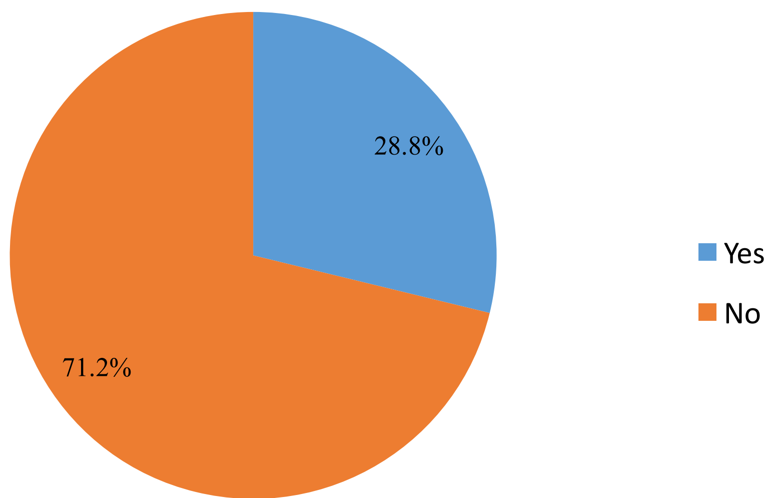
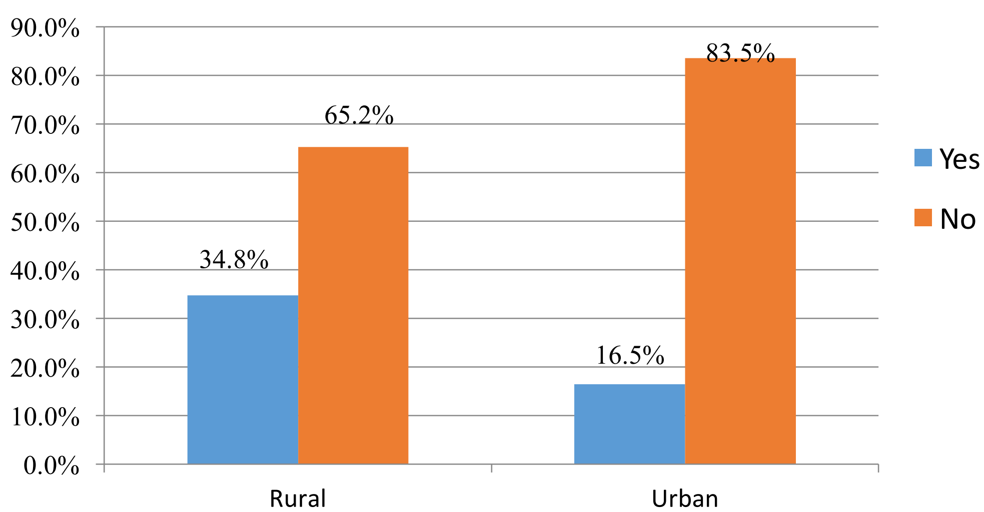


Figure 5.IV: Rural and Urban consultation of traditional healers



Overall nearly 30% (28.8%; 95% Confidence Interval:23.8-33.8) consulted a traditional healer 34.8% in the rural and 16.5% in the urban, the difference statistically highly significant($p<0.0001$).

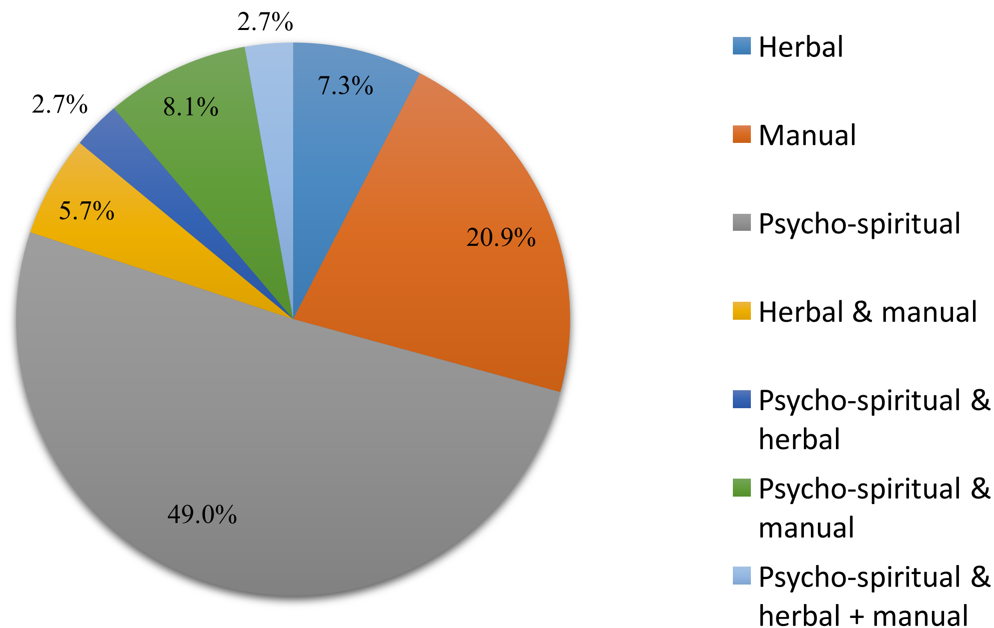
5.2.1.4 Traditional treatment of mental health problems

The traditional treatments given for each mental disorder combining both rural and urban samples are summarized in Table 5.7. The traditional treatments for each mental disorder are then shown by area - first among the rural samples as presented in Table 5.8 and urban samples as shown in Table 5.9.

Table 5.7: Traditional treatment given for each mental disorder combining both rural and urban samples

Mental Disorder	Treatment																	
	Herbal (H)		Manual (M)		Psycho-spiritual (PS)		H & M		PS & H		PS & M		PS & H+M		No treatment given		All	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%			No.	%
Organic mental disorders	0	0.0	11	57.9	1	5.2	1	5.2	0	0.0	3	15.8	1	5.2	2	10.0	19	100.0
Disorders due to psychoactive substance use.	0	0.0	1	25.0	0	0.0	0	0.0	1	25.0	0	0.0	0	0.0	2	50.0	4	100.0
Schizophrenia, schizotypal and delusional disorders	1	8.3	1	8.3	9	75.0	0	0.0	0	0.0	0	0.0	1	8.3	0	0.0	12	100.0
Mood [affective] disorders	4	9.8	6	14.6	27	65.9	1	2.4	0	0.0	3	7.3	0	0.0	0	0.0	41	100.0
Neurotic, stress-related and somatoform disorders	3	13.6	2	9.1	12	54.5	2	9.1	0	0.0	2	9.1	1	4.5	0	0.0	22	100.0
Behavioural syndromes	0	0.0	1	11.1	5	55.6	2	22.2	1	11.1	0	0.0	0	0.0	0	0.0	9	100.0
Mental retardation	0	0.0	0	0.0	0	0.0	0	0.0	1	50.0	1	50.0	0	0.0	0	0.0	2	100.0
Disorders of childhood & adolescence	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0
% Total	8	7.3	23	20.9	54	49.0	6	5.7	3	2.7	9	8.1	3	2.7	0	0.0	110	100.0

Figure 5.V: Traditional treatment given in rural and urban samples



The treatments given for each mental disorder combining both rural and urban samples reveal that mood disorders, mostly depression, which accounts for majority of the mental disorders for which traditional healers were consulted was mainly treated using psycho-spiritual form of healing (65.9%), manual treatment (14.6%) and herbal treatment (9.8%), a combination of psycho-spiritual and manual (7.3%) and a combination of herbal and manual (2.4%). For neurotic, stress-related and somatoform disorders too, psycho-spiritual form of treatment (54.5%) was the most common treatment given. The remaining few cases were treated using herbal (13.6%) and manual treatments (9.1%), a combination of herbal and manual (9.1%), a combination of psycho-spiritual and manual (9.1%) and a combination of all three modalities (4.5%). In contrast, most of the organic disorders such as Alzhiemer's dementia and seizure disorders were treated using manual treatments (57.9%) with only one

case being treated with psycho-spiritual form of treatment. The rest of the organic disorders were treated using a

combination of psycho-spiritual and manual treatments (15.8%), a combination of herbal and manual (5.2%) and a combination of all three modalities (5.2%). Majority of the schizophrenia and related disorders were also treated through psycho-spiritual form of treatment (75.0%) with the remaining few treated through herbal (8.3%), manual (8.3%) and a combination of all three modalities of treatment (8.3%). Behavioural syndromes associated with physiological disturbances and physical factors such as nonorganic insomnia disorders and sleep terrors were treated also mostly treated with psycho-spiritual form of treatment, two cases were treated with a combination of herbal and manual treatments, one case with manual treatment and another case with a combination of psycho-spiritual and herbal treatments. Only two individuals with mental and behavioural disorders due to psychoactive substance use were given traditional treatment with one case treated with manual treatment and another with a combination of psycho-spiritual and herbal treatments. The other two cases were given no treatment. Two cases of mental retardation were also treated using a combination of psycho-spiritual and herbal and a combination of psycho-spiritual and manual.

Table 5.8: Traditional treatment given for each mental disorder in rural samples

Mental Disorder	Treatment																	
	Herbal (H)		Manual(M)		Psycho-spiritual (PS)		H & M		PS & H		PS & M		PS & H+M		No treatment given		All	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%			No.	%
Organic mental disorder	0	0.0	11	64.7	1	5.8	1	5.8	0	0.0	3	17.6	0	0.0	1	5.8	17	100.0
Disorders due to psychoactive substance use	0	0.0	1	50.0	0	0.0	0	0.0	1	50.0	0	0.0	0	0.0	0	0.0	2	100.0
Schizophrenia, schizotypal and delusional disorders	1	8.3	1	8.3	9	75.0	0	0.0	0	0.0	0	0.0	0	0.0	1	8.3	12	100.0
Mood [affective] disorders	1	2.9	3	8.8	27	79.4	0	0.0	0	0.0	3	8.8	0	0.0	0	0.0	33	100.0
Neurotic, stress-related and somatoform disorders	1	7.1	2	14.3	11	78.6	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	14	100.0
Behavioural syndromes	0	0.0	0	0.0	5	62.5	2	25.0	1	12.5	0	0.0	0	0.0	0	0.0	8	100.0
Mental retardation	0	0.0	0	0.0	0	0.0	0	0.0	1	50.0	1	50.0	0	0.0	0	0.0	2	100.0
Total	3	3.4	18	20.7	53	60.9	3	3.4	3	3.4	7	8.0	0	0.0	0	0.0	89	100.0

Figure 5.VII: Traditional treatment given in rural samples

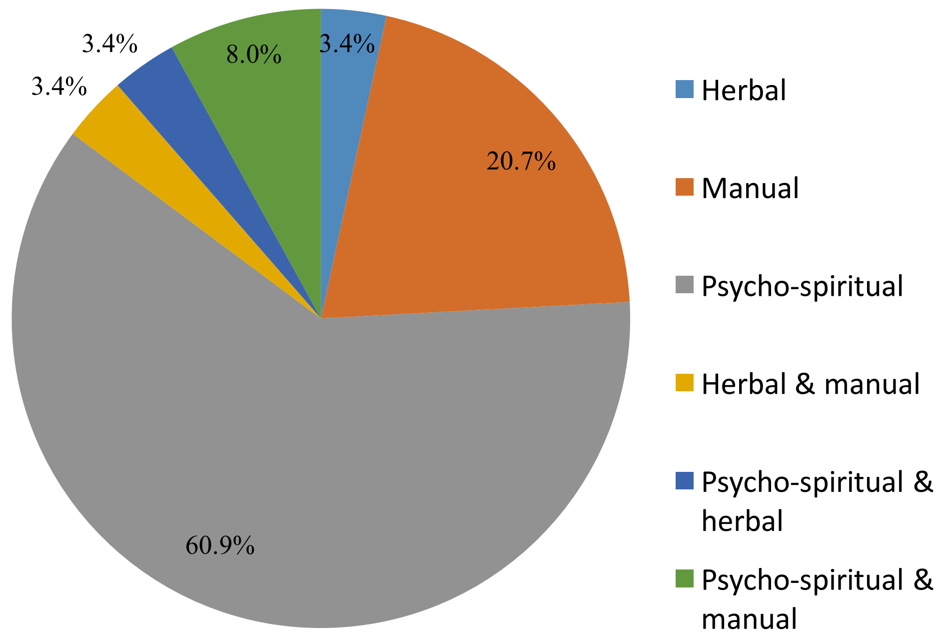
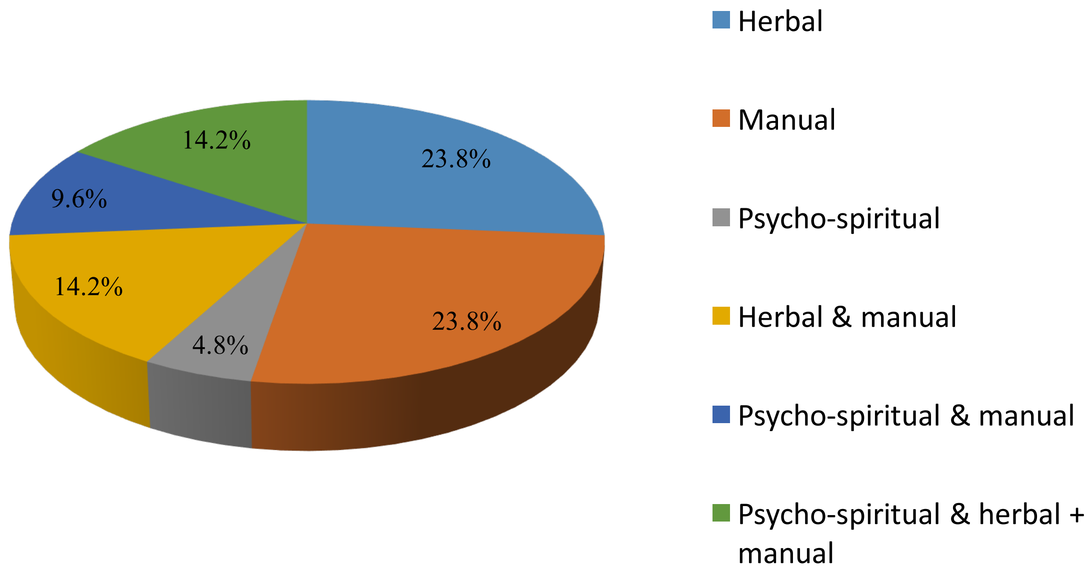


Table 5.9: Traditional treatment given for each mental disorder in urban samples

Mental Disorder	Treatment																	
	Herbal (H)		Manual(M)		Psycho-spiritual (PS)		H & M		PS & H		PS & M		PS & H+M		No treatment given		All	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Organic mental disorders	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	50.0	1	50.0	2	100.0
Schizophrenia, schizotypal and delusional disorders	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0	1	50.0	2	100.0
Mood [affective] disorders	3	42.9	3	42.9	0	0.0	1	14.3	0	0.0	0	0.0	0	0.0	0	0.0	7	100.0
Neurotic, stress-related and somatoform disorders	2	25.0	0	0.0	1	12.5	2	25.0	0	0.0	2	25.0	1	12.5	0	0.0	8	100.0
Behavioural syndromes	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0
Disorders of childhood & adolescence	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0
Total	5	23.8	5	23.8	1	4.8	3	14.2	0	0.0	2	9.6	3	14.2	2	9.6	21	100.0

Figure 5.VII: Traditional treatment given in urban samples



In general, herbal treatments were statistically significantly higher ($p<0.01$) in the urban as compared to rural (23.8 vs 3.4) while the psycho-spiritual treatments were statistically significantly higher ($p<0.001$) in the rural as compared to urban (60.9 vs 4.8). On the other hand, the mechanical treatments were not statistically significantly different between urban and rural.

5.2.1.5 Outcome of traditional healing:

The reported outcome of traditional healing of mental disorders are presented in Table 5.10.

Table 5.10: Reported outcome of traditional healing of mental disorders

Outcome	Rural	Urban	Total
	No. %	No. %	No. %
Healed	38 (43.6)	5 (25.0)	43 (40.6)
Improved	12 (13.6)	7 (36.8)	19 (17.9)
Poor	32 (36.4)	6 (30.0)	38 (35.2)
Worsened	1(1.1)	0 (0.0)	1 (0.9)
Died	4 (4.5)	1 (5.0)	5 (4.6)
Total	87 (100.0)	19 (100.0)	106 (100.0)

Figure 5.VIII: Reported outcomes of traditional healing

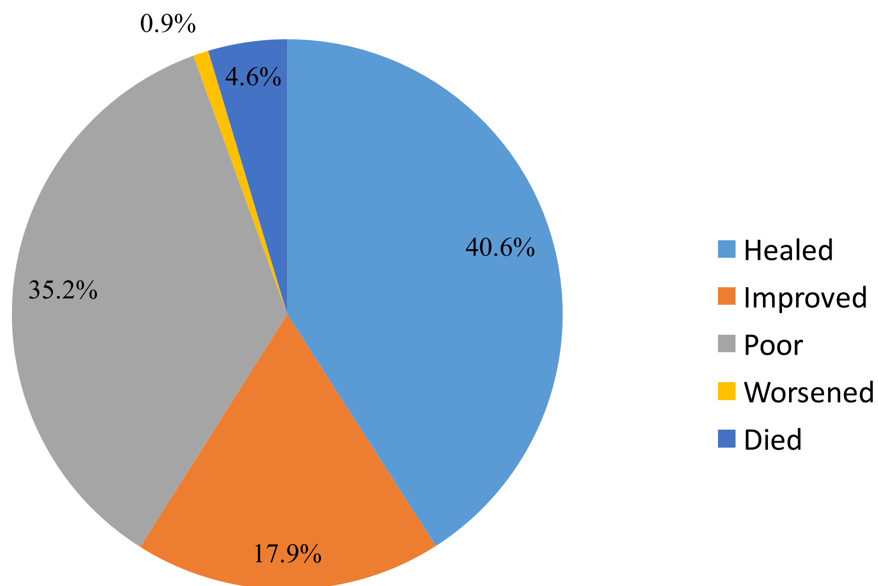
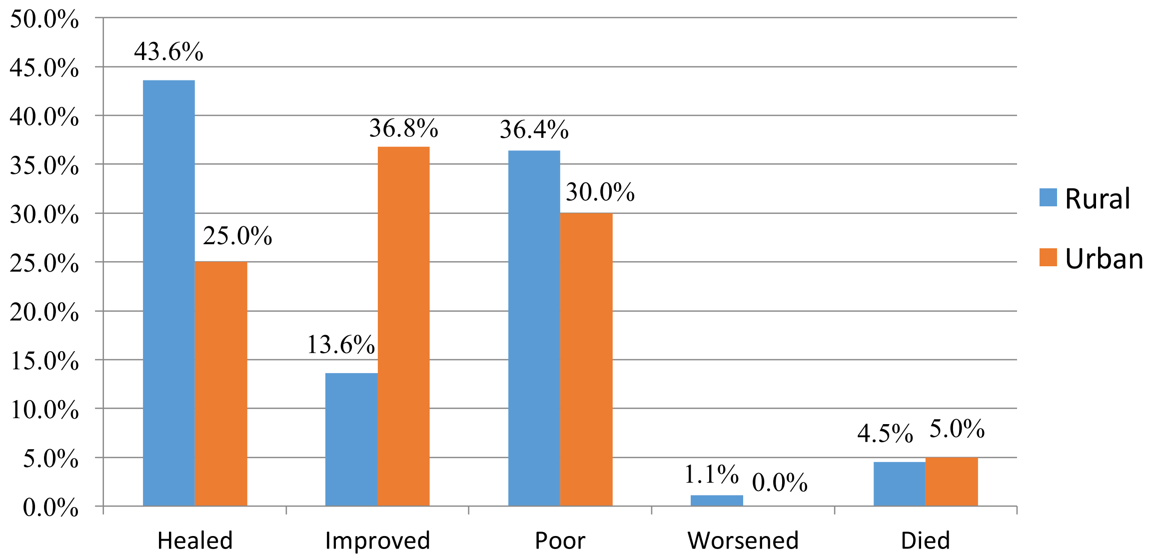


Figure 5.IX:Reported outcome of traditional healing in rural and urban samples



Of those with mental health problems who were given traditional treatment, nearly 60% reported that the outcome was good resulting in great improvement in their condition. Only 35.2 % reported that the outcome was poor. More than half in both the rural and urban areas reported that the outcome was good. Only 36.4% in the rural and 30.0% in the urban reported that the outcome was poor. The differences between rural and urban were not statistically significant

5.2.1.6 Satisfaction:

The overall satisfaction of traditional healing used for mental disorders among rural and urban respondents is displayed in Table 5.11

Table 5.11: Overall satisfaction of traditional healing for mental disorders

Satisfaction	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Excellent	15	17.2	1	5.3	16	15.1
Good	29	33.3	4	21.1	33	31.1
Satisfactory	15	17.2	6	31.6	21	19.8
Unsuitable for some illnesses	10	11.5	2	10.5	12	11.3
Not good	18	20.7	6	31.6	24	22.6
Total	87	100.0	19	100.0	106	100.0

Figure 5.X: Overall satisfaction of traditional healing

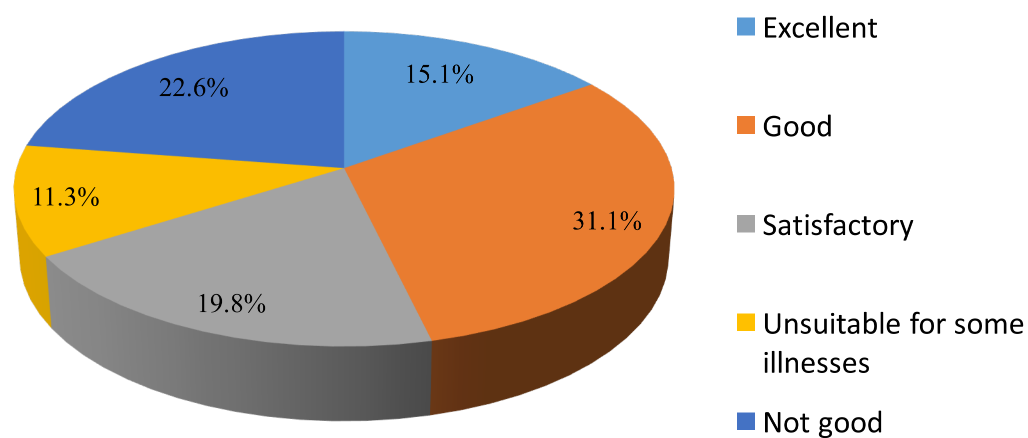
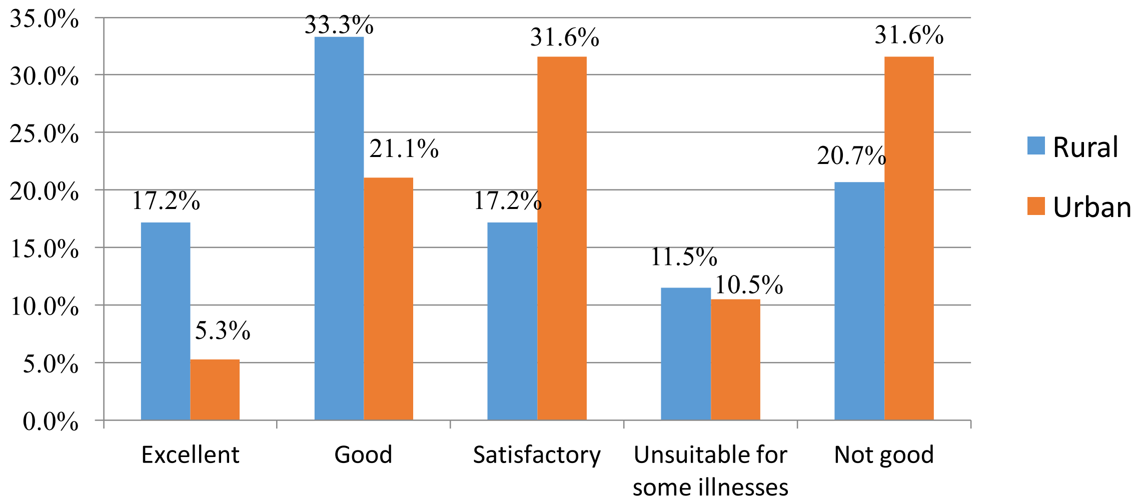


Figure 5.XI: Overall satisfaction of traditional healing in rural and urban samples



Excellent or good satisfaction was mentioned by slightly over 50% of rural respondents but only 26% for urban but the differences barely reach statistical significance
On the other hand, rural householders stated that traditional healing practice was unsuitable or not good for 32% of the illnesses, as compared to 43% in the urban.

5.2.1.7 Recommendation:

When asked if they would recommend traditional healing for mental disorders, nearly half in the rural but only a quarter in the urban said they would do so as presented in Table 5.12

Table 5.12: Recommendation of traditional healing for mental health in rural and urban samples.

Recommend	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Yes	238	46.7	77	25.7	315	38.9
No	272	53.3	223	74.3	495	61.1
Total	510	100.0	300	100.0	810	100.0

Figure 5.XII: Overall recommendation of traditional healing

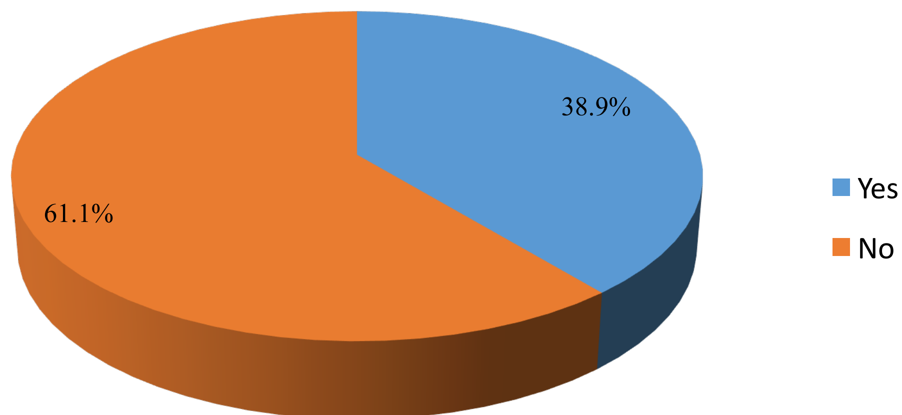
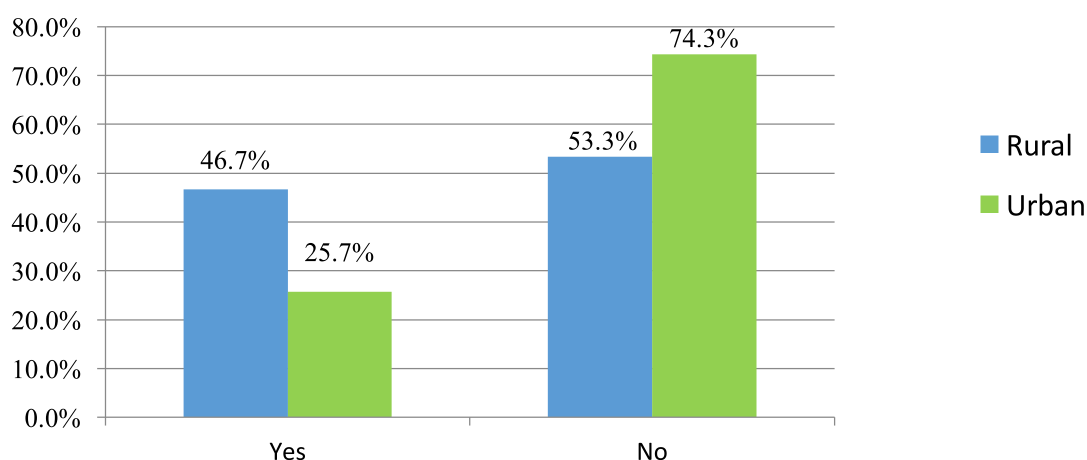


Figure 5.XIII: Overall recommendation of traditional healing in rural and urban samples



The difference between rural and urban is highly significant ($p<0.001$)

The reasons given by the households for such recommendations are summarized in table 5.13

Table 5.13: Reasons for recommendation of traditional healing for mental health

Area	Reason	No.	%
Rural	I have strong faith in traditional healing	51	21.4
	Able to offer effective treatment	65	27.3
	Depends on the severity of illness	8	3.4
	As a first step	23	9.7
	TH has diagnostic ability for mental disorders	12	5.0
	Capable of casting off evil spirits	6	2.5
	TH better when allopathy fails	23	9.7
	Witnessing other people getting healed	8	3.4
	More affordable	5	2.1
	TH more accessible and approachable	18	7.6
	TH has no side effects	5	2.1

	Some illnesses can be healed only by TH	10	4.2
	Seek all treatment options	4	1.7
Urban	I have strong faith in traditional healing	16	20.8
	TH better when allopathy fails	10	13.0
	Seek all treatment options	9	11.7
	Suitable for some illnesses	26	33.8
	Able to offer effective treatment	7	9.1
	TH has diagnostic ability for mental disorders	5	6.5
	Capable of casting off evil spirits	4	5.2

The main reasons for recommending traditional healing for mental health were their strong faith, belief that they can offer effective treatment and being suitable for some illnesses, if not all. Also they would recommend as a first step and believe that traditional healing is better when allopathy fails.

The reasons for not recommending traditional healing for mental health are summarized and presented in Table 5.14.

Table 5.14: Reasons for not recommending traditional healing for mental health

Area	Reason	No.	%
Rural	Modern medicine is better	36	13.2
	No faith in TH	18	6.6
	Faith only in Christian religious healing	15	5.5
	TH is ineffective	95	34.9
	Self coping skills is more important	3	1.1
	Unsuitable for some illnesses	81	29.8
	TH are uneducated, no formal training	5	1.8
	Seeking TH is against Christian beliefs	19	7.0

Urban	Faith in allopathy only	59	26.5
	Prefer prayer centers	15	6.7
	Seeking TH is against Christian beliefs	3	1.3
	Faith in God only	25	11.2
	TH is ineffective	12	5.4
	I have no faith in TH	61	27.4
	Seek only qualified counsellors and psychiatrists	16	7.2
	Prefer rehabilitation centers	2	0.9
	Unsuitable for some illnesses	13	5.8
	TH are uneducated, no formal training	17	7.6

The main reasons for not recommending were traditional healing being ineffective for mental health problems, not suitable for all illnesses, skepticism of traditional healing, faith in allopathy only and having complete faith in God alone. They also state that seeking help from traditional healers is against Christian beliefs, prefer Christian religious healing only and some would recommend only qualified mental health professionals and rehabilitation centres.

5.2.1.8 Popularity: The perceived popularity of traditional healing for mental health is given in Table 5.15.

Table 5.15: Popularity of traditional healing for mental health in rural and urban samples

Is traditional healing still popular	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Yes	283	55.5	71	23.7	354	43.7
No	222	43.5	206	68.7	428	52.8
Don’t know	5	1.0	23	7.7	28	3.5
Total	510	100.0	300	100.0	810	100.0

Figure 5.XIV: Overall popularity of traditional healing

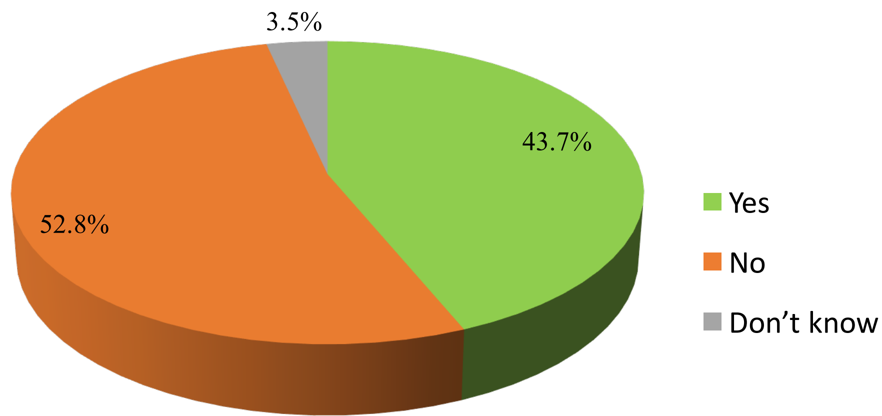
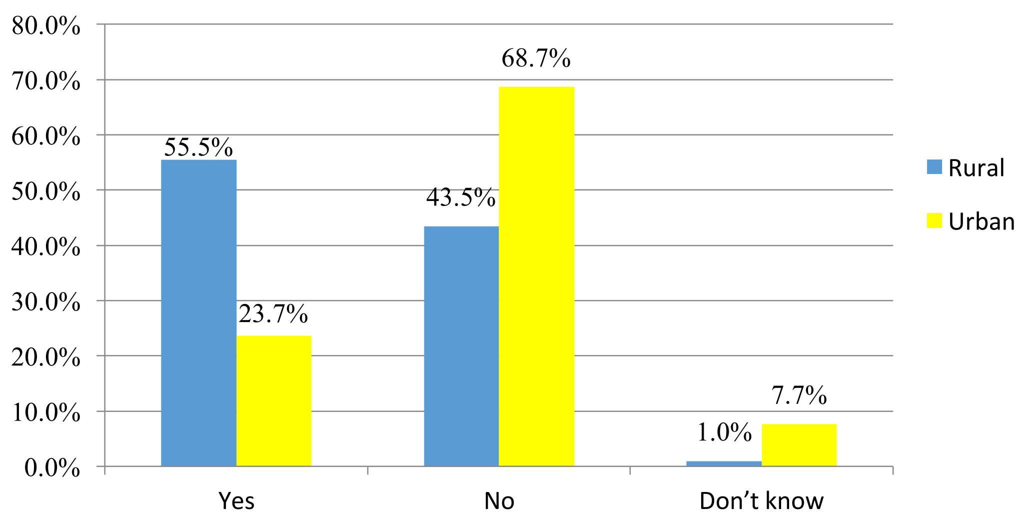


Figure 5.XV: Popularity of traditional healing in rural and urban samples



On enquiring if traditional healers are still popular for treating mental disorders, nearly 60% in the rural but only 24% in the urban felt that they were, the difference statistically significant (p<0.01). The reasons for popularity of traditional healing for mental health are summarized and presented in Table 5.16.

Table 5.16: Reasons for popularity of traditional healing for mental health

Area	Reasons	No.	%
Rural	Culturally acceptable methods of healing mental disorders	33	11.7
	TH has diagnostic ability for mental disorders	34	12.0
	TH better when allopathy fails	24	8.5
	Easily available	10	3.5
	Has power over spirits	48	17.0
	Through word of mouth of its effectiveness	12	4.2
	Affordable and flexible	16	5.7
	Traditional healers are more approachable	3	1.1
	Strong faith in TH	51	18.0
	Shorter duration of treatment	4	1.4
	As a first step for guidance and direction	25	8.8
	Lack of medical facilities	18	6.4
	Unaware of governmental mental health services	5	1.8
Urban	Strong faith in TH	16	22.5
	Has power over spirits	19	26.8
	More reliable & takes lesser time	6	8.5
	More effective than allopathy for certain illnesses	3	4.2
	Approach TH when allopathy fails	10	14.1
	Easily accessible	7	9.9
	TH has diagnostic ability for mental disorders	10	14.1

As stated for recommendation, the main reasons for mentioning that traditional healing were popular were their strong faith, belief that they have the diagnostic ability and because they adopt culturally acceptable methods. Also they affirm that traditional healing is better than allopathy in effectiveness, is more easily available, more affordable, more approachable and have power over spirits.

The reasons for perceived decline of popularity of traditional healing for mental health are summarized and presented in Table 5.17.

Table 5.17: Reasons for decline of popularity of traditional healing for mental health

Area	Reason	No.	%
Rural	The number of TH for mental health has declined	16	7.2
	TH incapable of treating mental disorders	61	27.5
	Faith in allopathy only	17	7.7
	TH more popular for physical ailments	22	9.9
	TH are uneducated, no formal training	4	1.8
	TH is generally ineffective	31	14.0
	Faith in God only	20	9.0
	Prefer prayer centers	2	0.9
	Stigma attached to consulting traditional healers	26	11.7
	Mental disorders not common	23	10.4
Urban	People seek help from psychiatrists and counsellors	25	12.1
	TH is generally not effective	8	3.9
	TH are uneducated, no formal training	10	4.9
	No faith in TH	37	18.0
	Christian religious healers and prayer centers are more popular	52	25.2
	First option is always allopathy	15	7.3
	Stigma attached to consulting traditional healers	21	10.2

Limited knowledge on treating mental disorders	20	9.7
TH healing practices differs from Christian beliefs	18	8.7

5.2.1.9 Additional training needs:

The perceived requirement of additional training of traditional healers among rural and urban respondents is given in Table 5.18.

Table 5.18: Perceived requirement of additional training of traditional healers

Do traditional healers need additional training	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Yes	56	11.0	105	35.0	161	19.9
No	450	88.2	184	61.3	634	78.3
Cant say	4	0.8	11	3.7	15	1.8
Total	510	100.0	300	100.0	810	100.0

Figure 5.XVI: Perceived requirement of additional training of traditional healers

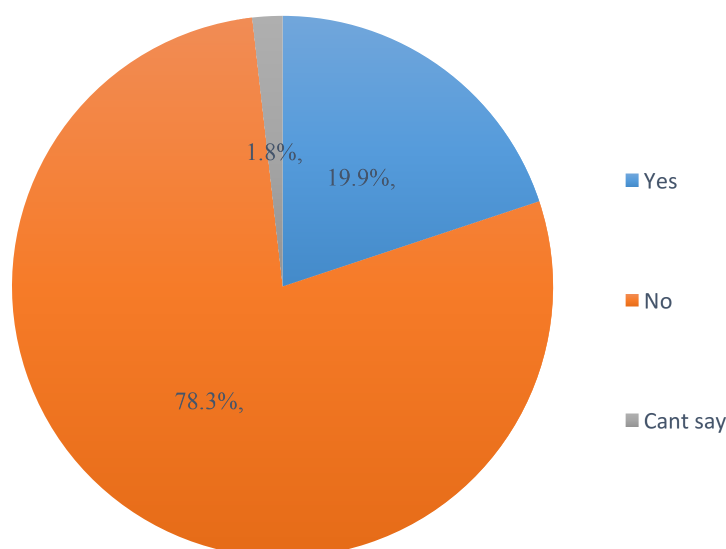
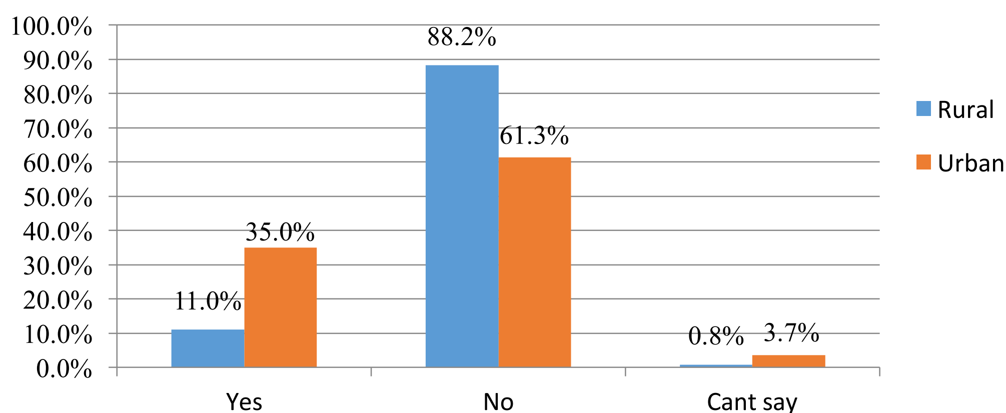


Figure 5.XVII: Perceived requirement of additional training of traditional healers in rural and urban samples



Only 11% of rural respondents felt that traditional healers require any additional training as compared to 35% in the urban.

5.2.1.10 Analysis of consultation of traditional healer with specific variables:

5.2.1.10.1 The number of households that consulted a traditional healer by mental disorder is given in Table 5.19.

Table 5.19: Consultation of traditional healer by mental disorder

Mental disorder	Consulted traditional healer				Total	
	Yes	%	No	%	No	%
Organic, including symptomatic, mental disorder	18	40.9	26	59.1	44	100.0

Mental and behavioural disorders due to psychoactive substance use	2	4.3	44	95.7	46	100.0
Schizophrenia, schizotypal and delusional disorders	14	77.8	4	22.2	18	100.0
Mood [affective] disorders	40	27.2	107	72.8	147	100.0
Neurotic, stress-related and somatoform disorders	24	27.3	61	69.3	88	100.0
Behavioural syndromes associated with physiological disturbances & physical factors	9	52.9	8	47.1	17	100.0
Disorders of adult personality and behavior	0	0.0	3	100.0	3	100.0
Mental retardation	2	11.8	15	88.2	17	100.0
Behavioural & emotional disorders with onset usually occurring in childhood & adolescence	1	33.3	2	66.7	3	100.0
Total	110	28.8	273	71.2	383	100.0

For mental disorders such as organic disorders and behavioural syndromes associated with physiological disturbances & physical factors, about half of the households had sought traditional healing. Majority (77.8%) of the households with schizophrenia and related disorders had consulted a traditional healer; whereas of those households with mental retardation and substance use, only few chose to seek traditional healing (11.8%, 4.3%). Also, for households with mood disorders and neurotic, stress-related and somatoform disorder, only a small number (27.2%, 27.3%) had consulted a traditional healer.

5.2.1.10.2 The number of households with mental disorders who sought traditional healing by age is presented in Table 5.20.

Table 5.20: Consultation of traditional healer by age

Age	Consulted traditional healer				Total	
	Yes		No		No.	%
	No.	%	No.	%		
Below 18	14	51.9	13	48.1	27	100.0
19-30	36	26.7	99	73.3	135	100.0
31-50	37	26.4	103	73.5	140	100.0
51-79	21	28.4	53	71.6	74	100.0
Above 80	2	28.6	5	71.4	7	100.0
Total	110	100.0	273	100.0	383	100.0

Comparison between consultation of traditional healer with age of the person with mental disorder shows that nearly half of those below 18 years had sought traditional healing as compared to only a small percentage of those above 19 years.

5.2.1.10.3 The number of households with mental disorders who sought traditional healing by gender is presented in Table 5.21.

Table 5.21: Consultation of traditional healer by gender

Age	Consulted traditional healer				Total	
	Yes		No		No.	%
	No.	%	No.	%		
Female	57	51.8	142	52.0	199	51.9
Male	53	48.2	131	48.0	184	48.1
Total	110	100.0	273	100.0	383	100.0

Comparison between consultation of traditional healer and gender shows that there is no variation between males and females with almost half of both having consulted a traditional healer.

5.2.1.10.4 Analysis of consultation of traditional healing by tribe shows that 30.0% from Ao tribe, 27.3% from Sumi tribe, 22.7% from Sangtam tribe and 14.5% from Yimjunger tribe had sought traditional healing as displayed in Table 5.22.

Table 5.22: Consultation of traditional healer by tribe

Age	Consulted traditional healer				All	
	Yes		No		No.	%
	No.	%	No.	%		
Ao	33	30.0	73	26.7	106	27.6
Angami	4	3.6	10	3.6	14	3.6
Sumi	30	27.3	69	25.2	99	25.8
Lotha	0	0.0	11	4.0	11	2.8
Chakesang	0	0.0	6	2.1	6	1.5
Zeliang	0	0.0	2	0.7	2	0.5
Chang	0	0.0	1	0.3	1	0.2
Yimjunger	16	14.5	26	9.5	42	10.9
Konyak	0	0.0	2	0.7	2	0.5
Phom	0	0.0	2	0.7	2	0.5
Khiamniungan	0	0.0	1	0.3	1	0.2
Rengma	0	0.0	1	0.3	1	0.2
Sangtam	25	22.7	67	24.5	92	24.0
Others	2	1.8	2	0.7	4	1.0
Total	110	100.0	273	100.0	383	100.0

On the other hand, only a small percentage from Angami tribe (3.%) and Others (1.8%) had consulted a traditional healer.

5.2.1.10.5 Analysis of consultation of traditional healer by occupation.

Only 35.6% of the unemployed, students and housewives, 28.0% of agricultural labourers and 16.2% of those with clerical and white collar jobs had consulted a traditional healer as seen in Table 5.23.

Table 5.23: Analysis of consultation of traditional healer by occupation

Occupation	Consulted traditional healer				Total	
	Yes		No		No.	%
	No.	%	No.	%		
Unemployed/ student/ housewife	65	35.6	113	63.4	178	100.0
Casual labourer/ part time vendor	5	29.4	12	70.6	17	100.0
Agricultural labourer	21	28.0	54	72.0	75	100.0
Small industry/ bakery/ repair-maintenance	1	50.0	1	50.0	2	100.0
Clerical/ white collar/ teacher/ lawyer	7	16.2	36	83.8	43	100.0
Communications/ IT/ Technical	0	0.0	1	100.0	1	100.0
Services- defence / police/ security/ transport	1	25.0	3	75.0	4	100.0
Private business	2	15.3	11	84.7	13	100.0
Other	8	16.0	42	84.0	50	100.0
Total	110	28.8	273	71.2	383	100.0

There seems to be no significant difference in consulting a traditional healer with the different occupational groups with majority in all groups having not consulted one.

5.2.1.10.6 Analysis of consultation of traditional healer by educational level.

In all the different educational levels, majority did not consult a traditional healer as presented in Table 5.24.

Table 5.24: Analysis of consultation of traditional healer by educational level

Occupation	Consulted traditional healer				All	
	Yes		No		No.	%
	No.	%	No.	%		
Illiterate	23	29.9	54	70.1	77	100.0
<5	39	37.9	64	62.1	103	100.0
5-9	29	38.1	47	61.9	76	100.0
10-12	15	16.9	74	83.1	89	100.0
Grad & above	4	10.6	34	89.4	38	100.0
Total	110	28.8	273	71.2	383	100.0

There is no significant difference in consulting a traditional healer in terms of different educational levels.

5.2.1.11 Analysis of treatment given with specific variables

5.2.1.11.1 Analysis of treatment given by age is summarized in Table 5.25.

Table 5.25: Analysis of treatment given by age of the person who sought traditional healing

Treatment	Age								Total	
	Below 18		19-30		31-50		51-79			
	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	0	0.0	4	11.4	2	5.6	2	9.5	8	7.5
Manual	7	50.0	5	14.3	7	19.4	4	19.0	23	21.7
Psycho-spiritual	4	28.6	17	48.6	21	58.3	12	57.1	54	50.9

Herbal & manual	0	0.0	3	8.6	2	5.6	1	4.8	6	5.7
Psycho-spiritual & herbal	0	0.0	1	2.9	1	2.8	1	4.8	3	2.8
Psycho-spiritual & manual	2	14.3	4	11.4	2	5.6	1	4.8	9	8.5
Psycho-spiritual &herbal + manual	1	7.1	1	2.9	1	2.8	0	0.0	3	2.8
Total	14	100.0	35	100.0	36	100.0	21	100.0	106	100.0

Analysis of treatment given with the age of the person by mental disorder shows that majority of those above 18 years of age were treated using psycho-spiritual form of treatment as compared to those below the age of 18 ears who were treated mostly using manual form of treatment.

5.2.1.11.2 Analysis of treatment given by gender is summarized in Table 5.26.

Table 5.26: Analysis of treatment given by gender

Treatment	Gender				Total	
	Male		Female			
	No.	%	No.	%	No.	%
Herbal	5	10.4	3	5.2	8	7.5
Manual	12	25.0	11	19.0	23	21.7
Psycho-spiritual	24	50.0	30	51.7	54	50.9
Herbal & manual	2	4.2	4	6.9	6	5.7
Psycho-spiritual &herbal	1	2.1	2	3.4	3	2.8
Psycho-spiritual &manual	4	8.3	5	8.6	9	8.5
Psycho-spiritual &herbal + manual	0	0.0	3	5.2	3	2.8
Total	48	100.0	58	100.0	106	100.0

Analysis of treatment given by the traditional healer by gender shows no variation with majority of both males and females (50.0%, 51.7%) having received psycho-spiritual form of treatment.

5.2.1.11.3 Comparison of treatment given by tribe is summarized in Table 5.27.

Table 5.27: Analysis of treatment given by tribe

Treatment	Age						
	Ao	Sumi	Lotha	Yimjunger	Sangtam	Others	Total
	No. %	No. %	No. %	No. %	No. %	No. %	No. %
Herbal	2 6.5	1 33.3	1 3.4	0 0.0	2 8.0	2 100.0	8 7.5
Manual	5 16.1	1 33.3	9 31.0	2 12.5	6 24.0	0 0.0	23 21.7
Psycho-spiritual	18 58.1	0 0.0	13 44.8	10 62.5	13 52.0	0 0.0	54 50.9
Herbal & manual	3 50.0	1 33.3	0 0.0	1 6.2	1 4.0	0 0.0	6 5.7
Psycho-spiritual & herbal	0 0.0	0 0.0	1 3.4	1 6.2	1 4.0	0 0.0	3 2.8
Psycho-spiritual & manual	0 0.0	0 0.0	5 17.2	2 12.5	2 8.0	0 0.0	9 8.5
Psycho-spiritual & herbal + manual	3 9.7	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	3 2.8
Total	31 100.0	3 100.0	29 100.0	16 100.0	25 100.0	2 100.0	106 100.0

Almost all the tribes except for Sumi and Others were mainly treated with psycho-spiritual form of treatment. Manual therapy was also used more than herbal treatment for treating mental disorders in almost all the tribes.

5.2.1.12 Analysis of satisfaction of traditional healing with specific variables:

5.2.1.12.1 Analysis of satisfaction of traditional healing by age is presented in Table 5.28.

Table 5.28: Analysis of satisfaction of traditional healing by age

Satisfaction	Age								Total	
	Below 18		19-30		31-50		51-79			
	No.	%	No.	%	No.	%	No.	%	No.	%
Excellent	0	0.0	3	8.6	6	16.7	5	23.8	14	13.2
Good	3	21.4	10	28.5	13	36.1	6	28.6	32	30.2
Satisfactory	5	35.8	10	28.5	5	13.9	5	23.8	25	23.6
Unsuitable for some illnesses	3	21.4	3	8.6	5	13.9	1	4.8	12	11.3
Not good	3	21.4	9	25.8	7	19.4	4	19.0	23	21.7
Total	14	100.0	35	100.0	36	100.0	21	100.0	106	100.0

Nearly half in all the age groups were satisfied with the treatment given by the traditional healer. 25.8% of those belonging between the age group of 19 to 30 years were not satisfied with the treatment.

5.2.1.12.2 Analysis of satisfaction of traditional healing by gender is presented in Table 5.29.

Table 5.29: Analysis of satisfaction of traditional healing by gender

Satisfaction	Gender				Total	
	Female		Male			
	No.	%	No.	%	No.	%
Excellent	9	17.0	5	9.4	14	13.2
Good	15	28.3	17	32.0	32	30.1
Satisfactory	11	20.8	13	24.6	24	22.7

Unsuitable for some illnesses	8	15.0	4	7.6	12	11.3
Not good	10	18.9	14	26.4	24	22.7
Total	53	100.0	53	100.0	106	100.0

In terms of analysis of satisfaction of traditional healing by gender, there is no variation. Both males and females were largely satisfied with the outcome. Only 18.9% of females stated that the outcome was not good as compared to 26.4% of males.

5.2.1.12.3 Analysis of satisfaction of traditional healing by educational level is presented in Table 5.30.

Table 5.30: Analysis of satisfaction of traditional healing by educational level

Satisfaction	Educational level										Total	
	Illiterate		<5		5-9		10-12		Grad.& above		No.	%
	No.	%	No	%	No	%	No	%	No	%		
Excellent	2	8.3	6	16.2	7	25.9	1	7.1	0	0.0	16	15.2
Good	6	25	16	43.2	5	18.6	3	21.4	2	50	32	30.1
Satisfactory	7	29.1	8	21.6	3	11.1	7	50	0	0.0	25	23.6
Unsuitable for some illnesses	3	12.6	0	0.0	3	11.1	3	21.4	0	0.0	9	8.4
Not good	6	25	7	19.0	9	33.3	0	0.0	2	50	24	22.6
Total	24	100.0	37	100.0	27	100.0	14	100.0	4	100.0	106	100.0

Analysis of satisfaction of traditional healing by educational level shows that there is no variation in satisfaction with most stating that the outcome was good irrespective of different educational levels.

5.2.1.13 Analysis of treatment given by outcome:

5.2.1.13.1 Analysis of treatment given by outcome in rural and urban samples

Nearly 78% of those who were treated using psycho-spiritual form of treatment reported that the outcome was good with only 17% stating that the outcome was poor as displayed in Table 5.29.

Table 5.31: Analysis of treatment given by outcome in rural and urban samples

Treatment	Outcome					Total
	Healed	Improved	Poor	Worsened	Died	
	No. %	No. %	No. %	No. %	No. %	No. %
Herbal	3 37.5	1 12.5	3 37.5	1 12.5	0 0.0	8 100.0
Manual	2 8.3	4 16.7	16 66.7	0 0.0	2 8.3	24 100.0
Psycho-spiritual	34 64.2	7 13.2	9 17.0	0 0.0	3 5.7	53 100.0
Herbal & manual	2 33.3	2 33.3	2 33.3	0 0.0	0 0.0	6 100.0
Psycho-spiritual & herbal	1 25.0	0 0.0	3 75.0	0 0.0	0 0.0	4 100.0
Psycho-spiritual & manual	0 0.0	3 37.5	5 62.5	0 0.0	0 0.0	8 100.0
Psycho-spiritual & herbal +manual	1 33.3	2 66.6	0 0.0	0 0.0	0 0.0	3 100.0
Total	43 40.6	19 17.9	38 35.8	1 0.9	5 4.7	106 100.0

Herbal treatment seems to have had a positive outcome for half of those treated. In contrast, almost 75% of those treated using manual treatment reported that the outcome was poor.

5.2.1.13.2 Analysis of treatment given by outcome in rural samples

Of those who were treated using psycho-spiritual form of treatment, a large percentage among the rural samples reported that the outcome was good, with 61.1% stating that they have been healed and 13.0% seeing an improvement in their condition as shown in Table 5.30.

Table 5.32: Analysis of treatment given by outcome in rural samples

Treatment	Outcome					Total
	Healed	Improved	Poor	Worsened	Died	
	No. %	No. %	No. %	No. %	No. %	No. %
Herbal	1 33.3	0 0.0	1 33.3	1 33.3	0 0.0	3 100.0
Manual	1 5.9	3 17.6	12 70.6	0 0.0	1 5.9	17 100.0
Psycho-spiritual	33 61.1	7 13.0	11 20.4	0 0.0	3 5.6	52 100.0
Herbal & manual	2 66.7	0 0.0	1 33.3	0 0.0	0 0.0	3 100.0
Psycho-spiritual & herbal	1 33.3	0 0.0	2 66.7	0 0.0	0 0.0	3 100.0
Psycho-spiritual & manual	0 0.0	2 28.6	5 71.4	0 0.0	0 0.0	7 100.0
Total	38 43.7	12 13.8	32 36.8	1 1.1	4. 4.6	87 100.0

In contrast, 70.6% of those treated using manual form of treatment reported that the outcome was poor. The outcome was again mostly poor for those treated using herbal treatment.

5.2.1.13.3 Analysis of treatment given by outcome in urban samples are summarized in Table 5.31.

Table 5.33: Analysis of treatment given by outcome in urban samples

Treatment	Outcome					Total
	Healed	Improved	Poor	Worsened	Died	
	No. %	No. %	No. %	No. %	No. %	No. %
Herbal	2 40.0	1 20.0	2 40.0	0 0.0	0 0.0	5 100.0
Manual	1 20.0	1 20.0	3 60.0	0 0.0	0 0.0	5 100.0
Psycho-spiritual	1 50.0	0 0.0	0 0.0	0 0.0	1 50.0	2 100.0
Herbal & manual	0 0.0	2 66.7	1 33.3	0 0.0	0 0.0	3 100.0
Psycho-spiritual & manual	0 0.0	2 100.0	0 0.0	0 0.0	0 0.0	2 100.0
Psycho-spiritual & herbal +manual	1 50.0	1 50.0	0 0.0	0 0.0	0 0.0	2 100.0
Total	5 26.3	7 36.9	6 31.6	0 0.0	1 5.2	19 100.0

In the urban area, those who were treated using manual treatment, most reported that the outcome was poor. Half of those treated using herbal medicine stated that the outcome was good with the other half stating that the outcome was poor. Psycho-spiritual treatment seems to have had a positive outcome with most stating that they either got healed or there was an improvement in their condition.

5.2.2 Traditional Healers Interview Survey:

The findings from the survey of traditional healers on practice, knowledge and attitude are presented in general and then analyzed according to specific variables such as age, gender and tribe.

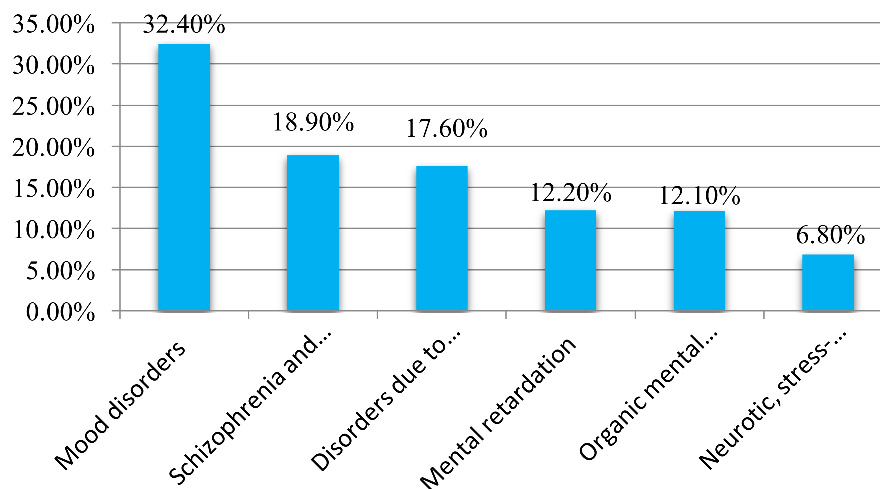
5.2.2.1 Practice:

The 30 traditional healers had treated a total of 74 cases of mental disorders as summarized in Table 5.34 based on ICD-10.

Table 5.34: Mental disorders treated by traditional healers

mental disorders treated	No.	%
Organic mental disorders	9	12.1
Disorders due to psychoactive substance use	13	17.6
Schizophrenia, schizotypal and delusional disorders (demon possession)	14	18.9
Mood [affective] disorders (ancestor spirits & soul illness)	24	32.4
Neurotic, stress- related and somatoform disorders	5	6.8
Mental retardation	9	12.2
Total	74	100.0

Figure 5.XVIII: Mental disorders treated by traditional healers



A third of the mental disorders treated by traditional healers were mood disorders (32.4%) which they described as due to disturbance by spirits of departed relations or ancestor spirits. 18.9% of the cases were schizophrenia and related disorders, all of the traditional healers describing them as ‘demon possession’ or ‘curse’ or ‘poison’.

Analysis of traditional treatments given for each mental disorder is summarized in Table 5.35.

Table 5.35: Traditional treatments given for each mental disorder

Treatment	Mental Disorder													
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation		All	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	1	11.1	2	15.4	2	14.3	1	4.2	0	0.0	0	0.0	6	8.1
Manual	3	33.3	2	15.4	0	0.0	2	8.3	1	20.0	4	44.4	12	16.2
Psycho-spiritual	2	22.2	5	38.5	9	64.3	17	70.8	2	40.0	3	33.3	38	51.4
Herbal and manual	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	1.4
Psycho-spiritual and herbal	0	0.0	3	23.1	1	7.1	4	16.7	0	0.0	0	0.0	8	10.8
Psycho-spiritual and manual	0	0.0	0	0.0	2	14.3	0	0.0	2	40.0	2	22.2	6	8.1
No treatment given	2	22.2	1	7.7	0	0.0	0	0.0	0	0.0	0	0.0	3	4.1
Total	9	100.0	13	100.0	14	100.0	24	100.0	5	100.0	9	100.0	74	100.0
% Disorders treated		12.2		17.6		19.0		32.4		6.7		12.1		

Figure 5.XIX: Traditional healing for mental health

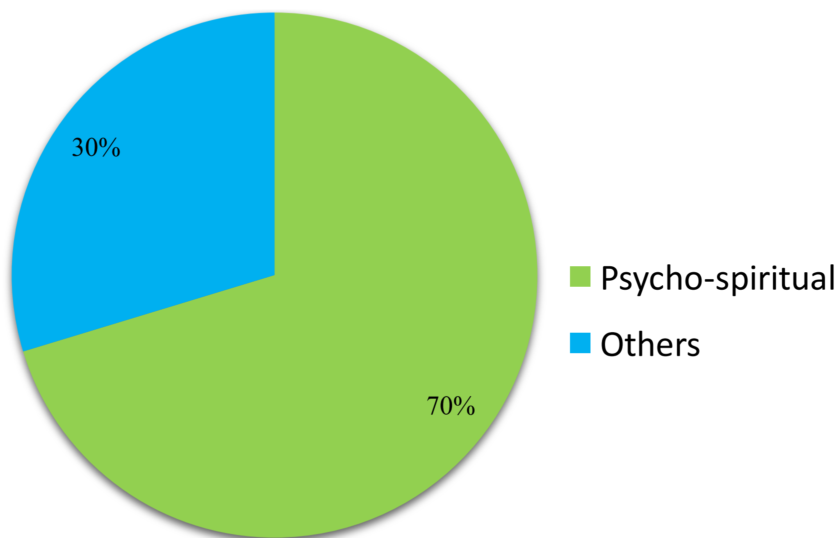


Figure 5.XX: Traditional healing for organic mental disorders

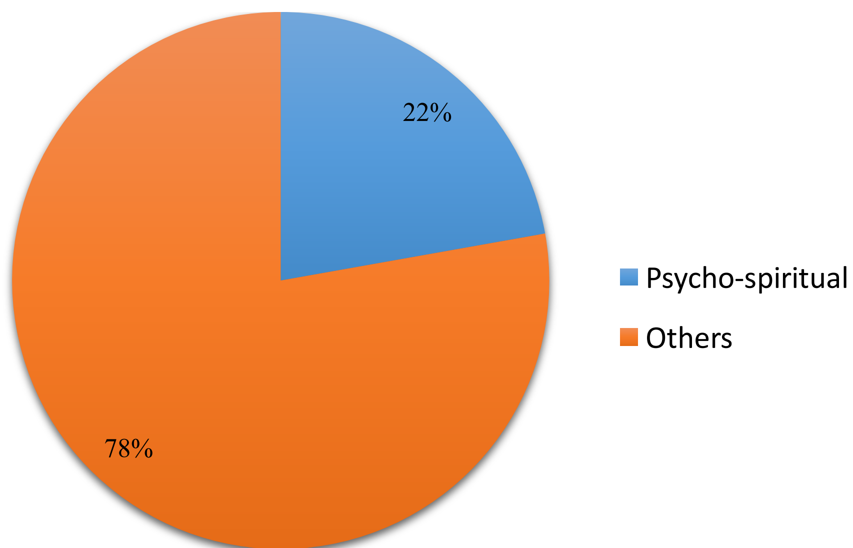


Figure 5.XXI: Traditional healing for disorders due to psychoactive substance use

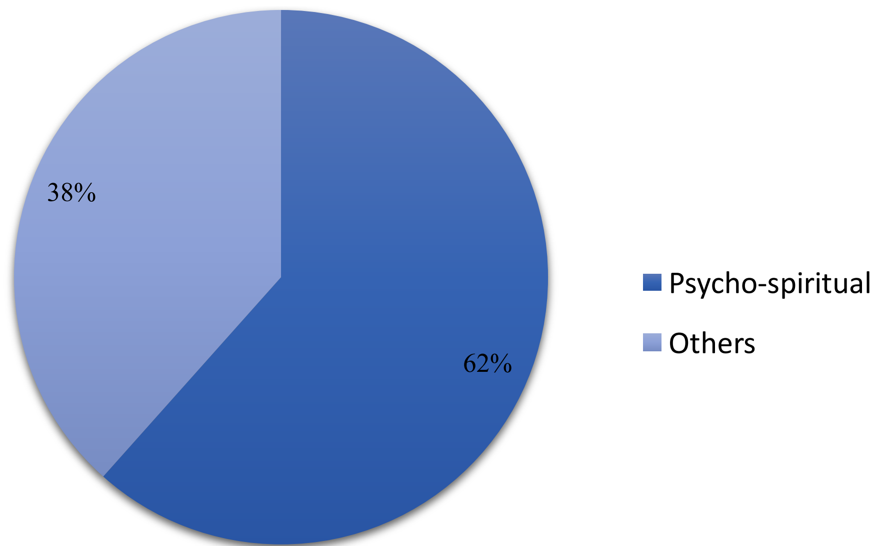


Figure 5.XXII: Traditional healing for schizophrenia and related disorders

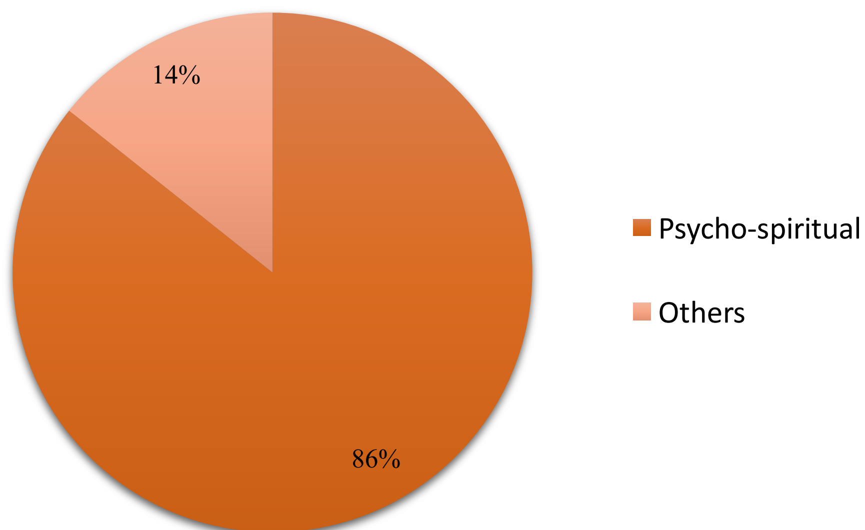


Figure 5.XXIII: Traditional healing for mental retardation

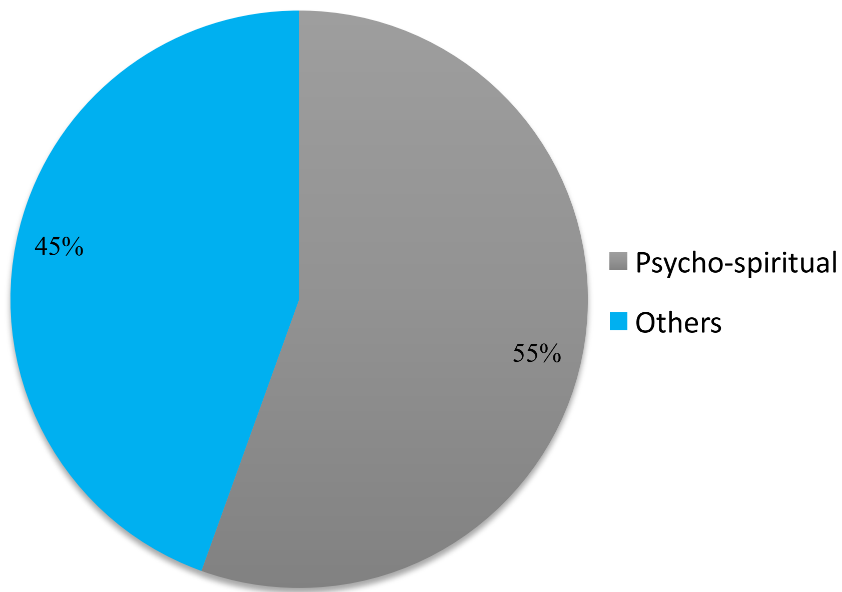


Figure 5.XXIV: Traditional healing for neurotic, stress-related and somatoform disorders

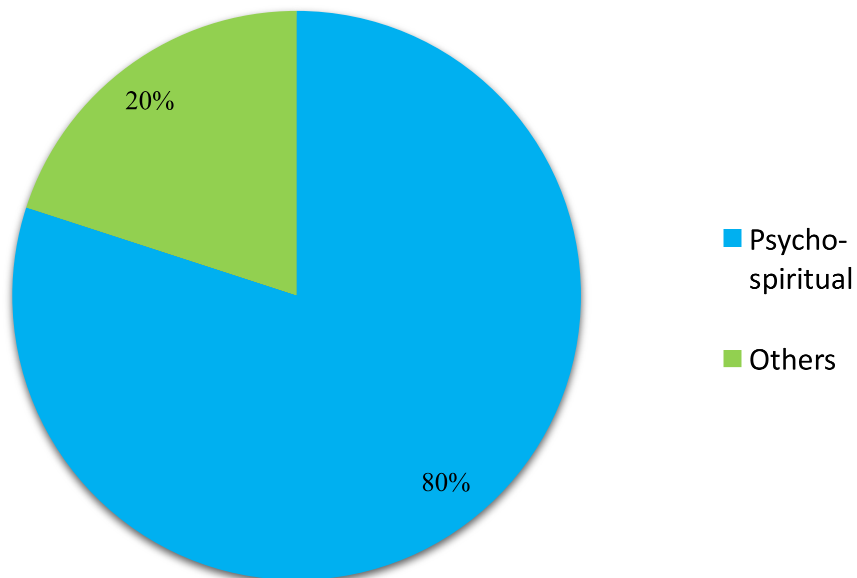


Figure 5.XXV: Traditional healing for mood [affective] disorders

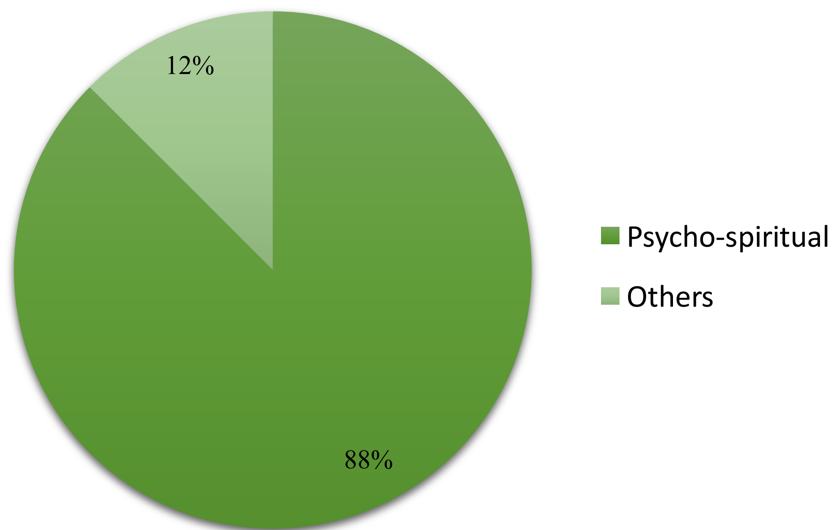
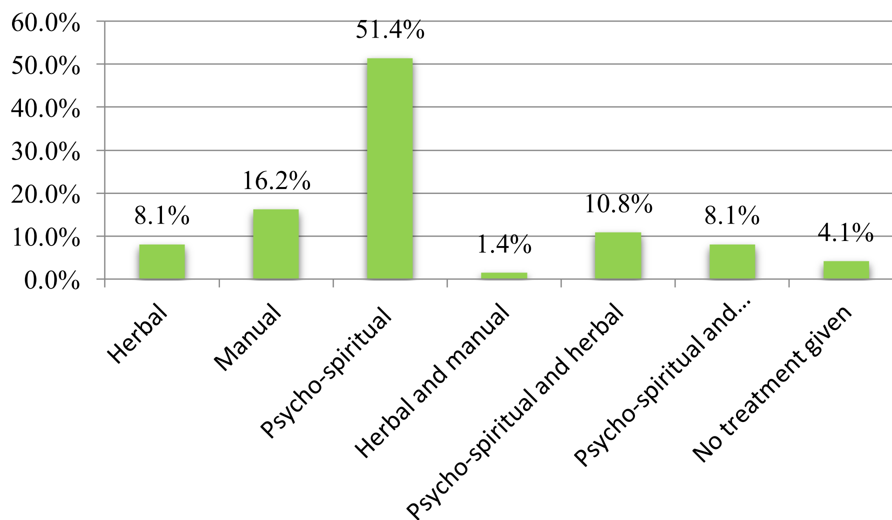


Figure 5.XXVI: Treatment given by traditional healers



The most common mental disorder treated being mood disorders was mainly treated through psycho-spiritual from of intervention (70.8%) and few in combination with herbal (16.7%). Majority of the schizophrenia and related disorders were also treated with psycho-spiritual from of treatment and few treated in combination with either herbal or manual. Psycho-spiritual treatment was again mostly used for disorders due to psychoactive substance use, with only a small proportion treated with herbal or manual treatments. No treatment was given for one case of substance use. Organic mental disorders were treated using mainly manual treatment and few with psycho-spiritual and herbal treatments. No treatment was given for two cases of organic mental disorders. Mental retardation was also mainly treated with manual therapy and psycho-spiritual intervention, some with a combination of the two modalities. Neurotic, stress-related and somatoform disorders were treated mostly with psycho-spiritual and manual treatments either singularly or in combination.

Table 5.36 and Table 5.37 indicate the mental disorders and treatment given by male and female traditional healers.

Table 5.36: Traditional treatments given for each mental disorder by MALE traditional healers

Treatment	Mental Disorder												All	
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	1	16.7	2	22.2	1	10.0	1	7.7	0	0.0	0	0.0	5	10.9
Manual	1	16.7	1	11.1	0	0.0	2	15.4	1	33.3	4	80.0	9	19.6
Psycho-spiritual	1	16.7	4	44.4	7	70.0	7	53.8	1	33.3	1	20.0	21	45.7
Herbal and manual	1	16.7	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	2.2
Psycho-spiritual and herbal	0	0.0	1	11.1	1	10.0	3	23.1	0	0.0	0	0.0	5	10.9
Psycho-spiritual and manual	0	0.0	0	0.0	1	10.0	0	0.0	1	33.3	0	0.0	2	4.3
No treatment given	2	33.3	1	11.1	0	0.0	0	0.0	0	0.0	0	0.0	3	6.5
Total	6	100.0	9	100.0	10	100.0	13	100.0	3	100.0	5	100.0	46	100.0
% Disorders treated	13.0		19.6		21.8		28.2		6.6		10.8			

Table 5.37: Traditional treatments given for each mental disorder by FEMALE traditional healers

Treatment	Mental Disorder													
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation		All	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	0	0.0	0	0.0	1	25.0	0	0.0	0	0.0	0	0.0	1	3.6
Manual	2	66.7	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0	3	10.7
Psycho-spiritual	1	33.3	1	25.0	2	50.0	10	90.9	1	50.0	2	50.0	17	60.7
Psycho-spiritual and herbal	0	0.0	2	50.0	0	0.0	1	9.1	0	0.0	0	0.0	3	10.7
Psycho-spiritual and manual	0	0.0	0	0.0	1	25.0	0	0.0	1	50.0	2	50.0	4	14.3
Total	3	100.0	4	100.0	4	100.0	11	100.0	2	100.0	4	100.0	28	100.0
% Disorders treated	10.8		14.3		14.3		39.2		7.1		14.3			

Figure 5.XXVII: Mental disorders treated by traditional healers' gender-wise

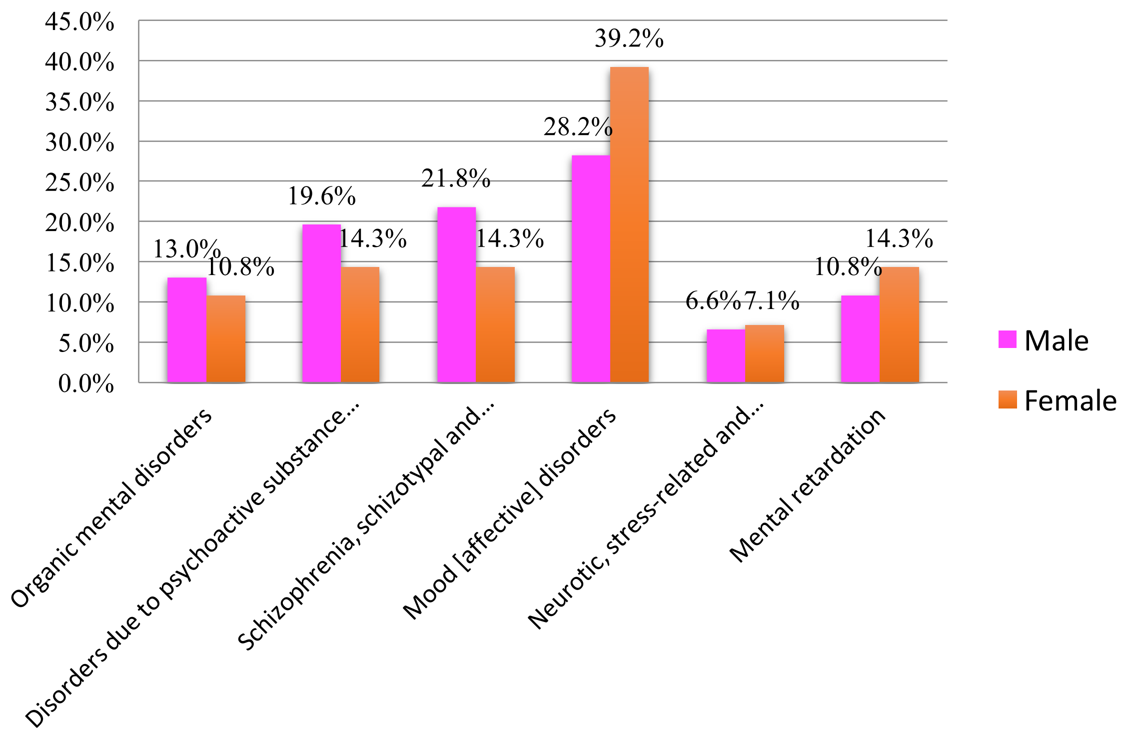
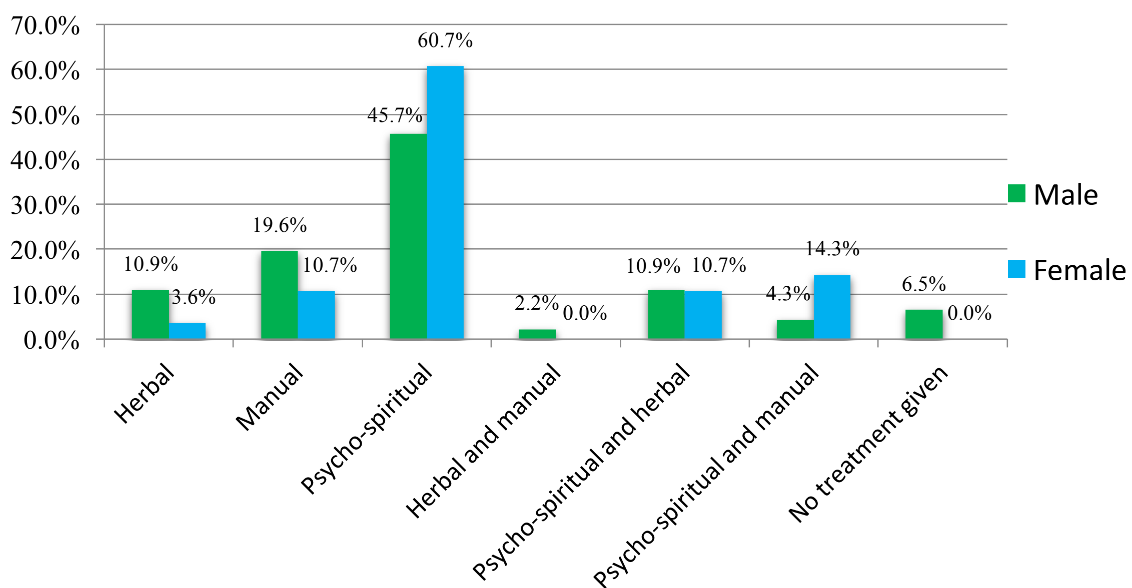


Figure 5.XXVIII: Treatment given by traditional healers' gender-wise



The most common mental disorder treated by both male and female traditional healers are mood (affective) disorders (28.2%, 39.2%) as shown in Tables 5.36 and Table 3.7. This is followed by schizophrenia and related disorders (21.8%, 14.3%). Both has also treated quite a number of disorders due to psychoactive substance use (19.6%, 14.3%). Only a small proportion of neurotic, stress related and somatoform disorders were treated by both male and female traditional healers (6.6%, 7.1%). In terms of treatment given, psycho-spiritual form of intervention is the most commonly used treatment by both the male and female traditional healers (60.9%, 85.7%). In comparison, only a small percentage of manual (19.6%, 10.7%) and herbal (10.9%, 3.6%) treatments were used by both male and female traditional healers. Analysis and comparison do not reveal any statistical significance between male and female traditional healers except for female traditional healers who seem to use significantly more psycho-spiritual therapy ($P<0.05$).

The following two tables -Table 5.38 and Table 5.39 indicate mental disorders and treatment given by traditional healers in the age group of 60 years and below and traditional healers in the age group of more than 60 years.

Table 5.38: Traditional treatments given for each mental disorder by traditional healers in the age group of 60 years and below

Treatment	Mental Disorder												All	
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	1	20.0	2	33.3	1	10.0	1	9.1	0	0.0	0	0.0	5	13.5
Manual	2	40.0	1	16.7	0	0.0	0	0.0	0	0.0	1	33.3	4	10.8
Psycho-spiritual	1	20.0	2	33.3	7	70.0	8	72.7	0	0.0	1	33.3	19	51.4
Herbal and manual	1	20.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	2.7
Psycho-spiritual and herbal	0	0.0	1	16.7	0	0.0	2	18.2	0	0.0	0	0.0	3	8.1
Psycho-spiritual and manual	0	0.0	0	0.0	2	20.0	0	0.0	2	100.0	1	33.3	5	13.5
Total	5	100.0	6	100.0	10	100.0	11	100.0	2	100.0	3	100.0	37	100.0
% Disorders treated	13.5		16.2		27.0		29.8		5.4		8.1			

Table 5.39: Traditional treatments given for each mental disorder by traditional healers in the age group of more than 60 years

Treatment	Mental Disorder												All	
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	0	0.0	0	0.0	1	25.0	0	0.0	0	0.0	0	0.0	1	2.7
Manual	1	25.0	1	14.3	0	0.0	2	15.4	1	33.3	3	50.0	8	21.6
Psycho-spiritual	1	25.0	3	42.9	2	50.0	9	69.2	2	66.7	2	33.3	19	51.4
Psycho-spiritual and herbal	0	0.0	2	28.6	1	25.0	2	15.4	0	0.0	0	0.0	5	13.5
Psycho-spiritual and manual	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	16.7	1	2.7
No treatment given	2	50.0	1	14.3	0	0.0	0	0.0	0	0.0	0	0.0	3	8.1
Total	4	100.0	7	100.0	4	100.0	13	100.0	3	100.0	6	100.0	37	100.0
% Disorders treated	10.8		18.9		10.8		35.1		8.1		16.2			

Figure 5.XXIX: Mental disorders treated by traditional healers age-wise

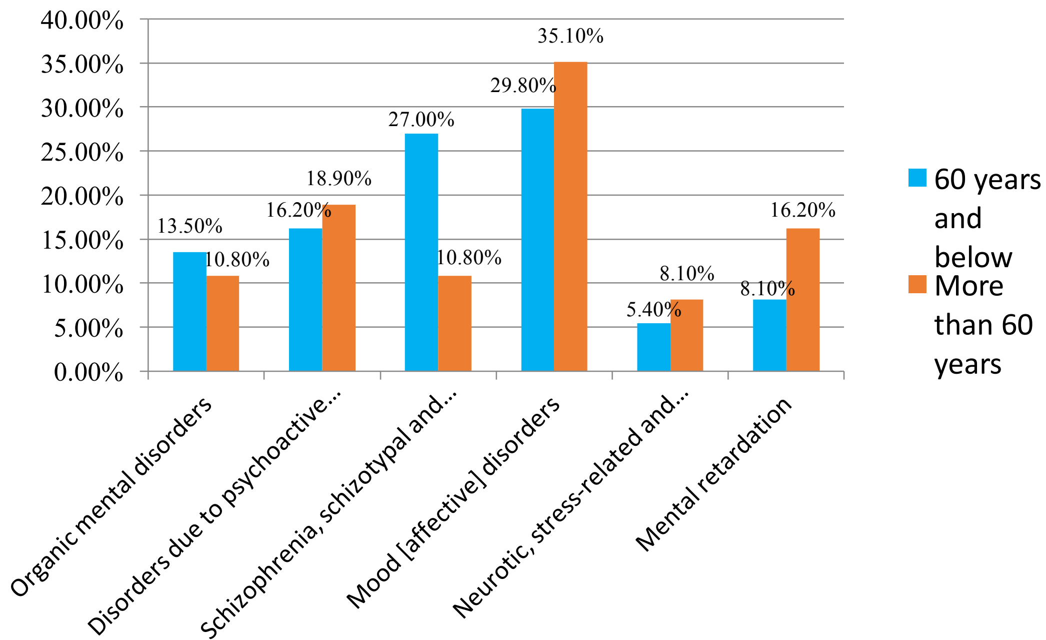
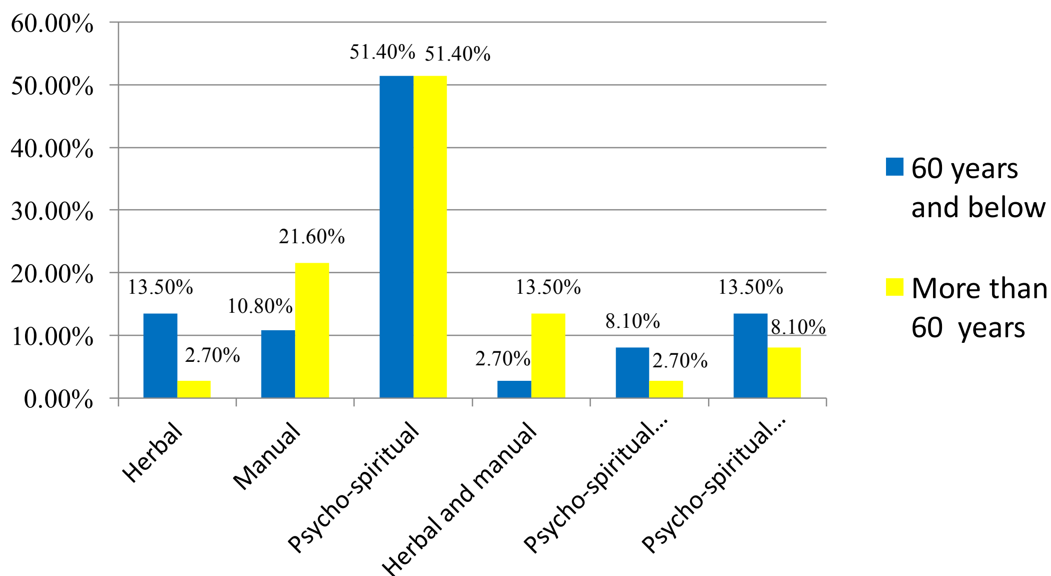


Figure 5.XXX: Treatment given by traditional healers age-wise



The most common mental disorder treated by both traditional healers *in the age group of 60 years and below and traditional healers in the age group of more than 60 years* are mood (affective) disorders (29.8%, 35.1%) as shown in Tables 5.38 and Table 5.39. This is followed by 27.0 % of schizophrenia and related disorders treated by traditional healers in the age group of 60 years and below as compared to only 10.8% of it treated by traditional healers in the age group of more than 60 years. Both in the age group of 60 years and below and in the age group of more than 60 years also quite a number of of disorders due to psychoactive substance use (18.9 %, 16.2%).

In terms of treatment given, psycho-spiritual form of intervention is the most commonly used treatment by both the male and female traditional healers (73.0%, 67.6%).
Age-wise differences were not statistically significant.

The following two tables -Table 5.40 and Table 5.41 indicate mental disorders and treatment given by Ao traditional healers and traditional healers from other tribes.

Table 5.40: Traditional treatments given for each mental disorder given by traditional healers belonging to AO tribe

Treatment	Mental Disorder													
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation		All	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	0	0.0	1	9.1	2	18.2	0	0.0	0	0.0	0	0.0	3	5.8
Manual	3	42.9	2	18.2	0	0.0	2	14.3	1	33.3	4	66.7	12	23.1
Psycho-spiritual	2	28.6	4	36.4	6	54.5	8	57.1	1	33.3	2	33.3	23	44.2
Psycho-spiritual and herbal	0	0.0	3	27.3	1	9.1	4	28.6	0	0.0	0	0.0	8	15.4
Psycho-spiritual and manual	0	0.0	0	0.0	2	18.2	0	0.0	1	33.3	0	0.0	3	5.8
No treatment given	2	28.6	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0	3	5.8
Total	7	100.0	11	100.0	11	100.0	14	100.0	3	100.0	6	100.0	52	100.0
% Disorders treated	13.4		21.2		21.2		26.9		5.7		11.6			

Table 5.41: Traditional treatments given for each mental disorder given by traditional healers belonging to OTHER tribes

Treatment	Mental Disorder												All	
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	1	50.0	1	50.0	0	0.0	1	10.0	0	0.0	0	0.0	3	13.6
Psycho-spiritual	0	0.0	1	50.0	3	100.0	9	90.0	1	50.0	1	33.3	15	68.2
Psycho-spiritual and herbal	1	50.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	4.5
Psycho-spiritual and manual	0	0.0	0	0.0	0	0.0	0	0.0	1	50.0	2	66.7	3	13.6
Total	2	100.0	2	100.0	3	100.0	10	100.0	2	100.0	3	100.0	22	100.0
% Disorders treated	9.1		9.1		13.7		45.4		9.1		13.6			

Figure 5.XXXI: Mental disorders treated by traditional healers tribe-wise

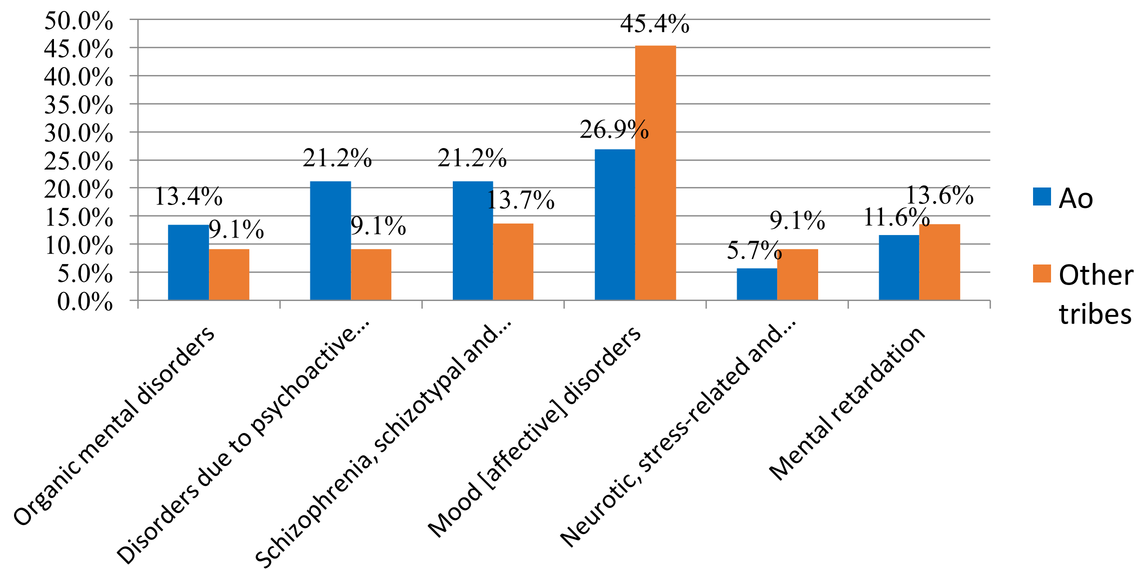
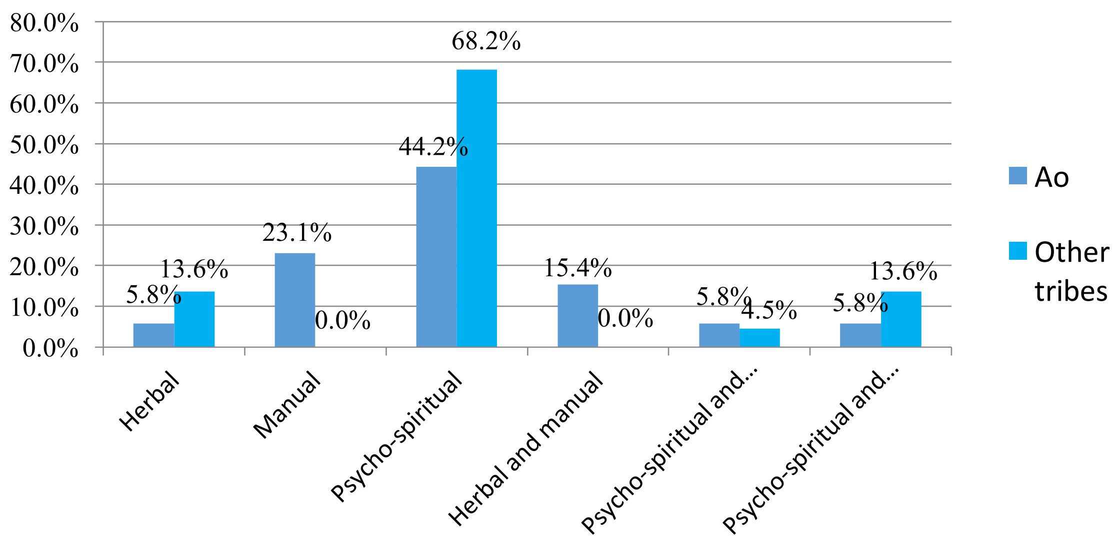


Figure 5.XXXII: Treatment given by traditional healers tribe-wise



The most common mental disorder treated by both Ao traditional healers and traditional healers from other tribes are mood (affective) disorders (45.4%, 26.9%) as shown in Tables 5.40 and Table 5.41. This is followed by schizophrenia and related disorders (21.2%, 13.7%) and disorders due to psychoactive substance use (21.2%, 9.1%). Treatment wise, psycho-spiritual is the most common intervention used by both the Ao traditional healers and traditional healers from other tribes. Although it appears that traditional healers from more tribes use more of psycho-spiritual treatment, the difference was not statistically significant, mainly due to the small sample size.

Of the 74 cases, 51.4% was reported to have been healed as shown in Table 5.42.

Table 5.42: Effectiveness of overall treatment given by traditional healers

Effectiveness	No.	%
Cant be treated	14	18.9
Effective	38	51.4
Effective only for some	20	27.0
Slight improvement	2	2.7
Total	74	100.0

However, the traditional healers also reported that the treatment given was effective only for some people (27.0%), 18.9% of the cases could not be treated and only a small percentage (2.7%) showed a slight improvement in the condition.

The effectiveness of each traditional treatment is summarized in Table 5.43.

Table 5.43: Effectiveness of each traditional treatment given

Effectiveness	Treatment														All	
	Herbal (H)		Manual (M)		Psycho-spiritual (PS)		H & M		PS & H		PS & M		No treatment given			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Cant be treated	0	0.0	4	33.3	5	13.1	0	0.0	0	0.0	2	33.3	3	100.0	14	100.0
Effective	2	33.3	5	41.7	20	52.7	1	100.0	6	75.0	4	66.6	0	0.0	38	100.0
Effective only for some	3	50.0	2	16.7	13	34.2	0	0.0	2	25.0	0	0.0	0	0.0	20	100.0
Slight improvement	1	16.7	1	8.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	100.0
Total	6	100.0	12	100.0	38	100.0	1	100.0	8	100.0	6	100.0	3	100.0	74	100.0

In terms of effectiveness of each treatment given by the traditional healers, majority of the psycho-spiritual and manual treatments was said to be effective. On the other hand, a large proportion of the herbal treatment was said to be effective only for some people. Few mental disorders treated with manual and psycho-spiritual treatments were, however, described as being incurable.

More than half of the patients treated by the traditional healers were adolescents and young adults as displayed in Table 5.44.

Table 5.44: The age of patients treated by traditional healers

Age of patients (yrs)	No.	%
< 18	21	28.4
19-30	24	32.4
31-50	25	33.8
> 51	4	5.4
Total	74	100.0

The remaining 40% were adults and elderly.

More than half of the patients with mental health problems treated by the traditional healers were females as shown in Table 5.45

Table 5.45: Gender of patients treated by traditional healers

Gender of patients	No.	%
Female	38	51.3
Male	36	48.7
Total	74	100.0

Of the 74 cases, 59.4% of it were not referred by the traditional healers as shown in Table 5.46.

Table 5.46: Referral of mental disorders by traditional healers

Referral	No.	%
Allopathy	25	33.8
Allopathy & another traditional healer	2	2.7

Another traditional healer	2	2.7
Prayer centre	1	1.4
Did not refer	44	59.4
Total	74	100.0

33.8% of the cases however were referred to an allopathic practitioner. The remaining few cases were referred to both an allopathic doctor and a traditional healer, another healer and Christian prayer centre.

5.11.6 Analysis of referral by traditional healer with mental disorders

Further analysis of referral by traditional healers with mental disorders reveals that majority of the disorders due to psychoactive substance use (84.7%) was referred to allopathic doctors as presented in Table 5.47. Almost half of the organic disorders and mental retardation cases were also referred to allopathic doctors. Majority of the schizophrenia and related disorders, mood disorders and neurotic, stress related and somatoform disorders were not referred.

Table 5.47: Analysis of referral by mental disorders

Treatment	Mental Disorder													
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation		All	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Allopathy	4	44.4	11	84.7	2	14.3	4	16.7	0	0.0	4	44.4	25	33.7
Allopathy & another traditional healer	0	0.0	0	0.0	0	0.0	1	4.1	1	20.0	0	0.0	2	2.8
Another traditional healer	0	0.0	0	0.0	0	0.0	2	8.3	0	0.0	0	0.0	2	2.8
Prayer center	0	0.0	0	0.0	1	7.1	0	0.0	0	0.0	0	0.0	1	1.3
Did not refer	5	55.6	2	15.3	11	78.6	17	70.9	4	80.0	5	55.6	44	59.4
Total	9	100.0	13	100.0	14	100.0	24	100.0	5	100.0	9	100.0	74	100.0

The remaining cases were referred to either allopathic doctors, another traditional healer or a prayer centre.

Of the 30 traditional healers, only three stated that they maintained a record of their patients. The rest asserted that it would be impossible to keep track of the number of people who seek their help.

On enquiring whether the traditional healers normally charge any fee from the patients, 28 of them stated that they don't but that they accept whatever people offer as a token of gratitude.

Of the 30 traditional healers, 20 stated that they follow up on their patients at home and eight of them follow up both at home and the patient's home depending on the severity of the illness as presented in Table 5.48

Table 5.48: Follow up on patients by traditional healers

Follow Up	No.	%
At clinic	2	6.7
At home	20	66.7
Both home and patient's home	8	26.7
Total	30	100.0

Only two traditional healers stated that they do a follow up in their own clinic.

5.2.2.2 Knowledge and attitude:

On enquiring what was the most common mental disorder seen in the area, majority of the traditional healers felt that it was depression as presented in Table 5.49

Table 5.49: Traditional healers' view of common mental disorders in the area

Common mental disorders in the area	No.	%
Substance use	4	13.3
Depression	19	63.3
Psychotic disorders	5	16.7
Stress & anxiety	2	6.7
Total	30	100.0

Five of them mentioned that psychotic disorders are also fairly common as well as substance use. Two traditional healers said that stress and anxiety were common in the area.

Of the 30 traditional healers, 29 of the traditional healers were of the opinion that traditional methods are popular for mental healthcare.

On questioning whether traditional methods are effective in treating mental health problems, almost all asserted that it was. Only two healers felt that it was effective for some mental disorders and not all disorders.

Majority of the traditional healers were also of the opinion that both allopathy and traditional methods are equally important in their own ways and that one isn't better than the

other. Of interest is one traditional healer who stated that while one prescribes allopathic medication, the other works on spiritual healing and that both are essential. Another stated that allopathy might work for some while traditional healing might work better for others depending on the faith of the person. On the other hand, five were of the view that traditional methods are better than allopathy with One healer asserting that with traditional methods there were no side effects.

On enquiring whether they require any professional help to improve their practice, all the 30 traditional healers responded that they don't require any such assistance.

Majority of the traditional healers were of the opinion that traditional medicine will be more popular in the future. Only one healer felt that it will become weaker.

Of the 30 traditional healers, only 12 was of the opinion that traditional methods and modern methods of treating mental disorders can be linked as shown in Table 5.50

Table 5.50: Traditional healers' view on whether traditional methods (TM) and modern methods for mental health can be linked

Can TM and modern methods for mental health be linked	No.	%
No	18	60.0
Yes	12	40.00
Total	30	100.0

The remaining healers strongly stated that collaboration was not possible.

Table 5.51 summarizes the reasons given by the traditional healers for possibility of collaboration between traditional methods and allopathy.

Table 5.51: Reasons for possibility of collaboration between TM and allopathy

Reasons for possibility of collaboration between TM and allopathy	No.	%
Diagnosis	3	30.0
If accepted by doctors	4	20.0
Spiritual & physical healing	3	20.0
Referral	2	10.0
Total	12	100.0

The reasons given by the traditional healers for possibility of collaboration between traditional methods and allopathy are helping in diagnosing the problem when the other fails to do so, if allopathic doctors respects and accepts traditional healing practices, referring patients to one another and if a mutual understanding can be arrived at wherein the medical doctors work on healing the body through medication and the traditional healers work on providing spiritual healing.

The reasons given by the traditional healers for non- possibility of collaboration between traditional methods and allopathy are presented in Table 5.52

Table 5.52: Reasons for non-possibility of collaboration between TM and allopathy

Reasons for non-possibility of collaboration between TM and allopathy	No.	%
Constant friction; egoistic doctors	2	10.0
Contradictory views of illness	1	5.0
Different methods of treatment	8	40.0
Disrespected by doctors & ignorant of TM	2	10.0
TH not accepted by doctors	4	15.0
TH serve humanity, not for profitability	1	5.0

Total	18	100.0

Majority of the traditional healers who felt that collaboration between traditional methods and allopathy is not possible stated that traditional healers and allopathic doctors use completely different methods of treatment- one practises after years of study and the other simply as a divine gift from God. Some stated that traditional healers and allopathic doctors have contradictory views of illness leading to constant friction and disagreements, some described doctors as proud and egoistic, some said that they felt disrespected by doctors who were ignorant of traditional methods of healing and looked down upon traditional healers, traditional methods not accepted by doctors. One healer asserted that traditional healers devote their entire lives to serving humanity and not for profitability in contrast to allopathic doctors who treat people for monetary gain.

5.2.2.3 Analysis of age of traditional healers with specific variables

Of the 74 cases, both age groups of 60 years and below and more than 60 years of age most commonly treat mood disorders as summarized in Table 5.53

Table 5.53: Analysis of age of the traditional healer with mental disorders treated

Mental disorders treated	Age of traditional healer				Total	
	60 yearsand below		More than60 years			
	No.	%	No.	%	No.	%
Organic mental disorders	3	12.5	6	12.0	9	12.2
Disorders due to psychoactive substance use	5	20.8	8	16.0	13	17.6
Schizophrenia, schizotypal and delusional disorders	6	25.0	8	16.0	14	18.9
Mood [affective] disorders	7	29.2	17	34.0	24	32.4

Neurotic, stress-related and somatoform disorders	1	4.2	4	8.0	5	6.8
Mental retardation	2	8.3	7	14.0	9	12.2
Total	24	100.0	50	100.0	74	100.0

Both age groups also treateda significant number of schizophrenia and related disorders and disorders due to psychoactive substance use.

More than half of the treatment given is psycho-spiritual for both the age groups, administered either singly or in combination with other methods of traditional treatment as shown in Table 5.54

Table 5.54: Analysis of age of the traditional healer with treatment given

Treatment	Age of traditional healer				Total	
	60 years and below		More than 60 years			
	No.	%	No.	%	No.	%
Herbal	5	20.8	1	2.0	6	8.1
Manual	1	4.2	11	22.0	12	16.2
Psycho-spiritual	12	50.0	26	52.0	38	51.4
Herbal & manual	1	4.2	0	0.0	1	1.4
Psycho-spiritual & herbal	3	12.5	5	10.0	8	10.8
Psycho-spiritual & manual	2	8.3	4	8.0	6	8.1
No treatment given	0	0.0	3	6.0	3	4.1
Total	24	100.0	50	100.0	74	100.0

However, those in the age group 60 years and below also seem to use more of herbal treatment (20.8%)as compared to manual form of treatment (4.2%). In contrast, those in the

age group ofmore than 60 yearsof age use more of manual techniques (22.0%) as compared to herbal treatment (2.0%).

Those in the age group 60 years and below have treated mostly young adults between the age group of 19 to 30 years of age (50.0%) as shown in Table 5.55.

Table5.55: Analysis of age of the traditional healer with age of patients

Age of patients	Age of traditional healer				Total	
	60 years and below		More than 60 years			
	No.	%	No.	%	No.	%
< 18	6	25.0	11	22.0	17	22.9
19-30	12	50.0	15	30.0	27	36.4
31-50	5	20.8	21	42.0	26	35.1
>51	1	4.2	3	6.0	4	5.4
Total	24	100.0	5 0	100.0	74	100.0

On the other hand, those in the age group 60 years and above have treated mostly middle aged patients between the age group of 31 to 50 years of age (42%).

Majority of the cases were not referred by both the age groups as displayed in Table 5.56.

Table 5.56: Analysis of age of the traditional healer with referral of patients

Referral	Age of traditional healer				Total	
	60 years and below		More than 60 years			
	No.	%	No.	%	No.	%
Allopathy	8	33.3	17	34.0	25	33.7
Allopathy &another traditional healer	0	0.0	2	4.0	2	2.8

Another traditional healer	1	4.1	1	2.0	2	2.8
Prayer centre	1	4.1	0	0.0	1	1.3
Did not refer	14	58.3	30	60.0	44	59.4
Total	24	100.0	50	100.0	74	100.0

The remaining cases were referred mostly to an allopathic doctor by both the age groups.

Both age groups do not maintain any record of patients. Only three traditional healers belonging to the age group of 60 years and below mentioned that they do.

No fees are charged by either of the age groups.

Almost all of the traditional healers of both the age groups do a follow up on their patients, mostly in their own homes and some in the patient's house.

Both age groups were of the opinion that traditional methods are popular and effective for mental health problems.

Majority of the traditional healers of both the age groups also mentioned thatneither allopathy nor traditional methods are better than the other and that both are equally important.

Both age groups mentioned that they don't require any professional help to improve their practice.

Regarding the future prospects of traditional healing for mental health, traditional healers of both age groups opine that it will grow more popular.

More number of traditional healers in the age group of 60 years and below were of the view that traditional methods and modern methods for mental health cannot be linked as presented in Table 5.57.

Table 5.57: Analysis of age of traditional healers with their opinion on whether traditional methods (TM) and modern methods for mental health can be linked

Can TM and modern methods for mental health be linked	Age of traditional healer				Total	
	60 years and below		More than 60 years			
	No.	%	No.	%	No.	%
Yes	5	33.3	7	46.7	12	40.0
No	10	66.7	8	53.3	18	60.0
Total	15	100.0	15	100.0	30	100.0

On the other hand, almost half of those in the age group of more than 60 years were of the opinion that collaboration between the two is possible.

5.2.2.4 Analysis of gender of traditional healers with specific variables

The most common mental disorders treated by both male and female traditional healers are mood disorders (28.3%, 39.3%) as presented in Table 5.58

Table 5.58: Analysis of gender of the traditional healer with mental disorders treated

Mental disorders treated	Gender of traditional healer				Total	
	Male		Female			
	No.	%	No.	%	No.	%
Organic mental disorders	6	13.0	3	10.7	9	12.2
Disorders due to psychoactive substance use	9	19.6	4	14.3	13	17.6
Schizophrenia, schizotypal and delusional disorders	10	21.7	4	14.3	14	18.9
Mood [affective] disorders	13	28.3	11	39.3	24	32.4
Neurotic, stress-related and somatoform disorders	3	6.5	2	7.1	5	6.8

Mental retardation	5	10.9	4	14.3	9	12.2
Total	46	100.0	28	100.0	74	100.0

Male traditional healers have also treated quite a number of schizophrenia and related disorders (21.7%) and disorders due to psychoactive substance use (19.6%). Female traditional healers, on the other hand, have treated a small proportion of mental retardation, schizophrenia and related disorders and disorders due to psychoactive substance use.

Both male and female traditional healers use psycho-spiritual form of traditional healing (45.7%,60.7%) as the most common intervention for mental disorders as shown in Table 5.59.

Table 5.59: Analysis of gender of traditional healer with treatment given

Treatment	Gender of traditional healer				Total	
	Male		Female			
	No.	%	No.	%	No.	%
Herbal	5	10.9	1	3.6	6	8.1
Manual	9	19.6	3	10.7	12	16.2
Psycho-spiritual	21	45.7	17	60.7	38	51.4
Herbal & manual	1	2.2	0	0.0	1	1.4
Psycho-spiritual & herbal	5	10.9	3	10.7	8	10.8
Psycho-spiritual & manual	2	4.3	4	14.3	6	8.1
No treatment given	3	6.5	0	0.0	3	4.1
Total	46	100.0	28	100.0	74	100.0

A small proportion of manual treatment was also used by both male and female traditional healers (19.6%, 10.7%). In contrast, only 10.9% and 3.6% of herbal treatment was used by male and female traditional healers respectively.

Both male and female traditional healers did not refer more than half of the cases of mental disorders as presented in Table 5.60.

Table 5.60: Analysis of gender of the traditional healer with referral of patients

Referral	Gender of traditional healer				Total	
	Male		Female			
	No.	%	No.	%	No.	%
Allopathy	14	30.4	11	39.2	25	33.7
Allopathy &another traditional healer	2	4.3	0	0.0	2	2.8
Another traditional healer	0	0.0	2	7.1	2	2.8
Prayer centre	0	0.0	1	3.6	1	1.3
Did not refer	30	65.2	14	50.0	44	59.4
Total	46	100.0	28	100.0	74	100.0

Most of the remaining mental disorders were mostly referred to an allopathic doctor by both the male and female traditional healers.

Both male and female traditional healers have treated mostly middle aged patients as displayed in Table 5.61.

Table 5.61: Analysis of gender of the traditional healer with age of patients

Age of patients	Gender of traditional healer		Total
	Male	Female	
	No. %	No. %	No. %
< 18	10 21.8	4 14.2	14 18.9
19-30	9 19.6	7 25.0	16 21.7
31-50	24 52.1	15 53.6	39 52.7
>51	3 6.5	2 7.1	5 6.7
Total	46 100.0	28 100.0	74 100.0

Both have also treated quite a number of adolescents and young adults.

Majority of the cases were not referred by both male and female traditional healers as displayed in Table 5.62.

Table 5.62: Analysis of gender of the traditional healer with referral of patients

Referral	Gender of traditional healer		Total
	Male	Female	
	No. %	No. %	No. %
Allopathy	16 34.8	11 39.2	25 33.7
Allopathy &another traditional healer	2 4.3	0 0.0	2 2.8
Another traditional healer	0 0.0	2 7.1	2 2.8
Prayer centre	0 0.0	1 3.6	1 1.3
Did not refer	28 60.9	14 50.0	44 59.4
Total	46 100.0	28 100.0	74 100.0

The remaining cases were referred mostly to an allopathic doctor by both.

Of the 30 traditional healers, only one female and two male healers maintain a record of their patients.

No fees are charged by both male and female traditional healers, except for two male healers.

Almost all of the traditional healers- both male and female do a follow up on their patients, mostly in their own homes and some in the patient's house. Only two male traditional healers do a follow up in their own clinic.

Both male and female traditional healers were of the opinion that traditional methods are popular and effective for mental health problems.

Majority of the traditional healers- both males and females also stated that allopathy and traditional methods are equally important, except for three male and two female traditional healers who stressed that the latter is better compared to allopathy.

Both male and female traditional healers were of the opinion that they don't require any kind of professional help to improve their practice.

With regard to the future prospects of traditional healing for mental health, both male and female traditional healers mentioned that it will grow more popular.

Majority of the traditional healers of both gender was of the view that traditional methods and modern methods for mental health cannot be linked as presented in Table 5.62

Table 5.62: Analysis of gender of traditional healers with their opinion on whether traditional methods (TM) and modern methods formental health can be linked

Can TM and modern methods for mental health be linked	Gender of traditional healer		Total
	Male	Female	
	No. %	No. %	No. %
Yes	7 41.2	5 38.5	12 40.0
No	10 58.8	8 61.5	18 60.0
Total	17 100.0	13 100.0	30 100.0

5.2.2.5 Analysis of tribe of traditional healers with specific variables

The most common mental disorders treated by traditional healers from both Ao tribe and other tribes are mood disorders (26.9%, 45.5%) as presented in Table 5.63.

Table 5.63: Analysis of tribe of the traditional healer with mental disorders

Mental disorders treated	Tribe of traditional healer		Total
	Ao	Other tribe	
	No. %	No. %	No. %
Organic mental disorders	7 13.5	2 9.1	9 12.2
Disorders due to psychoactive substance use	11 21.2	2 9.1	13 17.
Schizophrenia, schizotypal and delusional disorders	11 21.2	3 13.6	14 18.9
Mood [affective] disorders	14 26.9	10 45.5	24 32.4
Neurotic, stress-related and somatoform disorders	3 5.8	2 9.1	5 6.8
Mental retardation	6 11.5	3 13.6	9 12.2
Total	52 100.0	22 100.0	74 100.0

Ao traditional healers have also treated quite a number of schizophrenia and related disorders (21.7%) and disorders due to psychoactive substance use (19.6%). Traditional healers from other tribes, on the other hand, have treated a small proportion of mental retardation, schizophrenia and related disorders.

Traditional healers belonging to both Ao tribe and other tribes use psycho-spiritual form of traditional healing (44.2%, 68.2%) as the most common intervention for mental disorders as shown in Table 5.64.

Table 5.64: Analysis of tribe of the traditional healer with treatment given

Treatment	Tribe of traditional healer				Total	
	Ao		Other tribe			
	No.	%	No.	%	No.	%
Herbal	3	5.8	3	13.6	6	8.1
Manual	12	23.1	0	0.0	12	16.2
Psycho-spiritual	23	44.2	15	68.2	38	51.4
Herbal & manual	0	0.0	1	4.5	1	1.4
Psycho-spiritual & herbal	8	15.4	0	0.0	8	10.8
Psycho-spiritual & manual	3	5.8	3	13.6	6	8.1
No treatment given	3	5.8	0	0.0	3	4.1
Total	52	100.0	22	100.0	74	100.0

Traditional healers from both Ao and other tribes have treated mostly middle aged patients as displayed in Table 5.65.

Table 5.65: Analysis of tribe of the traditional healer with age of patients

Age of patients	Tribe of traditional healer		Total
	Ao	Other tribe	
	No. %	No. %	No. %
< 18	11 21.2	3 13.7	14 18.9
19-30	1121.2	5 22.7	26 35.1
31-50	21 40.3	11 50.0	22 29.8
>51	9 17.3	3 13.6	12 16.2
Total	52 100.0	22 100.0	74 100.0

Both have also treated quite a number of adolescents and young adults.

Majority of the cases were not referred by both Ao traditional healers as well as those belonging to other tribes as displayed in Table 5.66.

Table 5.66: Analysis of tribe of the traditional healer with referral of patients

Referral	Tribe of traditional healer		Total
	Ao	Other tribe	
	No. %	No. %	No. %
Allopathy	19 36.5	8 36.3	27 36.4
Allopathy &another traditional healer	0 0.0	2 9.1	2 2.7
Another traditional healer	0 0.0	2 9.1	2 2.7
Prayer centre	1 2.0	0 0.0	1 1.4
Did not refer	32 61.5	10 45.5	42 56.8
Total	52 100.0	22 100.0	74 100.0

The remaining cases were referred mostly to an allopathic doctor by both.

A small proportion of manual treatment was also used by Ao traditional healers. Whereas, it was used only in combination with psycho-spiritual treatment by the traditional healers from other tribes. Herbal treatment was mostly used in combination with psycho-spiritual treatment by Ao traditional healers as compared to healers from other tribes who used in singly.

Of the 30 traditional healers, only two of them belonging to Ao tribe and one from another tribe maintain a record of their patients.

No fees are charged by both male and female traditional healers, except for one Ao traditional healer and one from another tribe.

Almost all of the traditional healers- both from Ao tribe and other tribes, do a follow up on their patients, mostly in their own homes and some in the patient's house.

Almost all the traditional healers – belonging to both Ao and other tribes, were of the opinion that traditional methods are popular and effective for mental health problems.

Majority of the traditional healers- both males and females also stated that allopathy and traditional methods are equally important, except for four Ao traditional healers and onefrom other tribal background who stressed that the latter is better compared to the former.

All the traditional healers from both Ao tribe and other tribe were of the opinion that they don't require any kind of professional help to improve their practice.

With regard to the future prospects of traditional healing for mental health, almost all the traditional healers from different tribes mentioned that it will grow more popular.

Majority of the traditional healers from both A tribe and other tribe was of the view that traditional methods and modern methods for mental health cannot be linked as presented in Table 5.67.

Table 5.67: Analysis of age of traditional healers with their opinion on whether traditional methods (TM) and modern methods for mental health can be linked

Can TM and modern methods for mental health be linked	Tribe of traditional healer		Total
	Ao	Other tribe	
	No. %	No. %	No. %
Yes	9 47.4	3 27.3	12 40.0
No	10 52.6	8 72.7	18 60.0
Total	19 100.0	11 100.0	30 100.0

5.2.2.6 Analysis of treatment given for mental disorders by area:

Analysis of treatment given for mental disorders are presented by area - first in Chumukedima as shown in Table 5.68, second in Dimapur Sardar as shown in Table 5.69, third in Kiphire as shown in Table 5.70 and lastly in Mokokchung as shown in Table 5.71.

In Chumukedima, 30.0% of the treatment given was manual in nature mostly for the treatment of mental retardation and mood disorder as displayed in Table 5.68. Psycho-spiritual intervention was mostly used in combination with herbal and manual modalities for the treatment of schizophrenia, neurotic and stress related disorders, disorder due to psychoactive substance use and mood disorder.

Table 5.68: Traditional treatments given for each mental disorder in Chumukedima

Treatment	Mental Disorder												All	
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	0	0.00%	1	50.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	10.0%
Manual	0	0.0%	0	0.0%	0	0.0%	1	50.0%	0	0.0%	2	100.0%	3	30.0%
Psycho-spiritual	0	0.0%	0	0.0%	1	50.0%	0	0.0%	0	0.0%	0	0.0%	1	10.0%
Herbal and manual	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	10.0%
Psycho-spiritual and herbal	0	0.0%	1	50.0%	0	0.0%	1	50.0%	0	0.0%	0	0.0%	2	20.0%
Psycho-spiritual and manual	0	0.0%	0	0.0%	1	50.0%	0	0.0%	1	100.0%	0	0.0%	2	20.0%
Total	1	100.0%	2	100.0%	2	100.0%	2	100.0%	1	100.0%	2	100.0%	10	100.0%

Herbal treatment was used for treating one case of disorder due to psychoactive substance use. A combination of herbal and manual treatments were also used for one case of organic mental disorder.

Table 5.69: Traditional treatments given for each mental disorder in Dimapur Sardar

Treatment	Mental Disorder												All	
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	1	25.0%	1	33.3%	0	0.0%	1	25.0%	0	0.0%	0	0.0%	3	17.6%
Manual	2	50.0%	1	33.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	17.6%
Psycho-spiritual	1	25.0%	1	33.3%	3	60.0%	2	50.0%	0	0.0%	1	100.0%	8	47.1%
Psycho-spiritual and herbal	0	0.0%	0	0.0%	1	20.0%	1	25.0%	0	0.0%	0	0.0%	2	11.8%
Psycho-spiritual and manual	0	0.0%	0	0.0%	1	20.0%	0	0.0%	0	0.0%	0	0.0%	1	5.9%
Total	4	100.0%	3	100.0%	5	100.0%	4	100.0%	0	100.0%	1	100.0%	17	100.0%

In Dimapur Sardar, psycho-spiritual form of intervention was mostly used (47.1%) for treating mostly schizophrenia and related disorders and also other disorders such as mood disorder, organic disorder, disorders due to psychoactive substance use and mental retardation. A small proportion of herbal treatment (17.6%) was used by the traditional healers for organic mental disorder, disorder due to psychoactive substance use and mood disorder. Manual treatment, also only a small proportion (17.6%) was used mainly for organic disorders.

Table 5.70: Traditional treatments given for each mental disorder in Kiphire

Treatment	Mental Disorder												All	
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Psycho-spiritual	0	0.0%	1	100.0%	1	100.0%	8	100.0%	1	100.0%	1	33.3%	12	85.7%
Psycho-spiritual and manual	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	66.7%	2	14.3%
Total	0	100.0%	1	100.0%	1	100.0%	8	100.0%	1	100.0%	3	100.0%	14	100.0%

In Kiphire, majority of the mental disorders were treated using psycho-spiritual form of intervention either singularly or in combination with manual form of treatment. Mental disorders treated were mostly mood disorders and the rest includes disorder due to psychoactive substance use, schizophrenia, neurotic and stress related disorder and mental retardation. It was also used in combination with manual therapy for the treatment of mental retardation.

Table 5.71: Traditional treatments given for each mental disorder in Mokokchung

Treatment	Mental Disorder												All	
	Organic mental disorders		Disorders due to psychoactive substance use		Schizophrenia, schizotypal and delusional disorders		Mood [affective] disorders		Neurotic, stress-related and somatoform disorders		Mental retardation			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Herbal	0	0.0%	0	0.0%	2	33.3%	0	0.0%	0	0.0%	0	0.0%	2	6.1%
Manual	1	25.0%	1	14.3%	0	0.0%	1	10.0%	1	33.3%	2	66.7%	6	18.2%
Psycho-spiritual	1	25.0%	3	42.9%	4	66.7%	7	70.0%	1	33.3%	1	33.3%	17	51.5%
Psycho-spiritual and herbal	0	0.0%	2	28.6%	0	0.0%	2	20.0%	0	0.0%	0	0.0%	4	12.1%
Psycho-spiritual and manual	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	33.3%	0	0.0%	1	3.0%
No treatment given	2	50.0%	1	14.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	9.1%
Total	4	100.0%	7	100.0%	6	100.0%	10	100.0%	3	100.0%	3	100.0%	33	100.0%

In Mokokchung, the most commonly used intervention by the traditional healers was psycho-spiritual, mainly for the treatment of mood disorders (70.0%), schizophrenia and related disorders (66.7%), disorders due to psychoactive substance use (42.9%). On the other hand, herbal treatment was used mainly for schizophrenia and related disorders and also in combination with psycho-spiritual intervention for mood disorders and disorders due to psychoactive substance use. Manual treatment was used for treating a variety of disorders such as mental retardation, organic disorder, disorders due to psychoactive substance use, mood disorder and neurotic and stress related disorders.

5.3 Qualitative Surveys

The findings from the focus group discussions, key informant in-depth interviews, ethnographic study of State Mental Health Institute, Kohima and selected patients case reports are presented under the qualitative surveys.

5.3.1 Focus Group Discussions

5.3.1.1 Elderly people The group discussion started with a welcome note, overview of the topic and ground rules. Participation of all group members in the discussion was encouraged. The ground rules were explained clearly and made them understand that there was no right or wrong answers but rather differing points of view. The group was encouraged to share freely each person's point of view and that negative comments were as important as the positive ones. Confidentiality was emphasized and copies of informed consent given to each participant.

Highlights from the FGD:

The popularity of traditional healers is not so much for mental disorders as compared to general illnesses.

The focus group discussion started with a shared understanding of what is traditional healing and the different kinds of traditional healers so as to get the concept right and to avoid any confusion.

One participant at the very outset pointed out that there was a difference between 'Kopiraz' (bonesetter, medicine man) and 'Arasentsur' (spiritual healer/ diviner, regarded as a witch), the former is sought for treatment of general health problems like broken bones, nerve problems, backache, stomach ailment, etc while the latter is sought for demon possession and other mental problems.

The focus group discussion discussion brought out the reasons why traditional healing was popular in the olden times before the advent of modern medicine. Participants stated that earlier, there were no hospitals, there were no proper means of transportation and Christianity had still not reached Nagaland. Hence, people's only faith was in traditional healers for treatment of all kinds of illnesses. One participant said that *" In my understanding ,in the olden times, there were no hospitals, no medicine , no doctors, no nurses, were there. Our only understanding was that there was Arasentsur (TH) for help, for example, if I got sick, since no doctors, no nurses, if I go to the Arasentsur, she will say what the sickness is. She will say, hmm, you need to go to the forest, river filled with foam and bubbles. Some would say this sickness is serious, only if one cock is taken to the forest and offered to the mojing (devil), that person will get healed. Some Arasentrur would say that the land is where people die, one cock will not cure the person, take one dog and sacrifice it. That's how it was before… and that's how many people used to be healed".*

One participant also pointed pointed out that people were illiterates in the olden times and had no education. He added *" I think people get healed only because of their faith".* One participant in the discussion said that today, the scenario is different. There are more number of doctors, advancement in modern technology and science and high level of literacy in the state. He also added *"... mainly through Christianity I believe, traditional healing for mental health problems is on the decline".*

Those that still seek traditional healing were only because they lack financial resources. For such people, they go to traditional healers as the firs step. One participant however argued that *"...but in our Ao land, its like this... but in other remote backward areas, its still like the olden times. All of them seek only traditional healers, even for mental problems".*

One participant summarized the discussion saying that just like the olden times, due to no proper means of transportation and lack of education, for people in the remote backward areas traditional healing is still very popular for both general and mental health problems. He also added *"..no money, so still seek traditional healing".*

However, one participant argued that *"... but people with broken bones in hospitals still hidingly call traditional healers. Most of us don't want to use knives (surgery) on our body, so prefer traditional healers".* To this, another participant said *"people hidingly use traditional healers but operation is a must... allopathy is better."*

Mokokchung district is rich in medicinal plants but traditional healers are not using it.

According to the FGD participants, there are only a few traditional healers today who use traditional medicine. Also, due to the fact that allopathic medicine is easily available now, people prefer it for instant relief. One participant said that "*they do make ... but allopathy is expensive and people who are rich prefer it'*. The participants felt that because of allopathic

medicine, traditional healers don't make as much traditional medicine. One participant added *"…I think they make only for personal use now"*.

Another participant stated that *"the forest is filled with medicine … we don't know what medicine …but now due to farming and burning forests, we are losing all these medicine.. even traditional healers are losing precious medicine"*.

One participant also added *"…today how many medicinal leaves are there, even in our village, we send leaves to Australia… don't know what they make out of it, but we send. Scientists study and they send us money every year… we have a group, we maintain a fund"*.

Traditional healers are effective healers for soul sickness, disturbance by departed relations/ ancestors and demon possession.

The FGD discussion brought out the argument that only traditional healers can heal mental health problems caused by disturbance by dead ancestors and demon possession. One participant said "…something is there in Arasentsur, people who are possessed will die in the hands of doctors". When it come to Sümonu/ asürayimer (disturbance by dead family members who are believed to have come to take away the soul of the person), one participant said *"I have proof, I witnessed many people getting healed, we can see that the person is really getting healed"*.

Most of the participants felt that traditional healers are endowed with a special power to heal illnesses such as demon possessions and soul sicknesses. One participant stated "doctors can't see what's the cause …".

However, all participants also strongly felt that it all depended on the person's *tia* (luck/fate). One participant said *"…its 50-50, one person went but he didn't have luck, he couldn't be healed. But what I hear is more cases of people getting healed"*. Another participant agreed to this and stated that *"Ärasentsur can heal many people but also unable to*

heal many… just like doctors, doctors can heal many people but also can't heal everyone.". Another participant also added *"even in prayer centres, the faith healers can't heal everyone with mental problems, some gets healed, some can't be healed"*.

One participant argued however that majority goes to prayer centres nowadays and only very few people seek traditional healing for these kinds of problems. He added *"…maximum people are staying in prayer centres today"*. He felt that people who visit traditional healers have less faith in God and said that "*the person is a namesake Christian"*.

Traditional healers cannot manage some mental illnesses such as alcoholism or substance abuse.

When asked what they felt about traditional healers not being able to treat substance use disorders like alcohol, drugs and cannabis, all of the participant vehemently nodded their heads and strongly stated that only medical science can deal with such problems. One participant stated "*our forefathers didn't know what drugs were, what is ganja… so I think traditional healers did not have to deal with such kinds of problems then"*.

The participants felt that for alcoholism and drug use, traditional healers wouldn't be able to provide much help and that it was up to the person to try to overcome the addiction. One participant stated *"Even Arasentsur cant heal alcoholics, drug addcits …its upto the person to make a decision to change . Outside force cant help…faith in god and psychological support and proper food is also needed for them to recover"*. She also added *"…it breaks our brain nerve, the person becomes psycho… so Arasentsur wont be able to fix that"*.

Traditional healing is not as effective as modern psychiatric treatment.

The participants had a mixed view regarding traditional healing not being as effective as modern psychiatric treatment. Some of the participants felt that due to education and better

financial resources, more people are seeking modern psychiatric care and had less faith in traditional methods which was still deeply rooted in traditional beliefs. With recent advancements in medical science and modern technology, some participants felt that allopathic healthcare was more satisfactory and gave clear and effective results. However, some participants felt that even though traditional healers are not on the same page as modern treatment, they are still capable of helping a lot of people and is very effective. One participant said *"..depending on the problem, people still seek Arasentsur…don't spend money, is effective. They are better. They give instant healing and requires minimum expenditure."* Another participant also argued that *"when it come to sümuno, modern technology can't heal the person. 100% only Arasentsur can heal. People who are possessed by demons, doctors can't heal. Arasentsur is better. That's my opinion".* To this, however, another participant felt that *"…even if Arasentsur can find out the cause of the mental problem, without modern science and allopathic treatment too, it might not work".*

5.3.2.3 Working Youth

Highlights from the FGD:

The popularity of traditional healers is not so much for mental health problems as compared to general health problems.

The discussion started with a general discussion about what traditional healing is and the different kinds of traditional healing practices in Nagaland. This was mainly done so that all the participants were clear about the topic and to avoid any confusion as the discussion progressed.

In terms of popularity of traditional healing for mental health problems, the participants felt that it was not firstly because people were not aware that the problem itself is a mental health problem and secondly because people did not openly discuss about seeking help from traditional healers for mental health problems. One participant stated that *"…Yeah, for me I relate traditional healing to all these massages, for joints or muscles… otherwise I haven't come across like, it wasn't outright for this mental problem, for example, for dementia or depression or whatever … I haven't heard of these kinds of stories… like he's getting treated for this mental illness".*

Another participant felt that *"…Or maybe in Nagaland, they might be ashamed ..I mean they don't come out ..in that way they might not tell that they're suffering from some mental illness and all those things so… we don't know how many of them might be suffering… or family members might not come out and tell that she is suffering from this or all those things".* To this, another said that *"they are very reserved… their families also".* Another participant also added *"…When it comes to such mental issues, we're not that free .. open.. not aware actually".*

Majority of the participants stressed on the lack of awareness of mental disorders which could be the reason for non-popularity of traditional healing for mental disorders as one participant stated *"If we are aware of all these illnesses we would like, for example if a member in my family is not well mentally… if we can pinpoint that it is a mental illness we would go looking for treatment.. like for depression or seizures so if we can pinpoint the sickness maybe we can …. If we know any traditional healer who deals in all these, then we would go… but then even our people I think we're not aware, I mean how to pinpoint these sicknesses."*

Another participant felt that *" ...people are not going till now…they might be…but people might be ashamed so they might be scared… people are not open abut their mental illness".*

All participants agreed that even if people were seeking help from a traditional healer they would so do discreetly and would not discuss about it openly. Therefore, this made it hard to tell if traditional healing for mental health problems is really popular or not in Nagaland. One participant added *"…and many a times it might be a mental illness…we say its demon possession… and then they send to prayer homes and then try to get rid of the evil spirit … they just go to and maybe fasting…but in reality who knows the person might be mentally sick but instead of going to a hospital, we end up either in prayer centre and all these…or who knows maybe after multiple hospital visits and not getting healed, their last option being…it might be like this"*.

The discussion also brought out the popularity of traditional healing for mental disorders in the rural areas as compared to urban areas.

One participant felt that *"…In remote backward places… for them I think it will be even more difficult because even for us where there are so many good hospitals around and we're not seeking help for mental illness… so there especially I think they'll stick more to like, all these prayer and spiritual healing I think"*. To this, another participant added *"talking abut people from the rural area, first of all, availability of medical facilities.. that's also very important .. they've also financial problems.. they don't have the money for the medicines or travelling expenditure. So what they do is they go to people like them (traditional healers)"*.

Most of the traditional healers thinks that mental disorders are due to evil spirits or spirits of departed family members /ancestors.

The FGD brought out the argument about traditional healers perceiving all mental disorders as demon possession. The participants shared a mixed feeling about it with some stating that traditional healers are not really aware of the mental disorders that they treat while some felt that it was their inability to interpret and convey that it's a mental disorder due to

lack of formal education. One participant said that *"I don't think anybody has been treated by traditional healers, lets say, for depression. They're not aware of the problem they're treating"*.

To this, another participant disagreed saying that *"For me, I feel they have a different way of interpreting it… that sometimes… maybe they don't know the terms like depression… they can say…. but they have a different way of saying it, like, possessed by an evil spirit but actually they mean to say its depression.. and the healing happens … there are cases like that. So I think it's the interpretation…that they don't understand… they've never studied medical, like they don't have medical knowledge and everything… there are cases they don't know how to interpret… there are different terms in the villages"*.

Another participant also added that *"…they say that the person is possessed but they don't mean that it is demon possession or evil spirit… sometimes, when they say its evil spirit , they just mean that it is a sickness… their interpretation of it is … touched by hawa pia (evil spirit/force) or extra forces"*.

On the other hand, one participant felt that *"exorcism is mainly prevalent in the churches…on the religious side"*.

Traditional healers cannot manage some mental disorders such as alcoholism or substance use.

The focus group discussion also brought out the shared feeling and agreement that traditional healers are not equipped with the ability to treat substance use disorders like alcohol use disorders, opioid and cannabis addiction. All the participants strongly asserted that these kinds of mental disorders cannot be treated by traditional healers. One participant felt that *"…rehab is the only option here in Nagaland… they also send to prayer house"*.

Another stated that *"...I think they (traditional healer) just give the verdict (diagnosis) and not the treatment... like they only say its due to alcohol..."*.

Traditional healing is not as as effective as modern psychiatric treatments.

The FGD brought out the important issue of lack of mental healthcare services in the state and being left with no other option, many people with mental health problems could be seeking help from traditional healers. Most of the participants felt that this could be the reason as to why people believe that traditional healing is as effective as modern psychiatric care.

One participant asserted that *"Healers are more known right now in our state"*. Another participant explained that *"because a larger number of people are going to traditional healers ...so maybe it might seem that their methods are more effective...but I think if a lot more of people go to psychologists and psychiatrists, we will see that number rise I think. Lets say...not many psychologists or psychiatrist in Nagaland right? So lets say four people go to them and since there are so many traditional healers lets just say ten people go to them.. so even if it's a 50-50 chance of healing from both parties, 50% who go to traditional healers are five ... so 50% going to the psychiatrist is only 2." To this another added "...we don't have option only..."*.

Some of the participants, on the other hand, felt that it is mainly due to the strong belief and faith in traditional healing which leads people to think that it is as effective as modern medicine. One participant said that *"...Its also the perception ...how people think about it...passed on from generations.. they give importance to them (traditional healers)...it's the belief"*. Another participant also added that *"its the belief that plays a big role in healing...our bodies become programmed... so what the traditional healers says, we follow obediently ...and medical experts we are very skeptical of also at the same time..."*.

The discussion was summarized by one participant who felt that *"...For me, I think instead of phasing out all these beliefs (traditional healing), I would supplement. The people who are naturally gifted in all these healing, they should be supplemented with actual education you know… to modernize their approach .. supplementing their talent with actual education".*

1.3.1.3 College Students

<u>Highlights from the FGD:</u>

Depression and substance abuse is increasing among young people in Nagaland.

The participants in the focus group discussion felt that mental health problems such as depression and substance abuse were indeed increasing among young people in the state. Most participants readily shared their own stories and experiences of it. The participants felt that there were numerous reasons for the increase of mental health problems such as failure in studies, family problems and unemployment. One participant also stated that "…in our studies or if there is a feeling of bitterness with our society or relatives .. with friends, cousins .. the anger and pain doesn't subside. Somehow we guys try to look manly…showoff…when that happens we end up drinking alcohol or even take drugs or ganja… just to forget that depression…".

One participant on the other hand felt that *"... only fifty-fifty...due to tension .. especially those who are jobless and school dropouts. They become really depressed. The other 50% are those who are not able to correct themselves and fall into depression "*.

The discussion mostly brought out the fact that increase in depression and substance use among young people were mainly due to an inability to cope with failure in exams leading many students to give up on their education and resulting in various mental health issues. One participant shared that *"one of my friends ... when I was in class 10... he was brilliant in*

studies. He doesn't even chew betel nut, in fact he used to detest anybody who chewed it. Even in class everyone had some sort of respect from him…he was very regular in class too. But in class 10…he used to score very well in math while we were very weak at it…when the results came out, he was the one who flunked in the subject. After that I moved to another place. Two years later when I returned to kiphire , and when I went to play football…I saw that he was there smoking a cigarette. I was shocked. I asked his friends and neighbours what happened to him.. they said that he fell into depression ever since he failed in his exams. So after witnessing it first hand … how people change drastically …falling into depression …now he started drinking and smoking cigarettes …does all the bad things".

The discussion also highlighted one of the major causes in the rise of mental health problems among young people in Nagaland which is unemployment. All the participants felt that due to lack of job opportunities in the state, many young people after completing their studies end up becoming severely depressed. One participant shared *"…my cousin brother , after completing his studies , could not get any job…he was in tension for a long time…he became sick …he got depressed. Sometimes he loses his mind , like he doesn't have any sense…if we tell him to do something, he forgets even that …he doesn't remember…likewise when we have tension, we fall into depression".*

Traditional healing is best for treating depression and substance use among young people in Nagaland.

All the participants strongly disagreed that traditional healing is best for treating depression and substance use among young people with most stating that traditional healers maybe able to heal physical problems but not mental health issues. One participant said that *"My brother used to take drugs since he was in class 7 or 8…these people (traditional healers) used to come home to see him…but nothing changed…he passed away …".*

Some of the participants felt that it was the church and prayer centres instead which could play an important role in dealing with mental health problems among youngsters today. They felt that if some former drug addict or an alcoholic shared their life testimonies among the youngsters, it could help save a lot of young people from engaging in such destructive habits resulting in mental health issues. One participant said *"…it would touch our hearts…and our mentality would change …they can save our soul through God's testimony…but if its through traditional healing, I don't believe they can treat…".*

However, one participant felt that *"can't exactly say for sure that they can't treat… some might have been healed…".*

Depression and substance use are mostly due to breakdown of close relationships, like family, friendships and romantic relationships.

The discussion on breakdown of close relationships leading to mental health problems brought out a lot of issues like physical intimacy among young people, parents' role in breakups, teenage pregnancy, abortion, suicide and not being able to pursue a course of their choice because of pressure from parents and society.

One participant said that *" In our village, one young boy told his parents that he didn't want to stay in a hostel. But his parents didn't listen.. they forced him …took admission and even got his uniforms stitched... the following week when the school was about to re-open , he committed suicide…out of depression. He had no interest …he was very young …also sometimes parents force their children to study only science or commerce.. and unable to cope up with their studies, they develop a sense of unhappiness… parents and relatives give a lot of pressure".*

Another participant also shared that *"one of my friends was in a relationship and she got pregnant …but her boyfriend left her …she was in a lot of distress…didn't know what to*

do… she was scared of her parents… could not share with any of her friends too. She was severely depressed…finally she hung herself".

Due to stigma, many young people with mental health problems are not identified and treated properly.

There was a mixed feeling regarding mental heath problems among young people not being identified and treated properly due to stigma. Some of the participants agreed that people were not open about mental disorders due to the stigma attached and that most families never openly discuss about it. However, on the other hand, some of the other participants felt that it wasn't necessarily the stigma but a need to maintain a desirable image or reputation in society that all is fine with them.

One participant said that *"in society, people want to maintain an image…we think that our image will go down and so we hide these problems ... people don't want their image to be ruined".*

Yet, another participant felt that the educated ones do understand that it is a mental health problem and do seek treatment for it. Another one added *"…those who know they have some mental illness, they do get treated. Educated people or qualified people know that its something psychological …these pepole know that its depression. However, those who don't seek treatment are those who don't have a lot of education or you know like, lower class… there is no chance…don't seek treatment".*

Traditional healers / Kopiraz are not equipped to treat mental health problems among young people.

In terms of traditional healer's ability to treat mental health problems among young people, all the participants strongly asserted that they cannot treat mental disorders. The participants felt that most of the people who visit traditional healers for mental health problems

do so just to get a feeling a satisfaction and that traditional healers can't treat such problems. One participant also stated that *"Some people listen to whatever others say and starts believing in traditional healing…they come to trust them…".*

The discussion also highlighted the fact that the younger generation today had no faith in traditional healing, especially in terms of treating mental health problems since most are educated and completely discard it as superstitious beliefs and practices. One participant pointed out that *"Nowadays even young children say that its all just talk… can't believe in it. We've become modernized. Even class 7, 8 students use android smartphones ... they can google anything. They even stop believing in Christianity… so if they don't have any faith in their own religion, how can they believe in traditional healing… during our forefather's time, lots of superstitious beliefs… but now we stopped believing in all that ... no faith nowadays".*

5.3.2 Key Informant in-depth interviews

As part of the qualitative research, three key informant in-depth interviews were undertaken. Key informants were asked a number of open ended questions focusing primarily on the research objectives of how popular traditional healing for mental health was in Nagaland, help seeking habits and knowledge of traditional healers in treating mental disorders. Key informants consisted of a senior medical officer (specialized in psychotherapy and counselling) posted in the State Mental Health Institute, a Church pastor and an elderly traditional healer.

5.3.2.1 Key informant: Senior medical doctor

The in-depth interview with the medical doctor in the State Mental health institute highlighted various key points with regard to use of traditional healing for mental health in

Nagaland. He stated that traditional healing for mental health problems was quite popular only in the rural areas of Nagaland. Inaccessibility to medical practitioners, ignorance due to lack of education, tendency to view all mental disorders as demonic possession and other supernatural factors were pointed out as the main reasons for the popularity of traditional methods in the rural areas. He emphasized that ignorance and superstitious beliefs goes hand in hand in the rural areas. A strong faith in traditional healing practices seemed to be the reason for its popularity among rural people as he stated that "traditions die hard". In contrast, he stated that urban people are more educated and have become less superstitious leading to less reliance on traditional methods. He also brought out the fact that more people seem to favour Christian prayer centres for mental health problems than traditional healers in Nagaland today. As a doctor, he added that he doesn't discourage it since it gave people a sense of hope.

"We give medication to correct the biochemistry and help improve your mood… but who will give hope in the end…yes the family support…but beyond that, our relationship with the higher being...it is the thing that in fact instils hope…so people go to prayer centres to search for that hope.. it is the perfect antidote for stress".

He was also of the view that normally a lot of Naga people don't seek help for mental health problems because of the stigma attached to it. He added "*The reason why we're not so open like the western society yet..in our context, in our Angami context, telling out your problem to another person is a sign of weakness..which we don't want others to know…probably that is one deterrent factor for not immediately seeking mental hospitals. Nagas are still very conservative…its got something to do with our traditional mindset".*

On questioning whether the patients prior to coming to the institute would have consulted a traditional healer, he admitted that they have never made any such enquiry from their patients. However, he thinks that a lot of them would have done so. Regarding their help seeking behavior, he stated that majority of the patients would come to the institute only in the

last stage after exhausting all other options. Only few who were aware of its existence would come at the first stage of the illness. Most were referred from various government hospitals or primary health centres. Some would also be referred from prayer centres when the individual became uncontrollable. Most of the inpatients were cases of schizophrenia, substance use and bipolar disorders.

On further enquiry as to whether there was a role for traditional healers in Nagaland, he felt that it was the traditional system that sustained the community for many years.
"We can't totally ignore traditional methods. People are still going to them, which means something must be there. We were taught that traditional methods are all bogus, especially herbal medicines .. and now we're beginning to realize that there are limitations with allopathy too. Modern science is beginning to delve a little bit more into traditional healing methods. These healing methods have sustained tribal folks for thousands of years ... there must be some truth to that".

Traditional healers, he felt, were highly intuitive and were exceptionally gifted although they don't possess any educational qualification and also highly knowledgeable of the human anatomy. Traditional healers or kopiraz in Nagaland are especially popular in Nagaland who are able to heal many ailments. Even though he is a medical doctor, he too has sought help from a traditional healer. He was of the view that the only problem was that it is hard to authenticate the scientific basis of traditional methods since no proper scientific research has been done on the various traditional healing methods in Nagaland. He stressed that more research and documentation is urgently needed.

5.3.2.2 Key informant: Church pastor

The second key informant, a church pastor, had a similar view regarding the help seeking behavior of Naga people for mental disorders who felt that it was not as popular in the urban areas as compared to rural areas. Also, he stated that when it comes to mental health issues, Naga people are not open about it. In terms of traditional healing for general illnesses, he was of the view that it was extremely popular and that even medical doctors seek their help. Most of the traditional healers inherit their gift from their ancestors and since it gets passed on from one generation to the next, he felt that traditional healing practices would still be popular even in the future.

With regard to the specific use of traditional healing for mental health problems, he stated that it was on the decline. He stated that with the advent of Christianity in Nagaland, all sorts of traditional practices and especially the rites and rituals observed by traditional healers began to be considered as satanic. He stated that due to this, a lot of good in our traditional practices has also been discarded.

"It opened our eyes.. brought the light to the Nagas…. But we have lost all the good values".

Regarding the competency of the traditional healers in treating mental disorders, he stressed on the role of faith in healing.

"…Psychologically people are being healed… they believe that the treatment is working. That's how people get relief".

Some traditional healers have extensive knowledge of herbal medicine which he felt could be somewhat effective. In terms of psycho-spiritual treatment, he said that it was just psychological in nature.

"Just by offering a chicken or a pig… they have faith that the illness will go away. They have faith in it".

With regard to mental disorders due to substance use, he said that traditional healing will not work and that medical attention is what is needed. The high rise of substance use and depression among young people, he said, was mainly due to family problems, financial difficulties and majorly due to lack of job opportunities in the state. He stated that in his work he has come across many young people who were severely depressed and into substance use.

5.3.2.3 Key informant: Traditional healer

The third key informant interview gave an insight to the role of traditional healers for mental health from the perspective of the service provider. This particular traditional healer has years of experience treating people with mental health problems mostly psycho-spiritual in nature. He no longer sees patients due to old age.

During the time of the forefathers, these traditional healers were said to have been extremely gifted and exceptional people who also possessed animal spirits, mostly the spirit of a tiger. This gift would be passed on from the healer to his children, mostly the youngest son or the child he loved the most. These healers had the ability to foresee future events and could tell the causes of many ailments. They were people who were very truthful and faithful to both men and God. With the advent of Christianity, he stated that most have turned to Christian religious healers but the mode of healing is the same.

In terms of knowledge of mental disorders, he stated that there were three main types. One was where people had different alters and started behaving in bizarre ways. The person appears to be possessed by an evil spirit. This disorder, he said was due to a curse from God for doing evil deeds. The second disorder was hereditary in nature which he said was the hardest to cure. The third mental disorder was where the person is devoid of all emotions. This

happens when the person has been repressing his feelings for a long time due to shame or guilt or it could also be due to relationship problems.

It takes just one look at the person to know what the problem is and what has caused it. *"..It's like an x-ray…like a movie…I can see everything".*

He also mentioned that *"Traditional healers are like doctors who uses stethoscope… but we use our eyes to diagnose."*

In addition, he stated that *"traditional healers are also highly specialized in psychology. ..looking at the appearance and character of a person, they can tell everything . Medical doctors cannot do this… dealing with different kinds of people everyday, sitting and talking to them, through years of experience, they (traditional healers) just know…".*

He stressed majorly on wrong doing as the primary cause of most mental disorders. The shame and guilt which the person keeps repressed makes him mentally unstable.
"Traditional healers can tell what the person did…. Lots of people visit many big cities for treatment not knowing that that is the problem ….but if the source of the problem, the root cause can be found, the person can be healed".

In terms of mental disorders due to psychoactive substance use, they stated that it was very difficult to treat and that allopathic medicine is needed.

Traditional healing for mental disorders, he felt, was not as popular as the olden times and that Naga people today prefer Christian prayer centres for all kinds of mental health issues. The role of Christianity was emphasized as the main reason for the decline of use of traditional healing methods. However, he felt that not all can be healed in these prayer centres and that people should also approach the mental hospital in Kohima.

5.3.3 Ethnographic study: State Mental Health Institute Kohima, profile

In the entire state of Nagaland, there is only one apex mental hospital. It has been now been renamed the State Mental Health Institute Kohima (SMHIK) mainly to help remove the stigma attached to the word 'Mental Hospital' (Department of Health & Family welfare, n.d). Apart from regular OPD, IPD, MLC & emergency services, the institute also offers regular academic teaching classes in batch wise for the nursing students from different hospitals and provides field work/ internship opportunities for Master of Psychology & Master of Social Work students from different universities in India. SMHIK has a Medical superintendent as the head, one psychiatrist, one psychotherapist and one clinical psychologist. One MD (Medicine) also visits 2-3 times per week. Usually, the Institute gets around one to two OPD patients in a day, sometimes more than two. The official yearly statistics (from 2009- 2015 only), copies of which were given to the researcher revealed that the highest number of OPD new registration was 375 in 2015 and the lowest was 183 in 2013. Total no. of OPD follow-up in 2015 was 834, of which 526 were males and 311 were females. The diagnostic break-up indicates that the Institute receives patients with schizophrenia and other psychotic disorders as the leading mental disorder (137 in 2015). The statistic also shows a high number of depressive disorder, bipolar mood disorders, substance use disorders and organic disorder treated. Around 13 children with psychiatric illness also has been treated. At the time of interacting with the staff at the Institute which was in August 2018, there were 147 OPD new registration and 740 follow-up OPD cases.

In terms of In-patient service, the total number of admissions to open wards were 135 in 2015 of which 86 were males and 49 were females. The disorders for which admissions were made were 38 Schizophrenia, 35 other psychotic disorders, 24 bipolar mood disorders, 13

alcohol and drug use disorders, 12 organic psychiatric disorders, 11 depressive disorders, 1 anxiety disorders and 1 child with psychiatric disorder.

The Medical Superintendent stated that most of the patients comes to the Institute only at the last stage when all other options have been exhausted and when the patients become uncontrollable. He also mentioned that that quite a few have been referred by Christian Prayer Centres from different parts of Nagaland. Interaction with the in-patients and their family members with the approval of the Medical Superintendent revealed that most of them had sought help from a traditional healer, especially those from remote far flung areas at some point and had finally landed up at the Institute.

5.3.4 Selected Patients' Case Reports

As part of the qualitative research, three case studies are presented in light of use of traditional healing for mental health problems, help seeking pathways, and the outcome. These particular case studies are being used to address and give a better understanding of the research questions of how popular traditional healing is, satisfaction and outcome. The selected case studies include one case each of mental disorder due to psychoactive substance use, mood [affective] disorder and schizophrenia.

5.3.4.1 Case study 1

The individual is a 23-year-old male belonging to Rengma tribe in Longleng district. He was diagnosed as suffering from Cannabis use disorder. He had started using cannabis since 2012, initially using it just to experiment with his circle of friends. It was in February 2018 when he started showing symptoms of aggression, hallucinations, delusions, incoherent speech, loss of consciousness and self-harm. His family believed that he was possessed by an

evil spirit. Hence, they took him to a traditional healer who after examining him said that it was due to disturbance by his dead mother's spirit which was causing him to behave that way. The traditional healer prayed for him so that his mother's spirit would release his soul. The outcome was poor and his condition remained the same. Therefore, the family took him to a Christian prayer centre in Dimapur where a group of religious healers prayed for him for almost 3 hours. However, they had to leave since there was no attendant in the prayer centre to look after him. His condition seemed to have worsened and when he lost consciousness and fainted, they rushed him to the government civil hospital where he was simply given some injections. The father had heard about the State Mental Health Institute in the state capital Kohima and decided to take him there. He was admitted for two months where he was put under medication and monitored daily by the psychiatrist there. After being released from the hospital, the boy wanted to visit a prayer centre again in Kohima, where he created a lot of disturbance and did not sleep for an entire night. He stayed there for 11 days. However, there was no improvement. His father then contacted a Christian Prayer warrior who prayed for the patient over the phone and said that he was 'poisoned' by another person and asked them to bring him to their prayer centre. However, the father decided to take him back to the State Mental Health Institute where he finally started to recover. The father pointed out that *"This illness is different. There is no meaning going to a traditional healer. I would recommend only this Mental Health Institute.. this is the best".* The treatment almost over, he now realizes that if only his family or other people could have had an open discussion with him and given him some kind of counselling, he might have understood what was happening to him. He said that throughout the course of his illness, be believed that he had been possessed by an evil spirit.

5.3.4.2 Case study 2

The individual is a married 40-year-old female nurse, belonging to Sangtam tribe in kiphire district. In 2014, she fell into severe depression after the death of her newborn daughter who passed away only few days after delivery. She mentioned that she wasn't sick but that she always felt lethargic. She suffered from loss of appetite and had difficulty sleeping at night and at times would get nightmares. She felt like there was no sense of joy in her life. Believing that her soul was being troubled by the spirit of a beloved departed family member, she travelled to her village to seek help from an Amongrüh (traditional healer). She described that this was a very common illness that occurs when the soul of a person has been taken away to Asühlang, the land of the dead, by departed family members or ancestor spirits. She explained *"We believe that if our soul is trapped in Asühlang, we will never get healed…we will never be happy".* The traditional healer instructed that they needed to observe three nights of prayer and rituals whereby the healer would try to restore her soul through his dreams. She reported that the outcome was excellent and described what she experienced as being filled with a sense of complete peace and happiness immediately on the fourth morning. She also recounted that her appetite came back and she felt completely light-hearted. She stated that she was fully satisfied with the treatment given by the traditional healer and saw no reason to seek help elsewhere.

5.3.4.3 Case study 3

The individual is a 27-year-old female belonging to Ao tribe in Mokokchng district. She lives in Khar village with her parents which is close to Mokokchng town. She had been diagnosed as suffering from Schizophrenia. Her father recounted that it was in 2006 that she suddenly started exhibiting an extremely bizarre behavior whereby she completely stopped talking, working and eating. She also developed a flu like fever and became very violent and would start hitting other people including her parents. Her parents took her to a traditional

healer in another village who gave her some medicine, which resembled milk powder, to be consumed in order to get rid of the evil spirit which was believed to be the cause of the illness. Her condition worsened and so her parents took her to another traditional healer in their village who was a diviner. No treatment was given by the second traditional healer but referred her to the State Mental Health Institute in Kohima. Her parents travelled all the way to Kohima where they got her admitted for two months. Her father stated that her condition started improving after undergoing the treatment at the Institute. Upon returning home, her condition slowly started to worsen again. In 2014, some relatives recommended the Government Mental Hospital in Tezpur, Assam and so they travelled and sought treatment there for a while. However, due to financial difficulties they had to take her back to the village. Currently, she is under medication which was given by a government doctor who happened to visit their village as part of the State Mental Health Programme. Her father stated that the allopathic treatment was more effective than the treatment given by the traditional healer which in fact made it even worse. However, since they are unable to afford the treatment and travel expenses, they have decided to look after her themselves at home in the village.

Chapter 6

Discussion

6.1 Introduction

In this chapter, it is proposed to discuss the findings from the research project under five broad headings (a) Burden of Mental Illness in Nagaland (b) Popularity of traditional healing for mental health in Nagaland (c) Methodology of traditional healing for mental health (d)Integrated Mental health care and community based participatory approaches and finally (e)Limitations of present research and future research needs.

The outcome from this chapter should result in a set of recommendations that should assist mental health professionals, policy makers and the society at large.

6.2 Burden of Mental Illness in Nagaland

Although this research was not planned as an epidemiological study, the findings from both the surveys of households and of traditional healers provide ample evidence of high prevalence of a variety of mental disorders in both rural and urban areas, in all age groups, by gender and tribes. There was initial reluctance and hesitancy to report any mental disorder in the family but after establishing a good rapport and education, the respondents gave full details on help seeking habits including utilization of traditional healers.

Mental disorders contribute significantly to the burden of disease across the globe and constitute a formidable challenge for health services (World Bank, 1993: Bijl, Graaf, Hiripi, 2003; WHO, 2005; Belfer, 2008; Benjet, 2010; Alonso, Chattersi, & Yanling, 2013; Charles, Baxter, Cheng, Shidhaye & Whiteford, 2016).

In an earlier study, Dorji et al, 2017 reports that suicide and mental disorders are a growing public health issue in Bhutan, due in part to a rapidly transitioning society. Although population-level data on mental disorders are scant, health-facility morbidity reports indicate

that, from 2011 to 2015, there was an increase in the total number of documented cases of mental health disorders, from 2878 cases to 7004, of which 45% and 31% were depression respectively. The burden of suicide has been recognized by the Royal Government of Bhutan and, as a result, it introduced the country's first ever national suicide-prevention plan in 2015. In the country's history of 60 years of allopathic medicine, Bhutan only has four psychiatrists. In addition, the country lacks any psychiatric social workers or mental health counsellors with comprehensive training. Myths and lack of awareness about mental disorders abound, as the concept of mental health is relatively new in Bhutan. Stigma and discrimination related to mental health are universal challenges, and are prevalent in Bhutan, such that most people with mental disorders and depression receive no treatment or delay seeking care. The 3-year action plan takes a holistic approach to making suicide-prevention services a top social priority, through strengthening suicide prevention policies, promoting socially protective measures, mitigating risk factors and reaching out to individuals who are at risk of suicide or affected by incidents of suicide. Activities include suicide-prevention actions by sectors such as health, education, monastic communities and police; building capacity of gatekeepers; and improving the suicide information system to inform policies and decision-making.

In the present study, the prevalence of mental disorders in both rural and urban Nagaland is quite high (Table 5.5, Figure 5. II; Figure 5.III; Table 5.34, figure 5.XIX). Overall, 383 out of 810 households (47.3%) reported having suffered from some form of mental disorder in the past one to five years. Mood disorders, mainly depression, comprises majority of the mental disorders, more so in the urban area. Neurotic and stress related disorders are also significantly higher among urban people than their rural counterpart. This is consistent with the findings from the National Mental Health Survey of India 2015-16 (National Institute of Mental Health And Neuro Sciences, 2016) which revealed that mood disorders and neurotic (5.6%) and stress related disorders (6.93%) were nearly 2-3 times more in urban metros.

Mental disorders due to psychoactive substance use has been reported as quite low in both rural and urban Nagaland in the present study. These statistics, however, contrasts with the recent report released by the Ministry of Social justice and Empowerment (2019) on magnitude of substance use in India, in which Nagaland figured as among the top states in prevalence of psychoactive substance use with illegal cannabis products (4.7%), opioids (6.50%), sedatives and inhalants (5.4%) being the highest. This indicates that there was great hesitancy in discussing openly about substance use.

6.3 Popularity of traditional healing for mental health in Nagaland

In the light of such a high prevalence of mental health problems, 28.8% of those with mental disorders had consulted a traditional healer in the present study (Table 5.6, figure 5.IV, Figure 5.V). It is quite possible that the the low percentage in making use of traditional methods could be due to the decline in the number of traditional healers for mental health or that they are generally perceived as incapable of treating mental disorders (Table 5.17). Other reasons could also be that traditional healing is generally seen as ineffective or it could also be due to the stigma attached to consulting traditional healers after the advent of Christianity in the state and the popularity of Christian religious healers and prayer centers increasing in recent years (Table 5.17). On the other hand, those who had consulted might have had a preference for traditional healing which could mainly be due to a strong faith in the system and the use of culturally acceptable methods of healing by the traditional healers (Table 5.16).

In an earlier study on help-seeking behaviour of patients with mental health problems visiting a tertiary care center in north India (Mishra, Nagpal, Chaddha and Sood, 2011) it was found that nearly one third of the patients had consulted a traditional faith healer at some point in the course of their illness. Another Indian study conducted in 2015 (Shidhaye & Vankar) in

a tertiary care center in Western India found that 54.7% of the patients had consulted a traditional healer before going to the psychiatric hospital.

What is noteworthy in the present study is the significant differences between the rural and urban householders with 34.8% in the rural but only 16.5% in the urban seeking traditional healing (Table 5.6, Figure 5.IV, Figure 5.V). This indicates that the use of traditional methods for mental health is still quite popular especially in rural Nagaland, much less in the urban area but still popular at least as a first step. A similar case can be seen in Ghana (Poku, Laugharne, Mensah & Osei, 2001) whereby fewer patients with mental health problems present to traditional healers in modern, urban Africa compared to rural areas.

Although the number of households who consulted a traditional healer is small, majority (58.5%) felt that the outcome was good (Table 5.10, Figure 5.IX, Figure 5.X). Given that most of the mental disorders for which traditional healers were consulted were mood disorders, mainly depression (37.2%) and neurotic, stress related and somatoform disorders (20.0%) for which psycho-spiritual form of intervention was most commonly used, it is possible that their faith in the system might have played a big role in the healing process (Table 5.7, Figure 5.VI).

In terms of satisfaction of traditional healing for mental health, excellent or good satisfaction was mentioned by 25% for urban and slightly over 50% of rural respondents. Its also interesting to note that a quarter in the urban and nearly half in the rural would recommend traditional healing for mental disorders (Table 5.12, Figure XIII, Figure 5.XIV). Overall, 21.4% of the respondents stated that they had strong faith in traditional healing. Some were also of the view that traditional healers have diagnostic ability for mental disorders. (Table 5.13). Dr Otsyula, 1973 (as cited in Ndetei, 2006) reported that patients went to hospital only to look for the cure of their illness, whereas they went to see traditional doctors for both the cure and also to find out the cause of their illness. In a study conducted by Ae-Ngibise et al in

Ghana, Africa (2010) respondents indicated many reasons for the appeal of traditional and faith healers, including cultural perceptions of mental disorders, the psychosocial support afforded by such healers, as well as their availability, accessibility and affordability.

Again, 24% in the urban and nearly 60% in the rural felt that traditional healing for mental health is still popular in Nagaland (Table 5.15, figure 5. XV, Figure 5.VI). Besides strong faith in traditional healing, majority of the respondents felt that traditional healers have power over spirits. Similar responses were found from the studies of Campion & Bhugra (1998), Chadda et al (2001) and Mishra et al (2011) revealing people's attribution of supernatural causation of mental disorders. Popularity of traditional healing is also attributed to culturally acceptable methods of healing (Table 5.16). Dalal (2016) stresses on cultural compatibility and how indigenous treatments are rooted in the faith and beliefs of the local communities. He asserts that sharing the same culture, the healer and his/her healing practices are integral to the beliefs and practice of the local communities and that the explanatory system which a healer employs is mostly congruous with the thinking of the community to which he/she belongs. Healing also entails restoring equilibrium between the mundane and supernatural worlds where Gods, ancestors and evil spirits are all considered to be a part of the healing process. Different healing practices use different forms of sacred rituals (not religious) and certain rituals are part of the complete cure of the person (Dalal, 2016). Kleinman, 1980 (as cited in Dalal, 2016) notes that prevalent socio-spiritual beliefs, rituals and practices create the necessary conditions for fostering a positive mental state of hope, optimism and initiative and that they serve as important inner resources to combat illness and other related adversities, and thereby enhance the efficacy of indigenous medicine. Dalal (2006) also dwells on the question of how such community beliefs which are considered as false and delusional by the scientific community and are attributed to superstition, illiteracy and ignorance may actually play a positive role in the recovery process and in adjusting to adverse life conditions. He questions how belief in

God and supernatural can be tested or how one's faith in some person or group can be subjected to verification and reasons that faith and beliefs are often deep rooted, forming the basis of one's relation with self, family and community.

6.4 **Traditional healing practices for mental health**

In many countries, traditional healers play an important role in the treatment of mental health problems and these healers may be an important resource in the provision of primary mental health services (Young, 1983; Abiodun, 1995; Meissner, 2004; Aboo, 2011).
In the present study, three methods either singly or in combination were shown to be the common traditional healing practices (Tables 5.35, 5.36 & 5.37).

Despite the significant toll of mental illness on the Indian population, resources for patients often are scarce, especially in rural areas. Traditional healing has a long history in India and is still widely used, including for mental illnesses. However, its use has rarely been studied systematically as stated by Thirthalli et all (2016) who reported that no studies from India could be identified that investigated systematically the proportion of people with mental illness in the community who sought the services of traditional medicine. In a study of perceptions of traditional healing for mental illness in rural Gujarat (Schoonover et al., 2014), it was reported that subjects were largely dissatisfied with their experiences with traditional healers, but such healing was still an incredibly common first-line practice in Gujarat. They stated that because healers are such integral parts of their communities and so commonly sought out, collaboration between faith healers and medical practitioners would hold significant promise as a means to benefit patients. This partnership could improve access to care and decrease the burden of mental illness experienced by patients and their communities.

De-centralization of health services has been promoted and primary care services have been identified as playing the vanguard role in providing mental health care (World Health Organization, 1978, 1990, 2003; Famuyiwa, 1989; Ustun & Sartorius, 1995; Tol et al, 2011). In developing countries resources are limited, as are the skills and knowledge of primary care personnel (Appleby & Araya. 1991: Abas & Broadhead, 1994; Desjarlais et al 1995; Manson, 2000; Demyttenaere et al, 2004; Kohn, Saxena, Levav, Saraceno, 2004, Saxena, Thornicroft, Knapp, Whiteford 2007, Peterson et al, 2009; Azale, Fekadu, Hanlon, 2016). Hence, people engage in different pathways to psychiatric care (Gater et al, 1991; Poku, Laugharne, Mensah, Osei, & Burns, 2001). This can be seen in Poland (Pawlowshi & Kiejna, 2004), in Singapore (Chong, Mythily, Lum, Chan, & McGorry, 2005), in Eastern Europe (Richard, Vesna, & Nadja, 2005; Gater, Jordanova, & Maric, 2005), in Bali (Kurihara, Reverger, & Tirta, 2006), in Karachi (Naqvi &Khan, 2006) as well as in Australia (Steel et al, 2006). Uganda is no exception to this (Ovuga, Boardman & Oluka1999). This paper reports on a survey of such traditional healers in one area of Uganda. A significant proportion of people seek care from traditional and spiritual healers whom they consult for a range of medical problems. A Nigerian study noted that spiritual healers, traditional healers and general practitioners were the first to be contacted by 13%, 19% and 47% of patients respectively (Gureje et al, 1995).

Few studies have surveyed the practice of traditional healers in relation to mental illness. Odejide et al (1977) examined the characteristics and practices of 53 traditional healers in Ibadan, Nigeria and noted that while they engaged in some undesirable practices, they held a broad concept of psychopathology and provided an important force in the treatment of psychiatric disorders.

Traditional Healing is the oldest form of structured medicine, that is a medicine that has an underlying set of principles by which it is practiced. It is the medicine from which all

later forms of medicine developed, including Chinese medicine, Graeco-Arabic medicine, and of course also modern Western medicine (Traditional Healers Fellowship, 2003).

Many consider traditional medicine to be unsystematic and not based on science, with voluminous apprehensions (Pal, Mohanta, Sarker, Rustagi & Ghosh, 2015). Yet, due to reasons better known to them as care-seekers daily patronize traditional healers by accepting them as ‘Friend, Philosopher and Guide’. Otherwise in absence of 'receivers of treatment' these traditional healers would not have survived over years with respect from the community. From the age old concept of ‘Doctor’ as ‘healer, preacher and teacher’, we have currently reached the era of evidence based medicine- ‘What is the evidence that what you have just advised, works’. Practicing evidence based medicine will identify and apply the most efficacious interventions with ideas and concepts to think positively to maximise the chances of individuals, groups and communities to attain and sustain, long happy and fulfilled lives.

There are "four pillars" of Traditional Healing which according to the Roman historian Piny the Elder (23-79 AD.) were: "Eruditio, Perspicacitas, Beneficentia et Caritas". Roughly translated these mean: "learning, insight, kindness and empathy". These are the basic principles that should guide the Traditional Healer in all his or her actions. (Traditional Healers Fellowship, 2003).

Since the advent of 'big government', which in Europe occurred with the Roman invasions and in North America and Australasia with English colonisation, Traditional Healing has at best been misrepresented and suppressed and at worst been persecuted. This is not surprising, as the Traditional Healers' extensive knowledge and their independence, because of their use of freely available natural resources, tends to place them outside of the economic and political control of governments. Governments therefore have, through the ages, tended to view Traditional Healers as a legacy of the past freedoms of tribal life and thus as a threat to their

autonomy and power. This is why all governments have striven to fragment and control healing practices. Big government is generally only interested in control and power, and very rarely has had any real or genuine interest in the health of its subjects. This is proven by the fact that governments have, over the ages, been quite happy to sanction and give patronage to medical practices that were more lethal than helpful, as long as these were under their control. For the ability to control a country's medicine gives rulers unsurpassed control over its citizens.

In the past, the fear of reprisals by governments has caused a severe decline in Traditional Healing and has forced most Traditional Healers to do their work very quietly, within a circle of trusted supporters. Nevertheless, there are some areas in the world where governments have had limited impact and Natural Healers have continued to practice, but these are few and are mostly located in Central America, Central Asia and Korea. With the new resurgence of ethnic practices and medicine all over the world however, Traditional Healing is also gradually gaining strength and is making a slow, but sure return, although the number of Traditional Healers worldwide is still not large by any means. Traditional Healing is not looking for endorsement by any government however. Governments and civilizations exist at best for a limited time. Traditional Healing is both an ancient medicine and the medicine of the future.

The findings from this study clearly shows that psycho-spiritual intervention (49.0%) appears to be the most commonly used form of traditional healing for mental health problems (Table 5.7, figure 5.VI). It has been used by the traditional healers in treating mainly mood disorders (50.0%). Psycho-spiritual treatment involves various rituals observed mainly to cast away malevolent spirits or to restore the soul of a person taken away by ancestor spirts or spirits of departed relations. The traditional healers survey also reveals that the different modalities of traditional healing practice did not show any statistically significant differences by gender

(Table 5.36, Table 5.37), by age (Table 5.38, Table 5.39) or by tribe (Table 5.40, Table 5.41). Ndetei (2006) notes that spiritual therapy attempts to bring peace and harmony between the living and the spiritual world, especially spirits of the ancestors, which are believed to live on after death and continue to influence events in the living world. Without going into the merits and demerits of their beliefs about the ancestors, what really matters are the effects of the perceived harmony, which, translated into today's thinking, amounts to stress reduction (Ndetei, 2006). Comparatively, the use of manual (20.9%) and herbal (7.3%) treatments is quite low (Table 5.7).

Ramashankar, Deb & Sharma (2015) notes that during various studies it was observed that the traditional healers in the north-east region belong to different categories like herbalists, bone-setters, diviners and birth attendants etc. They emphasize that scientific validation and recognition of traditional healing medicines are urgently required for revitalizing this loosing traditional knowledge. Traditional healers neither always perform all the same functions, nor do they all fall into the same category. Each of them has their own field of expertise. Even the techniques employed differ considerably. Every healer has its own methods of diagnosis and its own particular medicine. It was found that there are different types of traditional healers on the basis of their expertise in north east India. The major types are herbalists who are ordinary people who have acquired an extensive knowledge or technique but do not, typically, possess occult powers. They are expected to diagnose and prescribe medicines for everyday ailments and illnesses, to prevent and to alleviate misfortune or evil, to provide protection against witchcraft and misfortune, and to bring prosperity and happiness. In the healing practices of herbalists, empirical knowledge plays an important role, as they are able to diagnose certain illnesses with certainty and to prescribe healing herbs for those illnesses. In general, magical techniques also have a decisive role to play, because virtually all medicines can contain ingredients that are endowed with magical powers. They feel that common people wouldn't be

able to become a good herbalist; it needs some spiritual power also. The second type are the diviners who are the most important intermediaries between humans and the supernatural. Unlike herbalists, no one can become a diviner by personal choice. The ancestors call them (more usually a woman) and they regard themselves as servants of the ancestors. Diviners concentrate on diagnosing the unexplainable. They analyze the causes of specific events and interpret the messages of the ancestors. They use divination objects and they explain the unknown by means of their particular mediumistic powers. Their vocation is mainly that of divination, but they often also provide the medication for the specific case they have diagnosed. Some of them use prayer for the treatment of the ailments. Another type are the traditional birth attendants who often serve the communities located in isolated and remote areas where they are consulted as a matter of necessity due to the unavailability of Western health care services. Others types include veterinary, bone setter, acupuncturist, breathing treatment, etc. But they state that the details about the method of treatment is not yet explored. It was observed that the traditional healers have some principles in their system of healing practices. Traditional healers can realize the mind-body relationship. According to them the natural harmony of the body can only be restored by an integrated and holistic approach. They use natural methods of treatment, because these were the resources that have nurtured since time immemorial. Traditional healers used to be taught by other traditional healers with many years of experience from generation to generation and some of them have god gifted power of this knowledge. Traditional healers have strong ethical principles that they extend to all life. They believe that it is their duty to promote and save life from suffering. They also believe that Nature's laws must be obeyed in order to avoid decline and ultimate disaster. Traditional healers do not only work at correcting the internal imbalances through which disease can manifests in an individual, but also work at re-establishing an individual's harmony with their environment and their relationship with the natural cycles to which all life is subject. Traditional healing practice views the universe as

operating according to natural laws that manifest according to specific rules and correspondences. There were and of course still are regional differences between the way traditional healers apply their knowledge, but this is simply a pragmatic adaptation by the traditional healer, because he/she cannot perform their role in a way that is isolated from the cultural perceptions and belief patterns of those whom they treat.

In a study to investigate patterns of treatment seeking behavior and associated factors for mental illness in Southwest Ethiopia (Girmal & Tisfaye, 2011). It was found that half of the patients sought traditional treatment from either a religious healer 116 (30.2%) or an herbalist 77 (20.1%) before they came to the hospital. The most common explanations given for the cause of the mental illness were spiritual possession 198 (51.6%) and evil eye 61 (15.9%), whereas 73(19.0%) of the respondents said they did not know the cause of mental illnesses. The researchers report that there is significant delay in modern psychiatric treatment seeking in the majority of the cases since traditional healers were the first place where help was sought for mental illness. Most of the respondents claimed that mental illnesses were caused by supernatural factors.

In another study by Assion, Zaruchas, Multamäki, Zolotova & Schröder (2007), it was reported that the traditional healers, while dealing with psychiatric patients, often mask their inability to understand and treat these disorders and attribute them to supernatural causes, further enhancing the disbeliefs of these patients.

Since time immemorial, people from Africa, and beyond, depended on traditional healers for treatment of all types of disorders, including those related to mental health (Hammond, 1989; Millogo et al, 2004; Pretorius, 2004; Baskind & Birbeck, 2005; Stekelenburg et al, 2005; Ndetei, 2006; Mzimkulu, & Simbayi, 2006; Pletzer, 2009; Owusu-Ansah & Mji, 2013). Similiar pattern can be seen even among native American Indians (Kim

& Kyok, 1998; Marbella, Harris, Diehr, Ignace & Ignace, 1998; Buchwald, Beals & Manson, 2000; Novin, Beals, Moore, Spicer & Manson,2004; 01; Whitbeck, McMorris, Hoyt, Stubben & Fromboise, 2002; Fortney et al, 2012; Shelley, Sussman, Williams, Segal & Crabtree, 2009; Melissa, Kurt, Les & Dan, 2006).

Even today, the use of traditional healers in East Africa is common, despite the introduction of modern drugs. (Ndetei, 2006). It is estimated that traditional practitioners manage atleast 80% of the healthcare needs of rural inhabitants in East Africa. Research statistics from Kenya and Uganda suggest that 25–40% of all people seeking medical care at primary health level have problems purely related to mental health and another 25–40% have a combination of both mental health problems and physical problems (Ndetei & Muhanji, 1979). It can therefore be expected that at least half of all patients who go to see traditional healers have mental health problems. Data from general hospitals in Kenya suggest that 30–40%of patients admitted to those facilities have a mental health problem which is not recognised as such by the medical professionals working there. It is also common knowledge that many patients would use both modern medicines (as offered in general hospitals) and traditional healers.

Mental health facilities in Uganda remain underutilized, despite efforts to decentralize the services (Nsereko et al, 2011). One of the possible explanations for this is the help-seeking behaviours of people with mental health problems. The findings revealed that in some Ugandan communities, help is mostly sought from traditional healers initially, whereas western form of care is usually considered as a last resort. The factors found to influence help seeking behaviour within the community include: beliefs about the causes of mental illness, the nature of service delivery, accessibility and cost, stigma. It was concluded that increasing the uptake of mental health services requires dedicating more human and financial resources to conventional mental health services. Better understanding of socio-cultural factors that may influence accessibility

engagement and collaboration with traditional healers and conventional practitioners is also urgently required.

Machinga (2011) describes the traditional Shona health and healing practices of the Zimbabwean people by exploring the philosophical, clinical, and theological issues surrounding the healing practice. It is through understanding and appreciating the traditional Shona people's worldview of sickness or disease that one can comprehend the thinking behind the traditional Shona healing practices. In Zimbabwe, people visit the traditional healers, the prophets from "Churches of the Spirit," hospitals, and clinics for medical treatment. Diseases or sickness are viewed not only as physical or psychological but also as religious issues. Thus, religious beliefs and values play a significant role in the traditional ways of treatment. Rituals, symbolic representations, dreams, and herbal therapy are some methods that have a central place in the traditional Shona healing practice. Along with the physical, social, emotional, and mental nature of human existence, the spiritual, transpersonal, and ecological aspects are highly regarded.

A study (Lin, Lee & Yang, 2009) used a nationwide population-based dataset to explore factors and patterns associated with traditional Chinese medicine (TCM) usage among schizophrenia patients. A retrospective population-based study. Administrative claims data obtained from the Taiwan National Health Insurance Research Database covering the periods 1996-2004 was used to examine patients hospitalized with schizophrenia between 1996 and 2001 (n=34,100) to determine whether they had visited TCM practitioners in 2004 for treatment of schizophrenia. Taiwan. Independent variables included patient's age, gender, comorbid medical disorders, number of visits to clinics, number of hospitalizations, income and the geographical location and urbanization level of patients' residences. Multivariate logistic regressions were performed to determine the association between these factors and visits to TCM practitioners for the treatment of schizophrenia. 3144 of the patients (9.2%) had

visited TCM practitioners during 2004. After adjusting for other factors, the odds of such visits by males were found to be 0.825 times those for females, with the odds decreasing with patient's age and urbanization level. The odds of visits to TCM practitioners for patients hospitalized more than once were 3.557 times as high as those for other patients, while those for patients with >or=50 prior visits to other conventional clinics were 54.9 times those with <or=10 prior clinic visits. We conclude that patient's gender, age, geographical location, urbanization level, severity of illness, number of visits to clinic, income and the presence of diabetes and hypertension all have significant associations with TCM usage.

Dr Otsyula, 1973 (as cited in Ndetei, 2006) Further, several studies have suggested that many cultures have names for various mental health disorders, implying that they have long recognised them (Otsyula, 1973). The types of management prescribed by these traditional healers (often concurrently) fall into several main groups. These include the use of herbal preparations (pharmacotherapy)and several types of psychotherapy.

At this point, it is important to differentiate between traditional medicine and witchcraft, although overlaps can be seen, especially in theories of causation. Traditional healers have theories that recognize genetic, social, psychological and environmental factors in the causation and maintenance of illness. They also embrace spiritual causation, usually ancestral. Witchcraft focuses on evil designs, usually on or by close relatives, associates or competitors, and its prescriptions are usually designed to bring pain and suffering or even death to assumed or alleged enemies, based on jealousy, the need to obtain wealth, fame, popularity and so on. This is usually done through agents known as witches. Witches are generally shunned and are often thrown out of their own communities. Witch-doctors are the people who hunt for and bring to book the witches (Otsyula, 1973). Spiritual therapy, on the other hand, attempts to bring peace and harmony between the living and the spiritual world, especially spirits of the ancestors, which are believed to live on after death and continue to influence

events in the living world. Without going into the merits and demerits of their beliefs about the ancestors, what really matters are the effects of the perceived harmony, which, translated into today's thinking, amounts to stress reduction. The effect of reduced stress especially in relation to immunological response, is not in any doubt, even by today's science. Although psychiatrists may not accept an explanation that does not make sense in terms of modern science, the explanation is not the issue here: what matters are the perceived effects by those who practise spiritual therapy. George Brown and Tirril Harris from London used the word *meaning* to explain this phenomenon when they wrote about contextual threat (Brown & Harris, 1978).

As mentioned above, a large proportion of psychiatric patients visit a traditional healer prior to seeking medical help Ravishankar, Saravanan & Jacob, 2006; Mohamed, Bader, Said & Sufyan, 2009; Pradhan, Sharma, Malla & Sharma, 2013; Tsigebrhan, Hanlon, Medhin & Fekadul, 2017). This practice was perceived to contribute to recovery in a variety of ways (Hickey, Pryjmachuk & waterman, 2016). However, there were mixed perceptions on the effectiveness of traditional treatment. Qureshi et al, 1998 (as cited in Hickey, Pryjmachuk & waterman, 2016) found that some participants with depressive or catatonic symptoms reported a temporary improvement from traditional treatment but that most were unsatisfied. Similarly, Salem et al, 2009 (as cited in Hickey, Pryjmachuk & waterman, 2016) found that about half of participants with a range of diagnoses experienced only a temporary benefit, with others experiencing no benefit at all. Both studies interpreted 'benefit' as a reduction in symptoms. While most authors exploring the effectiveness of traditional healing seem to assume that symptom reduction is of primary importance, this may not necessarily be the case for service users. For example, Al-Subaie, 1994 (as cited in Hickey, Pryjmachuk & waterman, 2016) found that, even those who did not perceive their symptoms to be reduced, reported feeling that God would reward them for having faith in traditional healing methods, which are primarily based on religious beliefs. This finding suggests that service users may place value on treatment

benefits other than a reduction of symptoms. However, these other potential benefits are largely ignored in the studies reviewed, as is the relative importance of various benefits to participants. Other studies, however, have demonstrated a preference for services outside of the healthcare system. Salem et al (2009) found that nearly half of the sample went to a faith healer prior to seeking psychiatric care. The majority of these participants continued to see a faith healer even after engaging with psychiatric services. Because convenience sampling was used in this study it is difficult to generalize results to the wider population. However, the participants originated from various countries in the Gulf region, had a range of diagnoses, and included nearly equal proportions of men and women. This diverse sample adds to the generalizability of the study. The author concludes that mental health professionals need to be aware of patient preferences for traditional healing and understand the reasons why they sometimes refuse medical treatment. A comparable study conducted by Al-Solaim & Loewenthal, 2011 (as cited in Hickey, Pryjmachuk & waterman, 2016)in Saudi Arabia demonstrated that psychiatric services seem to be seen as a last resort when other options (e.g. faith healers) are not successful. This reinforces Salem et al.'s argument that mental health professionals should not ignore the contribution of traditional healers to service users' treatment. However, Al-Solaim and Loewenthal's, results are drawn solely from the experiences of 15 women. It is possible that they may not represent the majority view. Men, in particular, as demonstrated earlier, may have different preferences.

6.5 Integrated mental health care

In this research, the household survey respondents were quite favourable in their opinion about the competence and effectiveness of traditional healing for mental disorders. (Table 5.13). They were also quite happy to recommend traditional healing for mental health disorders since they had strong faith in traditional healers (Table 5.16). However, the

respondents felt that additional training might be required for traditional healers to deal with mental disorders. it is, thus, possible to integrate traditional healing with modern psychiatric care (Table 5.18). The traditional healers were also quite favorable to consider appropriate linkages with modern psychiatric treatments (Table 5.50).

Various other studies indicate the need of an integrated mental health mental health programme (Jahoda, 1979; Tsey, 1997). Mohatt & Vrnin (1998) as well as Rhoades & Rhoades (2000) and U.S, Department of Health and Human Services (2001) advocate culture, race and ethnicity in management of mental health and combining modern with first nations healing methods in American Indian population. Abdool & Ziqubu (2004) recommend bridging the gap by developing partnership between African traditional healers and biomedical personnel in South Africa. Crawford & Lipsedge (2004) suggest interfacing Zulu traditional healing with western biomedicine, while Kou & Chen (2012) advocate integrated traditional and Western medicine for treatment of depression and Dasgupta, Dasgupta & Cutlass (2009) recommend psychiatrists' change in practice to integrate with traditional medicine.

Studies done in in low and middle income countries (Campbell et al, 2010; Ross, 2010; Lund et al, 2012; Hanlon et al, 2014; Fekadu et al, 2016) especially emphasize on this need.
In recent times there have been debates among health professionals on the desirability of integrating traditional health practices into orthodox medicine (Chukwuemeka, 2009). This thinking was influenced by the resistance of some ailments to the orthodox healing methods as well as the proven efficacy of traditional healing processes in the treatment of some ailments. In Nigeria, the ambience of psychiatric victims or madmen at every corner and under bridges has raised some concerns on the actual role of psychiatric hospitals and their efficiency and effectiveness in contemporary times. The need for new ways of handling psychiatric cases led to new interest in traditional healing processes which have been shown to be effective in the management of ailments. Consequently, traditional practitioners have availed themselves the

opportunity of this debate to call for recognition as partners in the provision of effective and affordable health care. It analyzed the various concepts, processes, perspectives and dimensions of traditional psychiatric healing in Igbo land and argued for the integration of this aspect of psychiatry into modern system of psychological or psychiatric intervention and general health care.

Thirthalli et al (2016) in their paper, part of *The Lancet* and *Lancet Psychiatry*'s Series about the China–India Mental Health Alliance, discusses about India and China facing the same challenge of having too few trained psychiatric personnel to manage effectively the substantial burden of mental illness within their population. Both countries have many practitioners of traditional, complementary, and alternative medicine who are a potential resource for delivery of mental health care. They provide a systematic overview of evidence assessing the effectiveness of these alternative approaches for mental illness and discuss challenges in research and suggest how practitioners of traditional, complementary, and alternative medicine and mental health professionals might forge collaborative relationships to provide more accessible, affordable, and acceptable mental health care in India and China. Systematic reviews of the effectiveness of traditional, complementary, and alternative medicine find several approaches to be promising for treatment of mental illness, but most clinical trials included in these systematic reviews have methodological limitations. Contemporary methods to establish efficacy and safety—typically through randomised controlled trials—need to be complemented by other means. The community of practice built on collaborative relationships between practitioners of traditional, complementary, and alternative medicine and providers of mental health care holds promise in bridging the treatment gap in mental health care in India and China.

In the present study, of the 30 traditional healers only 12 was of the opinion that traditional methods and modern methods of treating mental disorders can be linked (Table

5.50). This possibility of collaboration seems to be feasible only if allopathic doctors respects and accepts traditional healing practices, in helping each other diagnose the problem when the other fails to do so, referring patients to one another and if a mutual understanding can be arrived at wherein the medical doctors work on healing the body through medication and the traditional healers work on providing spiritual healing (Table 5.51). On the other hand, the reasons for the reluctance to collaborate between the two emerges in the traditional healers' assertion that the methods of treatment are entirely different, also that one treats people after years of study and the other simply as a divine gift from God. Some mentions that traditional healers and allopathic doctors have contradictory views of illness leading to constant friction and disagreements, some described doctors as proud and egotistic who were ignorant of traditional methods of healing and making them feel disrespected and belittling their method of treatment. One healer asserted that traditional healers devote their entire lives to serving humanity and not for profitability in contrast to allopathic doctors who treat people only for monetary gain (Table 5.52).

Limited research has been conducted to explore the factors that support or obstruct collaboration between traditional healers and public sector mental health services. Ae-Ngibise et al (2010) conducted a study was to explore the reasons underpinning the widespread appeal of traditional/faith healers in Ghana. This formed a backdrop for the second objective, to identify what barriers or enabling factors may exist for forming bi-sectoral partnerships. Eighty-one semi-structured interviews and seven focus group discussions were conducted with 120 key stakeholders drawn from five of the ten regions in Ghana. The results were analysed through a framework approach. Respondents indicated many reasons for the appeal of traditional and faith healers, including cultural perceptions of mental disorders, the psychosocial support afforded by such healers, as well as their availability, accessibility and affordability. A number of barriers hindering collaboration, including human rights and safety

concerns, scepticism around the effectiveness of 'conventional' treatments, and traditional healer solidarity were identified. Mutual respect and bi-directional conversations surfaced as the key ingredients for successful partnerships. Collaboration is not as easy as commonly assumed, given paradigmatic disjunctures and widespread scepticism between different treatment modalities. Promoting greater understanding, rather than maintaining indifferent distances may lead to more successful co-operation in future.

Abiodun (1995) after examining the routes taken by patients to mental health care in Nigeria, suggests that use of psychiatric care in developing countries could be improved by training primary health care workers to give mental health education to the communities they served. The data from this study is intended to be used in developing strategies for integrating mental health care into the primary health care program in Nigeria.

Another study (Mbwayo, 2013) aimed to investigate the types of mental illnesses treated by traditional healers, and their methods of identifying and treating mental illnesses in their patients. In urban informal settlements of Kibera, Kangemi and Kawangware in Nairobi, Kenya, we used opportunistic sampling until the required number of traditional healers was reached, trying as much as possible to represent the different communities of Kenya. Focus group discussions were held with traditional healers in each site and later an in-depth interview was conducted with each traditional healer. An in-depth interview with each patient of the traditional healer was conducted and thereafter the MINIPLUS was administered to check the mental illness diagnoses arrived at or missed by the traditional healers. Quantitative analysis was performed using SPSS while focus group discussions and in-depth interviews were analysed for emerging themes. Traditional healers are consulted for mental disorders by members of the community. They are able to recognize some mental disorders, particularly those relating to psychosis. However, they are limited especially for common mental disorders.

There is a need to educate healers on how to recognize different types of mental disorders and make referrals when patients are not responding to their treatments.

Practicing evidence based medicine will identify and apply the most efficacious interventions with ideas and concepts to think positively to maximise the chances of individuals, groups and communities to attain and sustain, long happy and fulfilled lives (Pal, Mohanta, Sarker, Rustagi & Ghosh, 2015).

Rinaldi & Shetty (2015) notes that for millennia, people have healed with herbal or animal-derived remedies, using knowledge handed down through generations. In Africa, Asia, Latin America and the Middle East, 70-95 per cent of the population still use traditional medicine (TM) for primary healthcare. But efforts to incorporate T M's knowledge into modern healthcare and ensure it meets safety and efficacy standards are far from complete. And conservationists worry that a growing T M market threatens biodiversity by overharvesting medicinal plants or using body parts from endangered animals. Traditional and modern medicine's different approaches challenge integration. Mixing them needs better regulation, quality control and profit sharing.

The WHO Traditional Medicine Strategy 2014-2023 will help health care leaders to develop solutions that contribute to a broader vision of improved health and patient autonomy. The strategy has two key goals: to support Member States in harnessing the potential contribution of T&CM to health, wellness and people- centred health care and to promote the safe and effective use of T&CM through the regulation of products, practices and practitioners. These goals will be reached by implementing three strategic objectives: 1) building the knowledge base and formulating national policies; 2) strengthening safety, quality and effectiveness through regulation; and, 3) promoting universal health coverage by integrating T&CM services and self-health care into national health systems.

Although, globally despite constructive efforts to preserve traditional healing practices, there has been a steady decline towards modern psychiatric care as seen in Bhutan, Kenya, Uganda, etc (Calabrese & Dorji, 2013; Burns & Tomita, 2015; Musyimi, Mutiso, Nandoya & Ndetei, 2016; Sorsdahl et al, 2009). The scenario in Nagaland seems no different. There is a transformation of traditional healing for mental health, especially in the urban Nagaland (Table 5.6) although traditional healers are still the first point of contact and are respected for their knowledge, wisdom and approachability. No doubt, higher educational status., public education on mental illnesses especially alcoholism and substance abuse especially among the younger generation and access to modern psychiatric care in the urban areas will have their impact on transforming traditional healing of mental health in Nagaland, as seen in other developing countries.

6.6 Role of Community Based Participatory Approaches (CBPA) in future linkages between traditional healing and modern psychiatric care.

Proper mental health education programs need to be planned and implemented in the Naga community with special emphasis on mental disorders, its causes and treatment, so that the public become more aware of such problems and seek timely appropriate treatment. This does not imply ignoring the traditional role of healers but integrating modern psychiatric concepts into cultural aspects of local practices. The most acceptable and effective strategy is to adopt a community-based participatory approach (CBPA) including the traditional healers, complementary and alternative medicine practitioners, modern allopathic healers and other stakeholders. The basic principles of a CBPA are recognizing the community as a unit of identity, building on collective strengths and shared resources, facilitating partnership and capacity building throughout the process, spread relevant information, data and other findings

to all participants, involving a long-term process and commitment and seeking balance between research and action. A Community-Based participatory approach (CBPA) to promoting health is recognized as a critical strategy in addressing health unfairness among socially disadvantaged and marginalized communities. There are many examples of successful implementation of CBPA for mental health (Padmavati, 2012; Chatterjee, Patel & Weiss, 2003; Wiley-Exley, 2007; Chandrashekar, (2007). The findings from this research (Table 5.13) show that the time is now ripe to start a dialogue of bridging traditional healing with modern psychiatric care using appropriate counselling strategies and community support.

Traditional healers come under many categories, some generalists and several specialists including witch-doctors. Thus, much discrimination will be required to counsel the affected persons and their families to choose wisely, and follow a safe pathway for taking care of the illness. The Traditional healer has no formal training and depends largely on oral tradition and experiences. Success in treating one case may snowball into further cases increasing the popularity, but the counsellor's role will be to provide suitable education and other options. Wrong help-seeking leads to delay, complications and tragic outcomes.

As mentioned earlier, the findings from this research highlight the continuing popularity and preferences to seek traditional healing for alleviating the mental illnesses in Nagaland. The reasons for their popularity emphasizes the acceptable methodology followed by the traditional healers based on local culture, approachability and good rapport.

6.7 Limitations of present research and future research needs

An ideal study on traditional healing practices among Nagaland population for mental illnesses might require a prospective longitudinal study on fairly large samples using qualified field investigators. Given the level of stigma for mental illness and the attitudes of the public, even

this may not guarantee a valid evidence and further requires a large investment of financial and other resources apart from the time needed. Based on expertise advice and scientific calculations, this research therefore adopted a more practical study design and data collection techniques. A fairly large sample of about 500 rural households and 300 urban households from representative rural and urban districts through multistage random cluster sampling methods were chosen and interviewed in depth by the researcher after establishing a good rapport and proper introduction to the research. This household survey was expected to be complemented by a survey of rural and urban traditional healers, and only 30 were finally interviewed who were actually treating mental illnesses. A larger number would have been desirable given more time and resources. However, these 30 healers had treated more than 70 mental disorders to provide a reasonable description of their practice. The interview schedules were fairly detailed and explored the help seeking habits, their current satisfactions and attitudes as well as their evaluation of the competences of the healers. The respondents were fairly cooperative and forthcoming in their responses once they appreciated the purpose and scope of this research. Thus far, this is the largest study in Nagaland that should provide leads for meaningful action programs to benefit the people of Nagaland as well as provide possible leads for further research. A limitation of this study would perhaps be the evaluation of the effectiveness of traditional healing which was based solely on the personal opinion of the respondents. However, it was not practical to verify the responses through some specific laboratory or clinical parameters. Another limitation would be with regard to assessing the knowledge of the traditional healers about mental health issues since proper documentation regarding patient’s symptoms, progress or outcome of disease is not maintained among the traditional healers except their own personal testimony.

More qualitative research in terms of specific case reports and ethnographic studies as well as biographical and professional sketches of the traditional healers would also provide better guidance on integrating traditional healing practices with modern psychiatric care and contemporary counselling programs for the people of Nagaland. There is much to learn and adapt to the normal counselling procedures in dealing with mental health issues. Moodley (2007) states that "As a reflexive process, counselling and psychotherapy has been accommodating change since its earliest beginnings." Traditional healing is commonly used in most parts of the world and mental health counsellors have adopted innovative integration in absorbing local culture into their counselling practice.

Serious efforts must continue to integrate and chose the best in traditional and modern mental health care, so that we do not make the mistake of "throwing the baby with the bath water". Nagaland offers a unique opportunity to integrate the best traditional healing practices into formalized counseling and psychotherapy programs. Further research could focus on in-depth interview surveys on more traditional healers from different parts of Nagaland and combining this survey with qualitative approaches such as focus group discussions to develop linkages and bridges between traditional healing and modern psychiatric care.

Further research is also required in developing appropriate practical community based counselling strategies to help both the clients as well as traditional healers/ kopiraz in arriving at a more effective decision making to manage the mental disorders. future research should focus on mental health action plans as envisioned by WHO for the period 2013- 2020.

Chapter 7

Conclusions and recommendations

7.1 Introduction: In this chapter is presented a summary of the major findings from both the household and traditional healer survey. The household survey was designed to capture the responses from a large representative random survey of more than 800 households in two rural areas and one urban area of Nagaland using an intensive interview schedule. For the traditional healers' survey, 30 representative healers were intensively interviewed. In both surveys, the purpose of the research was explained in detail, the definitions and descriptions of common mental disorders were given and the informed consent obtained. The interviews were held in a leisurely manner and clarifications given whenever needed.

Section 7.2 presents the summary and conclusions from the household survey, 7.3 presents the summary and conclusions from the traditional healer survey and finally 7.4 presents a set of suggestions and recommendations for follow-up and future studies.

7.2 Conclusions from household interview survey

1. Traditional healing practices are widely followed more for general sicknesses than for mental disorders.
2. For a majority of people in Nagaland, traditional methods of healing mental disorders still remain the first point of contact and pursued till the problem is alleviated.
3. There are significant rural urban differences with less urban population resorting to traditional methods.

4. The main modalities of traditional healing are the use of ethno-botanical or herbal concoctions, manual methods such as massaging, performing psycho-spiritual rituals and procedures, and occasionally ethno-zoological remedies.

5. Mood disorders were the predominant mental health problem and in a majority of cases, psycho-spiritual therapies were administered.

6. The outcome of traditional treatments for mental health problems is mostly positive, with more than half of those who used traditional healing reporting that there was a change in their condition.

7. There are significant rural urban differences with regard to satisfaction of traditional methods for mental health problems, with over 50% of rural respondents more satisfied as compared to only 25% for urban.

8. There are significant rural urban differences with regard to recommendation of traditional healing for mental health problems, with nearly half in the rural but only a quarter in the urban stating they would.

9. The general decline in use of traditional healing in the urban appears to be related to educational background, access to modern psychiatric care, and less access to a traditional healer.

10.While traditional healers are still popular, their number is decreasing and also their capacity to deal with increasing substance abuse, stress disorders and younger clientele.

It is concluded that integration of traditional healing with modern allopathic psychiatric practices will significant benefit the Nagaland population and appropriate counselling programs will be necessary.

7.3 Conclusions from Traditional Healer Survey

1. Mood disorders were the leading mental health problems treated by the traditional healers, majority attributing it to supernatural causes.

2.The most commonly employed traditional method is psycho-spiritual, administered either singly or in combination with other modalities.

3. Traditional healers are able to offer effective treatment for only about half of the mental disorders seen.

4. Majority of the traditional healers view traditional methods for mental health as still popular, growing more so in the future.

6. Majority of the traditional healers acknowledged that both western medicine and traditional methods are equally important for mental health care.

8. More traditional healers were of the opinion that collaboration between traditional methods with modern methods of treating mental disorders may not be possible, with most feeling disrespected and devalued by allopathic doctors.

9. There are no significant differences in treatment given for mental disorders by gender, age and tribal backgrounds of the traditional healers.

7.4 Recommendations

1. Develop feasible, effective counselling strategies to educate, provide and guide the people, especially those with mental health problems and their care-givers.

2. Further research on integrating traditional healing of mental health problems with other systems of medicine.

3. Larger, more in-depth quantitative surveys as well as qualitative studies on specific mental disorders.

4. Pharmacokinetic research on herbal remedies to prevent, delay adverse effects of mental health problems of aging such as Alzheimer's.

5. Community based participatory approach research on mental health problems among the younger ages especially substance abuse, depression, suicide.

6. The Department of Health and Family Welfare, Government of Nagaland may take initiatives for dialogue with the Traditional Healers to recognize their contribution to society, identify their needs and analysis of their present status to see what can be done to enhance their practices through mutual sharing of ideas and resources and building respect for each other's system.

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ANNEXURE 1

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VI/1(8)/UREC/EA/272/2015- 3669 August 18, 2017

Ms. Ningsarenla Longkumer
PhD Research Scholar
Martin Luther Christian University
Shillong

Subject: Ethical approval of research project

Dear Ms. Longkumer

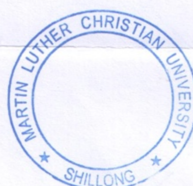
We are pleased to inform you that your research project entitled ***"Traditional Healing practices and perspectives of mental health in Nagaland"*** has been approved by the University Research Ethics Committee (UREC).

Please include a copy of this letter in your thesis as an annexure.

We wish you all the best in your research study.

Yours sincerely,

Dr Melari Shisha Nongrum,
Secretary, University Research Ethics Committee



ANNEXURE 2

INTERVIEW SCHEDULE FOR TRADITIONAL HEALERS

STRICTLY CONFIDENTIAL: NO NAMES WILL BE MENTIONED

1. STUDY NUMBER: ____

PART I: PROFILE OF TH

Name (only for this record):

2. Age:

3. Sex: 1) M 2) F

4.Tribe: 01) Ao 02) Angami 03)Sumi 04)Lotha 05)Chakesang 06)Zeliang 07)Chang 08)Kachari 09)Yimjunger 10)Konyak 11)Kuki 12)Phom 13)Pochury 14)Khiamniungan 15)Rengma 16)Sangtam 16)Others

5.Religion: 1) Christian 2) Hindu 3) Muslim 4)Buddhist 5)Indigenous religion 6)Other

6. Village of normal residence:

7. Village (s) for Practice if different from above):

8. Staying with Family: 1) Yes 2) No

9. Educational qualification: 1) Illiterate 2) <5 3)5-9 4)10-12 5) Grad.& above

10. Occupation other than local practitioner:

11. Is traditional healing a family practice: 1) Yes 2) No

12. Training received: 1. Formal 2. Informal 3. No training when: 13. Practicing since:

PART II: Practice

20. Do you treat mental Illnesses: Yes No

21. If No, have you treated earlier or occasionally? Yes Never No

If treating or treated earlier mental illness, can you give details:

Mental illness	Who: Age	Sex	How treated	For how long	Effectiveness	Referred	Approx. no/year
	23	24	25	26	27	28	29

30	21	32	33	34	35	36	37
38	39	40	41	42	43	44	45

46	47	48	49	50	51	52	53

60. Do you maintain any records: Yes No Give details:

61. Do you normally charge your patients? Yes No

62. Do you refer your cases to any other doctor? Yes No Give details:

63. Do you do a follow up on your patients: Yes No If yes: 1) At home 2) At clinic 3) At patient's house

PART III: KNOWLEDGE & ATTITUDES ON TRADITIONAL HEALING FOR MENTAL DISORDERS

64 What are the common mental disorders in this area?

65 Are Traditional Methods(TM) popular?

66 Are TM effective?

67. Is use of TM declining? No Yes If yes, why?

68. Compared to Allopathic medicines, is TM better? No Yes If yes, How

PART IV: PERSPECTIVES

70 Do you require any professional help to improve your practice? Yes No Explain:

71. What will be the future prospects of traditional healing in mental health?

1) It will become stronger 2) It will become weaker 3) It will be more popular 4) It will be less popular

72. Can traditional methods and modern methods of treating mental health be linked? Yes No

If yes how?

73. Other Observations/Comments:

74 Do you know of other healers for mental ill health? Yes No

If Yes, in your own village:

Elsewhere:

Will you be able to introduce me to them?

Interviewer name and Signature **Date:**

ANNEXURE 3

INTERVIEW SCHEDULE FOR HOUSEHOLDS

STRICTLY CONFIDENTIAL

NAME (ONLY ON RECORD, WILL NOT BE SHOWN ANYWHERE):

STUDY NUMBER: (AREA-SERIAL) -------/---------

Village/Ward: Address:

PART I: ATTITUDES TO AND UTILISATION OF TRADITIONAL MEDICINE DURING LAST YEAR

Health problem	Treatment(s)	Who: Sex	Who, Age	Was it effective 1.Yes/ 2.No	Was it supplemented by any other therapy	Will you seek TM again for this problem/ Why

PART 2: KNOWLEDGE OF MENTAL DISORDERS

What are the mental disorders you have heard of:

Do you think that they are common in Nagaland: YES NO Explain:

PART 3: MENTAL HEALTH PROBLEMS/ DISORDERS DURING THE PAST ONE YEAR- FIVE YEARS:

Problem	Who: Age	Who: Sex	When	What symptoms caused you to seek help/ treatment?	What do you think was the underlying cause of the problem?	Seek help from TH at any stage?	Treatment given by the TH (Details)	Outcome

PART 4. SATISFACTION AND OUTCOME

Overall satisfaction of traditional healers:

100. For general health: Excellent Good Satisfactory Not Good Unsuitable for some illnesses As first level only

101. For mental health: Excellent Good Satisfactory Not Good Unsuitable for some illnesses As first level only

102. Would you recommend other people to seek traditional healing for mental illness: Yes No

103. Reasons:

104. Is traditional healing still popular: For general illnesses Yes No Explain

105: For mental illnesses Yes No Explain

106 Do you think that traditional healers need additional training : Yes No What

107. Do you keep any traditional remedies at home: Yes No If yes, what:

Names and addresses of the traditional healers mentioned earlier:

Any traditional healers in nearby villages/ward:

DEMOGRAPHIC PROFILE:

110. Age: Age Group: (1) <30 (2) 30-49 (3) 50 & over

111. Sex 1) Male 2) Female

112. Tribe: 01) Ao 02) Angami 03) Sumi 04)Lotha 05)Chakesang 06)Zeliang 07)Chang 08)Kachari 09)Yimjunger

10) Konyak 11) Kuki 12)Phom 13)Pochury 14)Khiamniungan 15)Rengma 16)Sangtam 16)Others

113. Religion: 1) Christian 2) Hindu 3) Muslim 4) Buddhist 5) Indigenous religion 6) Other

114. Education: 1) Illiterate 2) <5 3)5-9 4)10-12 5) Grad. & above

115.Occupation: 1) Unemployed/student/ housewife 2) Casual labourer/part time vendor 3)Agricultural labourer 4)Agricultural manager 5)Small industry/bakery/repair- maintenance/ shopkeeper 6)Clerical/white collar/teacher/lawyer 7)Communications/IT/Technical 8)Services-defence /police/security/transport 9)Private business 10)Major industry 11)Other, specify

116.Marital status: 1. Never married 2. Married 3. Widowed 4. Divorced/Separated

117.Number of family members living with him/her:

Details are shown:

S. No	Age	Sex	Relationship to Respondent	Education	Occupation
1					
2					
3					

118 Number of children living with him/her:

119.Type of family: 1. Nuclear 2. Joint

ANY OTHER REMARKS OR OBSERVATIONS:

Interviewer Signature & Date:

ANNEXURE 4

INFORMED CONSENT FORM

I ……………………………………………………………………………… hereby consent to be included in the interview for the study on 'Traditional healing practices and perspectives of mental health in Nagaland' conducted by Ningsangrenla Longkumer, Ph.D scholar from Martin Luther Christian University Shillong, Meghalaya.

I have been informed about the classified and sensitive nature and purpose of the study and have been informed about the participation in this study that requires to be interviewed. I have been informed that my identity will be kept confidential and will not be disclosed to anyone, but my responses will be used for the purpose of the research. I am free to withdraw at any point, if I wish to do and will have no obligations for discontinuing.

I hereby agree to participate in the study willingly after clarifying all of my doubts.

Name of the participant and signature

Name of the researcher and signature