
Future Partnerships in Global Mental Health

Foreseeing the Encounter of Psychiatrists and Traditional Healers

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Abstract

Mental disorders are highly prevalent worldwide, yet mental health care is scarce or inappropriate, especially in developing countries. The majority of the 450 million patients with mental disorders around the world are not receiving even the most basic mental health care. In developing countries, 76.3–85.4% of serious cases receive no treatment. Unfortunately, the unnecessary suffering is likely to worsen, as the global burden of disease attributable to psychiatric and substance use disorders is expected to rise in the coming decade.

This chapter unveils some important traditional healers' contributions. Among them are the following: (i) the role their psychosocial and clinical skills have played in the implementation of community and public health treatment programs for physical illness; (ii) their facilitation of culturally competent clinical care; and (iii) their limited, although effective, participation in unique collaborations with psychiatric treatment personnel. It also highlights their role in diminishing stigma related to mental illness and the reintegration of prison inmates and children soldiers into their communities.

This chapter urges that the contributions of traditional healers should be welcomed in a world characterized by serious biomedical workforce shortages, limited funding, global mental health service inequalities and enormous unmet needs for mental health services.

20.1 THE GLOBAL BURDEN OF MENTAL ILLNESS

During the past two decades, research on illness prevalence in countries around the world has shown that mental disorders are highly prevalent worldwide, and mental health care is

scarce or inappropriate, especially in developing countries (Alarcon, 2003; Desjarlais *et al.*, 1995). Until recently, the true magnitude and social impact of mental disorders was literally unknown. The landmark Global Burden of Disease study, conducted by the World Health Organization, and the World Bank, in conjunction with Harvard University, (Murray *et al.*, 1996) found that four of the ten leading causes of disability through the world, for persons age five and older, are mental disorders. Together, mental disorders (including suicide) account for 15.4% of the overall burden of disease from *all* causes; second only to cardiovascular conditions (18.6%) and slightly more than the burden associated with all forms of cancer (15%). Respiratory conditions (4.8%) and even infectious and parasitic diseases (2.8%) are far behind. However, despite the worldwide public health importance of psychiatric disorders and their associated higher rates of disability, they are under-treated compared with physical illnesses in high-, low- and middle-income countries alike (Ormel *et al.*, 2008).

The four most pervasive psychiatric disorders worldwide are unipolar major depression, bipolar disorder, schizophrenia and obsessive-compulsive disorder. The main message of the Global Burden of Disease study is that the impact of mental illness on overall health and productivity throughout the world is profoundly under-recognized. It also clearly indicates that there is a great need to re-order health care service priorities if we are to improve the health status of the world population (Murray, Lopez, Harvard School of Public Health, World Health Organization, and World Bank, 1996).

The World Health Organization (WHO), in its report in 2001 that focused on mental health, estimated that 'one in every four people develop one or more mental or behavioral disorders at some time in their life, both in developed and developing countries' (World Health Organization, 2001). The WHO estimates that around 450 million people are currently suffering from mental conditions and are in need of care. According to the former WHO Director-General, Dr Gro Harlem Brundtland, the organization is, 'making a simple statement that mental health – neglected for far too long – is crucial to the overall well-being of individuals, societies and countries' (World Health Organization, 2001).

Even in the United States, one of the most technologically advanced countries in the world; mental illness is far from adequately diagnosed and treated. The first US Surgeon General's report on mental health and mental illness was not published until 1999. It is a groundbreaking summary of 3000 scientific papers, as well as consultations with mental health care providers, advocacy groups and patients. The report made two main points: (i) that mental health is fundamental to health and that good mental health is essential to leading a healthy life, and (ii) that mental disorders are real health conditions (U.S. Department of Health and Human Services, 1999).

According to the National Advisory Mental Health Council Behavioral Science Workgroup report, about one in five Americans will be affected by mental illness in their most productive years of life (National Institute of Mental Health, 2000). It is estimated that mental illness costs American society nearly \$200 billion annually in lost earnings alone; patients with serious mental illness earned, on average, \$16 306 less in their 12 months earnings (Kessler *et al.*, 2008). The current social and economic burden of mental illness in the United States of America is enormous. Realizing the national importance of mental illness, the National Institute of Mental Health responded with a strategy to confront this enormous challenge 'to improve mental health and clinical care in the United States and beyond' (National Institute of Mental Health, 2000).

20.2 NEEDLESS SUFFERING

It is estimated that there is about half a billion people in the world suffering from mental illness. The number of identified cases is probably an underestimation due to difficulties of Western trained mental health workers in making a psychiatric diagnosis of patients from other cultures (Mackin *et al.*, 2006). And the median age for the onset of any mental disorder is around age fourteen (Kessler *et al.*, 2005). Nevertheless, mental illness in young people goes unrecognized and untreated (Friedman, 2006). Beyond the suffering associated with the psychiatric condition itself, there is the additional suffering due to lost productivity. According to Patel, Saraceno and Kleinman (2006) the overwhelming majority of the 450 million patients with mental disorders 'are not being provided with even the basic mental health care that we know they should and can receive'.

The inequalities in access to mental health services is an immense challenge globally. In a recent international mental health survey conducted in 14 countries in the Americas, Europe, Middle East, Africa and Asia, 35–50% of serious psychiatric conditions in developed countries were untreated in the year before the interview. In developing countries, 76–85% of serious cases received no treatment (Demyttenaere *et al.*, 2004). As McKenzie, Patel and Araya pointed out, mental health services in the developing world 'are often greatly under-resourced, under strain, and leave most people with mental health problems with no care' (McKenzie, Patel and Araya, 2004).

The above-mentioned neglect becomes inexcusable when considering the mental health of the world's indigenous peoples (Cohen, 1999; Durie, 2003b; Kunitz, 2000). Not only is there an almost complete absence of mental health services designed for their particular needs, but psychiatric research on this vulnerable population is very limited (Cohen, 1999). In South America, there are no mental health services available to the indigenous peoples that take into account their socio-cultural characteristics and languages. The fact is that 30 million indigenous people in South America, comprising up to 10% of the general population, live in conditions of severe misery and neglect (Incayawar, 2007).

20.3 MEDICAL WORKFORCE SHORTAGE AND ALLOCATION OF FUNDS

The medical workforce shortage is a major contributing factor to inadequate mental health care in both developed and developing countries (World Health Organization, 2006). Although the shortage is most severe in the poorest countries, the medical workforce shortage also affects more affluent countries, especially their rural communities, and is threatening their health care organizations (Cofer and Burns, 2008; Goodyear-Smith and Janes, 2008). In the United States, a physician shortage is likely if current levels of medical education and training and population ageing trends persist (Salsberg and Grover, 2006).

The migration of physicians from poor to rich countries such as the United States, the United Kingdom, Canada and Australia is an important contributor to the medical workforce shortage in many lower-income countries and is a growing obstacle to global health (Mullan, 2005) For example, 'Ghana, with 0.09 physician per thousand population, sends doctors to the United Kingdom, which has 18 times as many physicians per capita' (Chen and Boufford, 2005).

The World Health Organization (WHO) acknowledges the existence of immense disparities in allocation of resources and funds. The Americas, with 10% of the global burden of disease, has 37% of the world's health workers and spends more than 50% of the world's health financing. In contrast, the African Region has 24% of the burden of disease, but only 3% of the world's health workers and spends less than 1% of the world's total health expenditure (World Health Organization, 2006).

There is a wide disparity in the type and size of the mental health workforce throughout the world. The median number of psychiatrists varies from 0.06 per 100 000 population in low-income countries to nine per 100 000 in high-income countries. For psychiatric nurses, the median ranges from 0.1 per 100 000 in low income countries to 33.5 per 100 000 in high income countries (World Health Organization, 2001).

The needless suffering is expected to worsen as the global burden of disease attributable to mental, neurological and substance use disorders continues to rise in the coming decade. Understandably, Patel, Saraceno and Kleinman emphasize that, '... research evidence will not reduce this inequity. To make a change, the moral case must be heard' (Patel, Saraceno and Kleinman, 2006).

20.4 UNVEILING TRADITIONAL HEALERS' CONTRIBUTIONS

The data reviewed above suggest that the world's population cannot rely completely on biomedicine to solve their mental health problems. They look insurmountable, at least in the mid and short term. It is in this context of global and local health inequalities, mental health service scarcity, and mental health neglect, that the contributions of traditional healers should be highlighted.

There are two lines of analysis on how traditional healers could help improve the mental health status of the most underserved populations in the world. The first is related to the sizeable traditional healers' workforce that is living in just those regions of the world with the most limited biomedically-oriented mental health workers and resources. The second is associated with traditional healers' roles in social action, community- and family-centered interventions, and their clinical diagnostic and therapeutic skills.

20.4.1 Valuable Overshadowed Partners

In Africa, South America and some regions of Asia and the Pacific Islands, traditional healers are widely available, although their precise numbers are undetermined. Moreover, it is in precisely those places that bio-medically oriented mental health practitioners are scarce, making it very difficult to expand the coverage of mental health services. For example in Tanzania, Uganda and Zambia, the ratio of traditional healers to general population is 1:200 to 1:400, while the availability of Western trained health professionals is 1:20 000 or less. A survey of the US Agency for International Development found that in the sub-Saharan Africa, traditional healers outnumber biomedically-oriented health practitioners by 100 to 1 (WHO, 2002).

It is estimated that in low-income countries there is one psychiatrist for one million people, with no multidisciplinary team and availability of few psychiatric drugs

(McKenzie, Patel and Araya, 2004). In the Andean region of South America the situation is even more dramatic. In 1986, the first two Quichua (Inca) physicians graduated from the medical school in Quito, Ecuador. Today, almost 20 years later, there is a total of five Quichua physicians, including one psychiatrist, for an estimated population of 5 million indigenous people in the country 'With this pace of change, the existing staff, the available psychiatric services, and the mental health of our communities will not improve in the foreseeable future' (Incaayawar, 2007).

Given the meager presence of Western psychiatry in the developing countries, some people might quite easily conclude that nothing can be learned from poorer countries or that nothing exists there to improve their population mental health.

20.4.2 Traditional Healers' Psycho-Social and Clinical Skills

Traditional healers are actually a sizeable force in global mental health. Their community-, family-based psycho-social interventions have been found to yield positive clinical outcomes (Frank and Frank, 1991; Jilek and Todd, 1977; Kleinman, 1980; Kleinman and Gale, 1982; Torrey, 1986). Some evidence points in the direction that they also have the necessary clinical skills to identify patients with major psychiatric disorders (Beiser *et al.*, 1972; Incaayawar, 2008; Westermeyer and Zimmerman, 1981). Their 'explanatory models' of illness and their healing techniques are complex and diverse. Traditional healers' therapies include the use of herbal medicines, physical manipulative techniques, and healing rituals involving the spirit world and supernatural intervention. Some of their clinical skills that could be utilized in a collaborative effort with biomedically-oriented health service staff are listed below.

Physical Illness and Disease. In recent decades, African traditional healers have actively participated in health promotion, health education and preventive public health programs using the WHO's approach of primary care teams. They have participated in projects to treat and to prevent diarrhea, HIV infection/AIDS treatment and prevention, referral to tuberculosis, leprosy and malaria treatment programs, and referral of children immunization programs. Healers have participated in projects designed to improve nutrition and food supplies, safe drinking water and sanitation. Their contribution has been promising in child delivery, maternal and child health care and family planning (pregnancy monitoring, risk referral, contraceptive distribution), and pain management. In other regions of the world such as China, New Zealand, India, South Korea and Malaysia, biomedicine and traditional medicine are practiced alongside each other in a systematically-integrated manner (Akpede, Igene and Omotara, 2001; Bannerman, 1983; Bastien, 1994; Bodeker, 2001; Droz, 1997; Durie, 2003a; Hesketh and Zhu, 1997; Hoff, 1992; Lethlaka, 1978; Oswald, 1983; Smit, 1994; WHO, 2002).

Culturally Competent Clinical Care. Having access to health services sensitive to patients' and communities' values, language, notions of illness causation and treatment preferences results in improved quality of care (Galanti, 1997; Gray, 1996). Local traditional healers, being members of the same community and culture as their patients, could fulfill this needed role. They could play a key role in expanding mental health care delivery by reaching remote rural communities, as well as marginalized urban ones, or culturally different minority communities that are currently underserved or not served at all by their national health care systems.

They can also help reduce clinicians' diagnostic and evaluation bias when they are working with unfamiliar and culturally diverse populations (Malgady, Rogler and Costantino, 1987) or in circumstances where clinicians are trying to apply their biomedical knowledge to interpret culturally-specific syndromes such as 'nervios', 'wounded heart', 'amok' and so on. The chapter by Incayawar in this book provides intriguing results related to the psychiatric diagnostic abilities of Quichua traditional healers. The author proposes that their diagnostic skills could be useful for screening purposes (Incayawar, 2008).

Current Outstanding Psychiatrist-Healer Collaborations. Attempts to establish mental health partnerships or collaborations with traditional healers have been rare. In North America, some efforts to do that started decades ago, but were limited in scope and impact (Jilek and Jilek-Aall, 1978; Jilek and Todd, 1974; Koss, 1987; Ruiz and Langrod, 1976). It is worth noting that mental health has been neglected even in China, where traditional healers have gained a prominent role in community and public health programs, as described in the chapter by Dr Xudong Zhao in this book. Most countries in Latin America have not adopted the World Health Organization's recommendations concerning traditional medicine and the use of traditional healers; therefore, the lack of experience in the region is almost absolute.

Several chapters of this book do address this theme of the integration of biomedical and traditional healing. They include the experiences of Incayawar and Bouchard with the Quichua people in the Andean region of Ecuador, the experiences described by Shore, Shore and Manson with several American Indian communities, Durie's extensive experience with the Maori population in New Zealand; and the South African momentum conveyed as a case study by Mkize. They are truly unique and exemplary initiatives in the world that have the potential to improve global mental health through their close collaboration between indigenous healers and biomedically trained clinicians.

20.4.3 Additional Contributions of Traditional Healers

Traditional healers are contributing to the well-being of people not only in the clinical arena – they are directly or indirectly helping to relieve psychosocial problems that underlie mental illness.

Stigma. Stigmatization of people suffering from a mental disorder, and their families, is encountered in many, if not most countries around the world. The fear of being labeled as mentally ill, the personal and family shame associated with it and the risk of being ostracized by one's community are formidable barriers to accessing mental health care. The stigma carried by mentally ill patients and their families is dramatic in countries such as India, and China, as described in several chapters in this book. As stated in a recent newspaper article in India 'The fear of being labeled and rejected by society is so high that people don't come forward. It is the hypocrisy of urban Indians that adds to the stigma. 'In contrast, visiting a traditional healer for any mental condition is not stigmatizing. Pakaslahti's chapter in this book rightly notes another aspect of traditional healing; the setting in which traditional healing occurs, 'provides a positive culturally valued, non-stigmatizing atmosphere'.

Reintegrating Prison Inmates into the Community. Barlowe's chapter is a unique account of his experiences as an American Indian traditional healer helping those who few mental health clinicians want to treat. Barlowe describes the means by which American Indian

prison inmates in the United States are receiving culturally meaningful support, gaining direction in their lives and enhancing their self-esteem. This experience could probably be applied in other contexts and countries.

Integrating Child Soldiers into the Community. Another example of traditional healers' contribution comes from the treatment of rape victims and child soldiers in sub-Saharan Africa. In a moving presentation titled 'Trauma Recovery in War-Torn Africa: Incorporating Traditional Healing' in Psychosocial Recovery Programs, Leslie Snider, M.D., M.P.H., from Tulane University School of Public Health and Tropical Medicine, documented the roles of traditional healers in assisting the psychosocial recovery of African communities impacted by civil war. 'They have assisted in burial rituals, cleansing ceremonies for rape victims and child soldiers, designed to pave the way for their meaningful re-entry into society. In these settings, indigenous healers function not only as health practitioners, but also as guardians of native history, beliefs, culture, values and social order – all critical for the recovery of post-war societies'.

After the civil war in Sierra Leone, for example, many former child soldiers were welcomed back into their communities only after a meaningful cleansing ceremony was performed that included fasting, repentance and bathing in local rivers. Those ceremonies were instrumental for social acceptance and forgiveness for the children. Their role in the war initially left them marginalized, isolated, and often times abandoned or repelled.

Psychiatric Agricultural Rehabilitation. In Tanzania, a unique community psychiatric program emerged from the concerted effort of local villagers, traditional healers and biomedically trained mental health workers. The program aimed to treat and rehabilitate people with severe mental illness in rural communities. Patients and relatives were relocated in a village of farmers, fishermen or craftsmen. Local villagers, healers and mental health workers provided the treatment and follow-up, while a psychiatrist provided weekly consultation. They even planned shared mental health training programs (Kilonzo and Simmons, 1998).

20.5 FORESEEING FUTURE PARTNERSHIPS

Considering the many workforce and financial struggles of biomedically oriented mental health services to improve the mental health of most national populations around the world, and the contributions of traditional healing techniques, such as those described in the chapters of this book, the role that traditional healers can play in global mental health could be considerable. Western psychiatry is capable of impressive results when dealing with specific psychiatric conditions and individual patients, but its ability to impact the turmoil and misery generated by social upheaval, natural disaster and civil war is very limited.

Contemplating a partnership between psychiatrists and traditional healers looks plausible and beneficial for improving access to mental health services. Avoiding critical delays may help reduce the duration of untreated mental disorders, treatment-resistance and disability. These issues are important to the development of services that are effective, efficient and culturally competent.

Around 40% of the clients of traditional healers suffer from mental illness (Saeed *et al.*, 2000). In addition, most of the world population relies on traditional medicines to meet their health care needs. We also know that patients and their families often make

simultaneous use of both traditional and biomedical treatments and value both approaches to healing. Research from the developing world has shown that pathways to care for mental illness are diverse and pluralistic and consistently include the use of traditional medicines. In developed countries, the majority of the population practices medical pluralism as well. A clear example is given in Drs Thachil and Bhugra's chapter in this book, relating to Indian communities in the United Kingdom. Durie, referring to the situation in New Zealand, in which 15% of the population is Maori, proposes that a 'combination of conventional services and indigenous programs is needed' (Durie, 2003a; Durie, 2003b).

Little is known about the efficacy, safety or cost-effectiveness of the involvement of traditional healers in the provision of mental health care. Research is needed to determine how mental health workers can better collaborate with traditional healers in order to improve access, diagnosis and successful treatment of persons suffering from mental illness. It is also necessary to understand the effects of different types of mental health policy decisions concerning traditional medicines on access, equity and treatment outcomes.

This book proposes that future partnerships with traditional healers are a promising option in improving global mental health. It argues that the contribution of traditional healers should be welcomed in a world with widespread biomedical workforce shortages, limited funding, global mental health service inequalities and enormous unmet mental health care needs.

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