Traditional Healing and Mental Health in Rural Nepal

by

Tony V Pham

Duke Global Health Institute

Duke University

Date: ______________________

Approved:

___________________________

Nathan Thielman, Advisor

___________________________

Brandon Alan Kohrt

___________________________

Kearsley Stewart

___________________________

Melissa Watt

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Abstract

To explore the relationship between traditional healers and psychotherapy, we conducted a combined qualitative study and structured observational rating of healers in the middle hills region of central Nepal. We interviewed and observed 84 participants, of which 29 were traditional healers. We conducted qualitative observations of healing, as well as rated healing behavior using an observational multiple measure of empathy, emotional validation, and therapeutic alliance. We applied the rated measures of healing behaviors in a case study and found that healers who were perceived by their clients as successful scored well on alliance, empathy, promoting expectations of recovery, and use of cultural models of distress. From our general thematic analysis on the entire dataset, participants described a range of interventions that improved health through belief, satisfaction in the soul, social support, and symbolic transference. The results of our structured observation suggest healers use the same processes also observed in psychotherapy. Our qualitative results suggest that healers offer an explanatory paradigm for their patients to accept a disease state, cope with it, and to experience palliation of distress. Further research is needed to explore if these practices can be generalized to healers in other parts of Nepal and other settings.
Dedication

This thesis is dedicated to Dr. Julian T Hertz, my dear friend and eternal rival.
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1. Introduction

“Medicines won’t work for people with mental illness since sometimes bhut lagnu (ghost possession) can cause mental illness. For bhut lagnu we rely on mantra, brooms, and statues of mud.” Male Traditional Healer; Age 56

Despite proliferation of biomedical health services throughout Nepal, 75% of its population still seeks care from traditional healers, who once numbered between 400,000 to 800,000 (Shrestha and Lediard 1980), for medical treatment (Shankar et al. 2006). Although no formal current estimate exists, more recent reports still document patient uptake of traditional healer services (Luitel et al. 2017). What explains the traditional healer’s enduring presence within Nepal?

American psychiatrist Jerome Frank (1974) arguably set the stage for later research on healer psychotherapeutic factors. According to his work, healing involves the expectation of help, the therapeutic relationship, a rationale or conceptual scheme that explains symptoms and prescribes a ritual for resolving them, and the active participation of ritual or procedure (Frank 1974). This reinterpretation of healing is otherwise known as the common factors of psychotherapy (Wampold 2015). The common factors theory has progressively suggested that much of the effectiveness of psychological treatment stems from shared common factors rather than specific factors which accompany specific schools of thought and evidence-based practices.

In other words, the theoretical orientation of a therapist may account for only a small percentage of outcome variance with the common factors of psychotherapy accounting for the rest.

To further explore the relationship between traditional healers and mental health, we conducted a study in rural Nepal to 1) measure the potential overlap between traditional healing
and psychotherapy using a standardized psychological treatment observational scale, 2) ethnographically highlight themes in traditional healer interventions and patient experiences of healing, and 3) develop an overall pathways to care model relating traditional healers and mental health. Based on prior ethnographic studies we hypothesized that Nepali traditional healers would affect mental health through common psychotherapeutic factors along with their own healer specific factors.

The existing literature on traditional healing in Nepal explores how it is interpreted, how it works, and why traditional practices persist throughout the country. Some of the earliest traditional healing research on their roles (Macdonald 1976), sacrificial ceremonies (Fournier 1976), and patient spirit possessions (Jones 1976) was compiled by Hitchcock (1976). Holmberg (1989) studied traditional healer madness among the Tamang ethnic group. Desjarlais (1991) studied dreams as a vehicle for reporting mental distress to healers among the Yolmo Sherpa ethnic group. Hardman (1996) studied priest use of the soul as a complex symbolic code among the Lohorung Kirati ethnic group. More recently Nicoletti (2006) has studied order and meaning through ritual, Leeuwen (2008) the role of traditional healers in psychosocial counseling, and Alter (2014) spirit possession, biosemiotics, and alcohol dependence.

This wide range of practices and practitioners makes it challenging to define traditional healing as a unitary concept. A definition of exclusion is that traditional healing is not a biomedical practice in the governmental or private health system. A more conceptual definition is that traditional healing includes practices that rely upon spiritual, magical, or religious explanations for disease and distress (Nortje et al. 2016) through the use of physical symbols, narratives, and behaviors (Dow 1986) that are transmitted across generations and can be traced to practices preceding the introduction of biomedicine in communities.
One explanation is that traditional healers continue to be widely available in rural areas; 85% of the rural population turns to traditional healers in Nepal as their first point of care (Raut and Khanal 2011). Katry (2011) suggests that not only do Nepali traditional healers possess greater physical accessibility among the underserved rural population, they also possess greater cultural accessibility among indigenous customs, traditions, and communities. Traditionally inclined patients conceive of illness by drawing upon a rich history of magico-religious thinking ranging from ancestor worship to the more classical religions of Hinduism and Buddhism.

Within this complex framework, the human soul maintains normal bodily balance as malevolent powers threaten to enter the body each day. If these supernatural forces make an unwelcome entry, they capture the body’s essence, causing the individual to fall sick to any number of illnesses. Because an external source caused an external illness, the treatment, in contrast to conventional biomedical theory, requires external cosmic realignment. Patients who fall sick believe that traditional healers possess a relationship with a greater cosmic order which permits them to release the soul and realign the body for normal function once again.

Through this magico-religious framework, or perhaps even their own psychopathology (Paul 1979), the traditional healer conducts occult healing ceremonies to treat the patient. Their interventions interface with the patient’s cosmic realities (Miller 1979) to produce explanatory paradigms that make sense of, influence, and heal the distress related to physical injury (Desjarlais 1992). The traditional healer’s explanatory paradigms may serve in a vacuum or even overlap within different health systems thus yielding “complex selves” within complex health systems (Burghart 1984). If patients experience relief, they express it through their heart-mind, a Nepali phenomenological concept for the self which bypasses local notions of stigma classically associated with organic mental illness (Kohrt & Harper 2008).

Although the current literature suggests that non-Western healer rituals can alleviate illness-related distress, local and international humanitarian actors have proliferated Western
psychological treatments over the past four decades. In 1980, the WHO began mental health work in Nepal, and in 1984 the United Mission to Nepal initiated its first community mental health services (Acland, 2002; Chase et al. 2018).

As Nepal recovered from its 10-year civil war in 2006 and a major earthquake in 2015, NGO and the local government support shifted further focus onto biomedical mental health services (Chase et al. 2018; Upadhaya et al. 2014). In the wake of this movement, several high-profile global mental health projects emerged, and while many targeted non-specialists to deliver mental health care, few focused on traditional healers as potential non-specialists (Chase et al. 2018; Hanlon et al. 2014; Jordans et al. 2016; Kohrt et al. 2014, 2015; Mendenhall et al. 2014).

Studies which aim to expand mental healthcare services through traditional healers should rather focus on how traditional healers frame their approaches to healing, as well as how their approaches map onto psychotherapy from a Western psychological literature perspective. The prior literature relating Nepali traditional healers and psychotherapy is immense (Nortje et al. 2016; van der Watt et al. 2018) and Nepal’s history alone merits a systematic review. Within Nepal’s literature, the Nepali traditional healer, like conventional psychotherapists, is said to express empathy for their patients. To a rural Nepali, traditional healers appear more familiar, less frightening, and less intrusive (Maskarinec 1995). Also, unlike psychotherapists, traditional healers utilize acting skills and highly ritualized social acts. For instance, traditional healers can reenact myths about spirit possessions and exorcisms to configure a religious and psychological foundation that reinterprets, depersonalizes, and defuses baffling and disorienting misfortune for psychological benefit (Hitchcock 1976). Metaphorical divination expresses patient fears, wishes, and hopes without attributing intentionality (Gaenszle, 2016) while interrelating the patient’s physical and metaphysical worlds (Höfer 1974). Mediums and possession states can bring communal disputes, wrongdoings, and grievances into the public space for arbitration and confrontation among the gods (Lecomte-Tilouine 2009). Buddhist healers can sound buffalo
horns to reconceptualize the body and actualize soteriological beliefs about death and rebirth (Greene 2002). Regardless of the specific intervention or mechanism of healing, patients receive a satisfying explanation for sickness, psychological crisis, and sociological existence that is culturally accepted based on traditional Nepali beliefs (Macdonald 1976, 1979; Oppitz 1993; Ortner 2009).

However, of these available studies, most are informal, ethnographic texts that capture culturally contextual data and avoid the unique and rigid challenges of formal trial design, implementation, and evaluation of traditional healers. On the other hand, more empirical researchers have criticized this ethnographic research base for falling susceptible to response and expectancy biases (Brannen 2017).

Few studies have blended the need for rich ethnographic data with standardized psychological observational tools. Furthermore, few studies have teased out which components of the traditional healer’s intervention contribute to their perceived effectiveness (Nortje et al. 2016; van der Watt et al. 2018), and to date no study has observationally rated the factors which relate psychotherapy and traditional healers. Such components may possess value in multiple contexts and merit further investigation within countries where traditional healers are thought to possess psychotherapeutic value, mental health resources are scarce, and selfhood differs from the modern west (Anheier and Isar 2010; Everett 2012; Patten 2014).
2. Methods

The research was conducted within a small, rural, and remote village located in the valley areas of the central middle hills of Nepal between June to July in 2018. Given the qualitative nature of this study, the researchers chose to protect the participant identities by not disclosing the exact name or location of the research setting. Nonetheless, the research team’s collaborating NGO, Transcultural Psychosocial Organization (TPO) Nepal, supplied the researchers with knowledge of the region’s wide range of ages, castes, genders, and professional backgrounds thus allowing them to seek a diverse pool of participants.

The research team did not randomly select its patients. Instead, the research team relied on a cultural insider, discovered through TPO Nepal, to recommend participants, many of whom were middle to high caste acquaintances of the cultural insider. The researchers also established initial traditional healer contacts directly through TPO Nepal. Our initial contacts led to additional participants as the researchers established social networks within the community, its members, and other traditional healers.

The research team conducted visits at healer sites and non-healer homes. The researchers provided each participant a description of the research team along with a consent form. The research team enrolled only those participants who agreed in written form.

The primary field researcher performed interviews with the help of translation and cultural interpretation from a Nepali speaking research assistant hired through TPO Nepal. To systematize the interview’s language, facilitate translation, and avoid misunderstandings, the researchers used a glossary of common Nepali mental health terms compiled by TPO Nepal and local village elders. Several of these terms have been cited frequently in the results (Table 1).
### Table 1: Glossary of Nepali Specific Terms Commonly Found Within the Result

<table>
<thead>
<tr>
<th>Nepali</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>dhami-jhankri</td>
<td>generally Hindu traditional healers</td>
</tr>
<tr>
<td>jyotisi</td>
<td>astrologers</td>
</tr>
<tr>
<td>lama</td>
<td>generally Buddhist traditional healers</td>
</tr>
<tr>
<td>baidhya</td>
<td>ayurvedic healer</td>
</tr>
<tr>
<td>“naturopathic healer”</td>
<td>traditional healer with a focus on natural processes of illness such</td>
</tr>
<tr>
<td></td>
<td>as humors or energy</td>
</tr>
<tr>
<td>pujari</td>
<td>priests with a focus on puja rituals</td>
</tr>
<tr>
<td>jajmani</td>
<td>similar to pujari but can perform other rituals besides puja</td>
</tr>
<tr>
<td>dakshina</td>
<td>monetary payments for services</td>
</tr>
<tr>
<td>jhum-jhum</td>
<td>numbness or tingling in a “stocking and glove” distribution</td>
</tr>
<tr>
<td>bigar</td>
<td>a supernatural problem caused by others</td>
</tr>
<tr>
<td>“gastric”</td>
<td>common condition in Nepal that centers around stomach pain and</td>
</tr>
<tr>
<td></td>
<td>can contain any number of related symptoms</td>
</tr>
<tr>
<td>atma santushti</td>
<td>satisfaction in the soul</td>
</tr>
<tr>
<td>buti</td>
<td>enchanted necklace</td>
</tr>
<tr>
<td>lagan</td>
<td>a type of spiritual illness</td>
</tr>
<tr>
<td>deuta ko murti</td>
<td>deity statues</td>
</tr>
<tr>
<td>khangling</td>
<td>special flutes mainly made from a femur bone</td>
</tr>
<tr>
<td>dhangro</td>
<td>drum</td>
</tr>
<tr>
<td>jama</td>
<td>traditional dhami-jhankri attire – a white skirt adorned with</td>
</tr>
<tr>
<td></td>
<td>necklaces, bells, and a feathered head dress</td>
</tr>
<tr>
<td>bhut ko chitra</td>
<td>a spirit diagram</td>
</tr>
<tr>
<td>mohoni</td>
<td>damaging love spells</td>
</tr>
</tbody>
</table>
For translation, the research team trialed several styles at the beginning. Simultaneous translation disrupted participant concentration and added confusion. Tail-end translation lost out on the back and forth communication between researcher and participant. Ultimately, the researchers decided to translate after participants finished complete thoughts regardless of length while the research team took process notes.

The research team decided against structured in-depth interviews in favor of semi structured in-depth interviews. The semi structured in-depth interviews relied on an iterative interview format that changed based on participant feedback. At times, the researchers had to restructure interview questions to better promote free expression of thought. For example, participants had difficulty answering both open ended and closed ended questions. Whereas open ended questions about complex emotions elicited confusion, close ended questions elicited forced and generic answers. Many participants felt compelled to answer all questions even when instructed otherwise. Certain participants warned about the overall hesitation to report on personal mental illness, social conflict, or politically charged matters such as witchcraft, especially to a foreign researcher. Over time researchers identified questions that elicited bland or misleading answers and removed them. The researchers finalized their interview guide roughly a week into our study. The researchers audiotaped each interview, took observational
notes, and recorded, deidentified, and transcribed field notes for meaningful and contextually relevant information. The research team stored all non-electronic notes in a locked storage container within the research facility and stored electronic information online via Duke’s secured Box account.

One participant, Ms. T, presented a treatment course with considerable thematic scope, complexity, and narrative cohesion. We applied the process-tracing methodology to follow her story (Beach 2017). During her treatment sessions, we recorded audio/video while taking extensive process notes. We also interviewed her family, her primary treating dhani-jhankri (traditional healer type), her treating jyotisi (astrologer), her drug retailer, a dhani-jhankri she rejected, and a dhani-jhankri who “failed” to treat her. For the purpose of her case study, we numerically referred to the three dhani-jhankri as “Dhami-Jhankri I, II, and III.”

In addition to our case study interviews, we evaluated Ms. T’s treating dhani-jhankri, drug retailer, and jyotisi for the presence or absence of the common factors of psychotherapy, a feature which strongly sets the case study apart from the primary thematic analysis. To do this the research team used an 18-item scale, designed previously by one of the research team members. The tool, otherwise known as the ENhancing Assessment of Common Therapeutic factors (ENACT) scale, assesses for non-specialist clinical competence of the common factors of psychotherapy. It had been pilot tested and validated within Nepal and as a result carries significant importance and utility (Kohrt, Jordans, et al. 2015; Kohrt, Ramaiya, et al. 2015). I administered the assessment of common psychotherapeutic factors through his own observations and ratings. Simultaneously, I video-recorded the treatment sessions to allow for inter-rater agreement among two other members within the research team. Altogether, the research team assessed the common therapeutic factors directly from the drug retailer, the jyotisi, Dhami-
Jhankri II, and Dhami-Jhankri III. We assessed the common therapeutic factors indirectly from Dhami-Jhankri I.

The research team conducted all analyses using the software Nvivo (Version 12.0; QRS International Pty Ltd, Melbourne, Australia) according to guidelines for a modified thematic, ethnographic and phenomenological analysis (Taylor and Bogdan 1998).

The researchers analyzed the data using an iterative insider-outsider process to ground the participants’ responses within a wider body of theories. Using a prior systematic review on traditional healers and mental health, the researchers used an inductive approach to begin our codebook (Cope 2014; Nortje et al. 2016; van der Watt et al. 2018). The authors used a deductive approach and cross checked this inductive process with emerging concepts to avoid completely relying on a priori assumptions. The researchers used tree maps to visualize relationships among the emerging conceptual theoretical concepts or “meaning units” in order to connect and merge them together to form the higher-order themes of our descriptive model (Gale et al. 2013; Sparkes 2014). They made comparisons among the code sets, analytic memos, and emerging themes, discussed areas of disagreement, and resolved them by revisiting the data. This allowed for more adaptability during analysis and provided a rich, detailed, and complex account of the data. The researchers continued this process until they reached data saturation, the point after they could not identify new themes for the codebook. To support the interpretation of analyses, the research team presented rich participant quotes alongside emergent themes. Finally, the researchers visualized their emerging themes against the backdrop of previous research by creating an overall pathways to care model. The final conceptual framework was created using the graph editor Lucidchart (Lucid Software; South Jordan, UT).

We obtained Institutional Review Board (IRB) approval from Duke University (Pro00092884) and the Nepal Health Research Council (Reg. no. 115/2018). We performed our
research in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments.
3. Results

3.1 Context and Demographics

We organized our results and conclusion sections based on the original objectives. First we present the basic demographics of our participant population. Then we describe a case study which exclusively features the assessment of common therapeutic factors in accordance with the paper’s first objective, to measure the potential overlap between traditional healing and psychotherapy using a standardized psychological treatment observational scale. The case study then progresses to the primary thematic analysis of the entire dataset as per the paper’s second objective, to describe traditional healer interventions and experiences of healing. Finally, the conclusion section synthesizes the results according to the third and last objective, to develop an overall pathways to care model relating traditional healers and mental health.

We conducted 84 in-depth interviews comprising 29 traditional healers and 55 other community members (Table 2). Through convenience sampling, we captured 23 dhami-jhankri (generally Hindu traditional healers), and 1 traditional healer from each of the following healer types: jyotisi (astrologers), lama (generally Buddhist traditional healers), baidhya (ayurvedic healer), naturopathic healer (traditional healer with a focus on natural processes of illness such as humors or energy), pujari (priests with a focus on puja rituals), and jajmani (similar to pujari but can perform other rituals besides puja). Of the 29 traditional healers, all were male. Of all 84 participants, the mean age was 47 years (SD 18.5). The majority were male (n=65; 76.5%), Hindu (n=59; 70.2), and farmers (n=57; 67.9%). The most common level of education was none (n=30, 35.7%) and the most common caste Brahman (n=34, 40.5%).
Table 2: Demographics Characteristics of 84 Dhami-Jhankri, Other Traditional Healers, and Non-traditional Healer Participants Interviewed in the Valley Areas of the Central Middle Hills of Nepal between June to July, 2018.

<table>
<thead>
<tr>
<th></th>
<th>DJ (n=23)</th>
<th>Other TH (n=6)</th>
<th>Non-TH (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean age year (SD)</strong></td>
<td>55 (16.9)</td>
<td>49 (11.4)</td>
<td>46 (18.4)</td>
</tr>
<tr>
<td><strong>Gender (% male)</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>65.5</td>
</tr>
<tr>
<td><strong>Religion (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>11 (47.8)</td>
<td>5 (83.3)</td>
<td>43 (78.2)</td>
</tr>
<tr>
<td>Buddhist</td>
<td>11 (47.8)</td>
<td>1 (16.7)</td>
<td>9 (16.4)</td>
</tr>
<tr>
<td>Muslim</td>
<td>0</td>
<td>0</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Satsai</td>
<td>0</td>
<td>0</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (4.3)</td>
<td>0</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td><strong>Caste (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chetri</td>
<td>2 (8.7)</td>
<td>0</td>
<td>9 (16.4)</td>
</tr>
<tr>
<td>Newar</td>
<td>1 (4.3)</td>
<td>0</td>
<td>9 (16.4)</td>
</tr>
<tr>
<td>Yadab</td>
<td>0</td>
<td>0</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Brahman</td>
<td>5 (21.7)</td>
<td>4 (66.7)</td>
<td>25 (45.5)</td>
</tr>
<tr>
<td>Tamang</td>
<td>10 (43.5)</td>
<td>0</td>
<td>8 (14.5)</td>
</tr>
<tr>
<td>Badai</td>
<td>0</td>
<td>0</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Sheikh</td>
<td>0</td>
<td>0</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Lama</td>
<td>3 (13.0)</td>
<td>1 (16.7)</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Dalit</td>
<td>2 (8.7)</td>
<td>1 (16.7)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Non-Healer Profession (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>16 (69.6)</td>
<td>3 (50.0)</td>
<td>38 (69.1)</td>
</tr>
<tr>
<td>Occupation</td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>-------------------</td>
<td>------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>Business</td>
<td>0</td>
<td>0</td>
<td>2 (3.6)</td>
</tr>
<tr>
<td>Community Health Assistant</td>
<td>0</td>
<td>0</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Housewife</td>
<td>0</td>
<td>0</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Nomad</td>
<td>0</td>
<td>0</td>
<td>2 (3.6)</td>
</tr>
<tr>
<td>Student</td>
<td>0</td>
<td>0</td>
<td>2 (3.6)</td>
</tr>
<tr>
<td>Teacher</td>
<td>2 (8.7)</td>
<td>0</td>
<td>5 (9.1)</td>
</tr>
<tr>
<td>Mechanic</td>
<td>1 (4.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>None</td>
<td>4 (17.4)</td>
<td>3 (50.0)</td>
<td>4 (7.3)</td>
</tr>
</tbody>
</table>

**Education (%)**

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>12 (52.2)</td>
<td>1 (16.7)</td>
<td>17 (30.9)</td>
</tr>
<tr>
<td>Some Primary School</td>
<td>9 (39.1)</td>
<td>3 (50.0)</td>
<td>23 (41.8)</td>
</tr>
<tr>
<td>Primary School</td>
<td>1 (4.3)</td>
<td>0</td>
<td>10 (18.2)</td>
</tr>
<tr>
<td>Bachelors</td>
<td>1 (4.3)</td>
<td>2 (33.3)</td>
<td>4 (7.3)</td>
</tr>
<tr>
<td>Masters</td>
<td>0</td>
<td>0</td>
<td>1 (1.8)</td>
</tr>
</tbody>
</table>

Note: DJ indicates dhami-jhankri. TH indicates traditional healer.

Village residents grew up mostly as Hindus, Buddhists, or a syncretic combination of the two. A small minority followed Satya: a Christian based religion loosely adherent to Hinduism. Historically, the Tamang population has used Christian conversion as an opportunity to avoid the expensive requests of dhami-jhankri, but we found no cases of this within our community (Fricke 2008; Ripert 1997).

From 1996 to 2006, civil war raged through the countryside with death sentences, murders, purges, abductions, and other war crimes against humanity. Two quotes highlight chronic poverty and natural disasters, including the 2015 earthquakes and the more recent 2017 summer flooding:
“My upbringing was not so good. We used to eat dhido (Nepali food made of flour). To eat rice, we had to wait for the rituals and traditions related to Dashain and Tihar. Because we were poor, none of us could wear proper clothing.” Male Farmer; Age 45

Villagers recalled losing loved ones not only to natural disaster but to medical illness left untreated because of the lack of health facilities:

“My father died when I was young. You [the translator] are Nepali so you can also understand my feelings. Afterwards my brothers and I had to take care of ourselves but there was never enough money.” Male Farmer; Age 38

However, in spite of these adverse outcomes, participants viewed their upbringing as worthwhile given the availability of food, shelter, and other basic amenities of living. Following the earthquake, Japanese investors constructed a nearby road which allowed for transportation to various previously inaccessible facilities.

At the time of the research project, villagers were noted to work mostly as farmers of corns and other grains. To supplement their income, many managed nearby shops and restaurants. Local villagers could not easily access electricity, clean water, and irrigation. For clean water, villagers carried gourds back and forth from the nearby river to their home. For electricity, some had access to solar panels, others landlines, and some none at all.

Although local villagers had access to a modern road, they did not have access to major health facilities within practical driving instance. By motorcycle, the closest hospital was approximately two hours away, the closest pharmacy 20 minutes away, and the closest bank 30 minutes away. Even with access to a pharmacy, local villagers had to choose from a limited
formulary. Though the relatively recent road developments made city physicians more accessible, traditional healers still lived closer to villagers and had intimate ties to patients as either family members or well-known community members. Given their close proximity and familiarity, traditional healers visited patients just as much as patients visit them. Local traditional healers did not always require *dakshina* (monetary payments for services) and at times offered their services for free or for bartered goods such as goats, hens, rice, roosters, eggs, beers, cigarettes, and ghee.
3.2 Ms. T: A Case Study

Because Ms. T’s story highlighted a number of the diagnostics, treatments, experiences of healing, and casual dynamics between traditional healers and mental health, captures the complex steps patients take to find treatment with meaning that is commensurate with their perception of illness, and showcases the structured observational scale of common psychotherapeutic factors the paper opens the broader thematic analysis with her case study (Figure 1).

Figure 1: Visual Summary of the Case Study’s Treatment Course from Individual to Individual as Captured During June of 2018.
Ms. T was a 48-year-old Tamang (one of the highly populated ethnic minority groups) woman who sought treatment for a number of complaints, but chiefly for stomach pain. Her treatment course took place from the beginning to the end of June 2018. She had no past medical history and initially complained about loss of appetite to her family.

While Ms. T willingly volunteered her story, she admitted to feeling constrained by her busy work schedule and the inherent explanatory difficulties. She could not approximate when she began to experience her symptoms. However, she believed her symptoms may have started as *jhum-jhum* (numbness or tingling in a “stocking and glove” distribution). Initially, she felt a nagging pain, especially when she had to walk throughout the day. Her *jhum-jhum* progressed to stomach pain, which then gave way to generalized weakness, dizziness, loss of appetite, and “tension” (idiom of distress related to anxiety). She described “tension” as a state of sleepiness throughout the day. During a medical and psychiatric review of symptoms, she could not further expand upon her symptom characteristics, associated factors, duration, constancy, or frequency.

Ms. T was born and raised in the village. She grew up uneducated and worked primarily as a farmer throughout her life. She denied any physical, emotional, or sexual trauma throughout her life. Growing up, she never saw a doctor, although when she had a headache she once sought help from a drug retailer, and although he prescribed her medications, she never took them.

She eventually married and continued life as a farmer until the 2015 Nepal Earthquake destroyed her home. However, she did not report any psychiatric sequelae following the earthquake.

At the time of her illness, she was living in the village with her husband, two daughters, and son in law while slowly recovering her prior life and constructing a new home. Together, they farmed the land throughout the day while maintaining a newly opened restaurant situated along the main road. Despite her opportune location, traffic along the road trickled through very slowly. Consequently, her restaurant earnings accounted for a small fraction of her family’s total
income. She pushed forward with the construction of her new home, however she admitted this also put her at risk for *bigar* (a supernatural problem caused by others).
3.2.1 The Drug Retailer

Ms. T’s stomach pain grew worse over the next two days. Hence, her son-in-law ushered her towards medical attention. He took her to the nearest drug retailer located approximately 20 minutes away by motorcycle. The drug retailer, a 43-year-old man from the village with a bachelors education, listened to her history, took her blood pressure, and diagnosed her with “gastric” (a common condition in Nepal that centers around stomach pain and can contain any number of related symptoms). The drug retailer offered Ms. T medications to treat her gastric and advised her to avoid fatty foods and meat. In the event that her symptoms might deteriorate, he strongly encouraged her to seek treatment from a *dhami-jhankri*. Altogether the interaction between the drug retailer and Ms. T lasted 10 minutes. Once Ms. T returned home, she expressed disbelief to her family that *bigar* could be treated with medications. Although she accepted and purchased the medications initially, she did not take them.

The drug retailer, during a subsequent interview, described how the older generation, like himself, relies on *dhami-jhankri* for *atma santushti* (satisfaction in the soul). The drug retailer informed the research team that as a drug retailer he believes in medicines but can’t completely rely on them given his traditional surroundings. Ultimately, he chose to align himself with Ms. T’s beliefs so as to appear less arrogant. Moreover, he himself admitted to partially believing in *dhami-jhankri* and *bigar*. 
3.2.2 The Jyotisi

Ms. T’s symptoms worsened since seeing the drug retailer. Approximately one week later, she sought the help of a 31-year-old jyotisi from Kathmandu who happened to be passing through the village. The jyotisi came to her attention given his status as the younger brother of a village elder. Moreover, Ms. T had heard about his talents in the past while healing a local villager following a motorcycle accident.

For context, we interviewed the motorcycle accident victim. The jyotisi visited him during his hospitalization. The accident victim told the jyotisi about his stress and fear of being tarsaunu (haunted) by other patients who had passed away in the hospital. Therefore, the jyotisi bequeathed upon the accident victim a buti (enchanted necklace). The accident victim reported an immediate relief in his symptoms.

After Ms. T’s family heard about the jyotisi’s arrival, they resolved to find time with him. Unfortunately, they caught him during his wait for a bus back to Kathmandu. Nonetheless, he accepted the family’s request and saw the client, albeit for a relatively short time period. The research team interviewed the jyotisi during this time. He talked to the patient in the same manner as he would friends and family. He listened to her story and concluded that she suffered from lagan (a type of spiritual illness) and prepared her for the necessary treatment. Ms. T reported the counseling alone gave her incredible relief.

During the jyotisi’s treatment, he performed a combination of verbal and non-verbal rituals. He recited several mantra, most of which were the baidik mantra (a type of verbal ritual taken from the Yajur section in the book of Veda). He combined his mantra with several non-spoken rituals including phuknu (a blowing technique), waving a mayur ko pwankh (peacock feather) around her body, and applying agar batti ko dhulo (incense ash) to her forehead. While the jyotisi refrained from ascribing specific meaning to his mantras, he stressed how his blowing
technique, peacock feathers, and incense ash removed *nakaratmak gun* (negative properties) from Ms. T’s body.

Finally, he advised Ms. T about what to expect and what to do. Should her symptoms persist, he advised her to seek treatment from a *dhami-jhankri*, because no doctor could treat her type of spiritual illness. He would have himself fully healed her, but without available time, he had to make do with what he had. Given Ms. T’s income level he did not accept her payment. Altogether their interaction lasted eight minutes.
3.2.3 Dhami Jhankri I

While there had been one dhami-jhankri (Dhami-Jhankri I) widely known across the village, Ms. T stated that she would not solicit his treatment. She reported not particularly trusting his powers given his history as a drunkard. Nonetheless, the research team conducted a separate interview with Dhami-Jhankri I to better understand Ms. T’s opinion. First, he walked the research team through his collection of dhami-jhankri tools. He showed them his old dhangro (drum), new dhangro, deuta ko murti (deity statues), maala (necklaces), and khangling (special flutes mainly made from a femur bone). He then adorned his jama (traditional dhami-jhankri attire – a white skirt adorned with necklaces, bells, and a feathered head dress).

After the tour, because a nearby neighbor complained of difficulty sleeping, he performed a blowing technique on a glass of water, notably while noticeably intoxicated, and asked the neighbor to drink it. He then performed a ritual dance while beating his drums. He transitioned his performance to the center of the village. There another dhami-jhankri borrowed his dhangro to demonstrate his own techniques as well, although this created some hostility between the two dhami-jhankri. As their performances went on, Dhami-Jhankri I threatened to make the research team tremble. The research assistant then expressed discomfort and asked to leave.
3.2.4 Dhami-Jhankri II

The next day following the jyotisi’s treatment, Ms. T continued to experience pain, malaise, and loss of appetite. As instructed, she visited a nearby dhami-jhankri (Dhami-Jhankri II), her nephew. She heard about her nephew’s powers after he had treated a friend’s sick child and another local villager for his khutta ma sola hanne (mild leg pain).

For context, the research team interviewed the local villager with mild leg pain and learned about his account of Dhami-Jhankri II’s treatment method. This local villager initially went to the hospital where he received an extensive workup that cost him around 10,000 Nepali rupiya (100 US dollars). As a result, the local villager turned to Dhami-Jhankri II for treatment. The local villager described Dhami-Jhankri II as “mayalu” (caring) and “bujna lai sajilo” (easy to understand). Dhami-Jhankri II performed panchaunu (a phuknu treatment requiring flowers, rice, and incense that removes spiritual problems), beat his drums, trembled, and worshiped both his guru and the gods. After the healing ceremony, the local villager reported an instantaneous recovery.

However, Ms. T described a less favorable account of Dhami-Jhankri II when he treated her friend’s sick daughter. Both Dhami-Jhankri II and her friend agreed upon a time and place for treatment. Dhami-Jhankri II then arrived late and failed to cure her friend’s daughter. Ms. T perceived Dhami-Jhankri II’s then behavior as arrogant.

When it came time for Ms. T’s nephew to treat her, he used a blowing technique. Her symptoms did not improve later that day, and so the next day he repeated his technique but her symptoms nonetheless continued. Dhami-Jhankri II declined to later interview with the interview team, citing that the they might steal his techniques.
3.2.5 Dhami-Jhankri III

Despite continued disappointments, Ms. T’s family reached out to yet another dhami-jhankri (Dhami-Jhankri III), this time a local friend known for his dhami-jhankri skills. Despite being the most familiar dhami-jhankri to Ms. T’s family and the most sought after dhami-jhankri within the village, they could not seek out his care initially because of his own busy schedule as a farmer.

However, a few days following the Dhami-Jhankri II’s failed treatment, Dhami-Jhankri III managed to allocate a portion of his time to talk to Ms. T and her family. On this day, they informed Dhami-Jhankri III of her illness. To Ms. T’s astonishment, Dhami-Jhankri III asked Ms. T about her unwitnessed fall, an incident that she had previously told no one. Ms. T and Dhami-Jhankri III agreed on 900 Nepali rupiya (nine US dollars) in exchange for her treatment later that night. Dhami-Jhankri III then informed Ms. T and her family about the treatment plan. He gave specific instructions to each family member in regards to the necessary preparations. Dhami-Jhankri III advised the son to bring, among other items, agar batti (incense), kera ko paat (a banana leaf), vaale (a rooster), and materials to build an aago (fire). Ms. T’s family clarified the significance of each required object and action. The banana leaf would deal with the grahadasha (misalignment of astrological signs) and transfer Ms. T’s curse to the rooster. The fire would appease the gods while the incense would allow the dhami-jhankri to converse with them.

The ceremony would take place later that night and he suggested that Ms. T rest for the rest of the day, assuring her that the treatment would work. Ms. T and Dhami-Jhankri III then spoke about personal matters before the two temporarily departed.

Ms. T described Dhami-Jhankri III as empathic, skilled, and approachable. She could easily tell he understood her issues and sincerely cared about her welfare. As her family hurried
to find the necessary materials, Ms. T expressed complete confidence in the healing ceremony to come.

Dhami-Jhankri III, Ms. T, her husband, her two daughters, her-son-in-law, the primary researcher, and the research assistant reconvened later that night at a small hut nearby Ms. T’s home. There Dhami-Jhankri III prepared for the ceremony using the materials which the family had previously gathered. The healing ceremony began not soon after midnight. Although Dhami-Jhankri III spoke to no one throughout the ceremony, family members participated throughout the ceremony as previously instructed. Dhami-Jhankri III spent the first hour beating his dhango and chanting mantra as Ms. T’s family setup the fire. Midway through this performance he swallowed a wick of fire whole in order to demonstrate his powers. He then illuminated the ground with batti (a candle light made by mixing oil in cotton) and drew bhut ko chitra (a spirit diagram).

Afterwards, he tied a thread between the diagram and the banana leaf. He spent a considerable amount of this time trembling, chanting mantra, and dancing. Near the end of his performance he strangled the rooster until it fell unconscious. Moments later the rooster reawakened to everyone’s surprise. As his chanting and drum beating soared to a loud crescendo, the husband hacked the banana leaf, severed the string, grabbed the rooster, and threw all three out the door. Altogether, the treatment lasted for three hours. The family then spent the remaining time together sitting, talking, and resting.

Ms. T and her family reported a full recovery the very next morning. She returned to work later that afternoon. Ms. T related her full recovery to Dhami-Jhankri III's powerful treatment and the jyotisi’s amulet. When comparing Dhami-Jhankri II to Dhami-Jhankri III, she considered the possibility that Dhami-Jhankri III may have simply been lucky. In spite of her
swirling treatment course utilizing several providers and treatments, she reported no regrets (Table 3).

Table 3: ENACT Competencies Across Four Traditional Healers and One Drug Retailer from the June 2018 Case Study.

<table>
<thead>
<tr>
<th>Domain</th>
<th>DJ I</th>
<th>DR</th>
<th>JTC</th>
<th>DJ II</th>
<th>DJ III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Non-Verbal Communication and Active Listening</td>
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<td>N</td>
<td>Y</td>
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<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>Explanation and promotion of confidentiality</td>
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<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td><strong>Emotion</strong></td>
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<tr>
<td>Rapport building &amp; self-disclosure</td>
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<td>N</td>
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<td>Y</td>
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<tr>
<td>Exploration, interpretation &amp; normalization of feelings</td>
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<td>N</td>
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<td><strong>Social relations</strong></td>
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<tr>
<td>Connection to social functioning &amp; impact on life</td>
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<td>N</td>
<td>N</td>
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<tr>
<td>Exploration of patient’s &amp; social support network’s explanation for problem</td>
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<td>Appropriate involvement of family &amp; other caregivers</td>
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<td>N</td>
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<td>N</td>
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<tr>
<td><strong>Planning and process</strong></td>
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<tr>
<td>Collaborative goal setting &amp; addressing patient’s expectations</td>
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<td>N</td>
<td>Y</td>
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<tr>
<td><strong>Assessment</strong></td>
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<tr>
<td>Assessment of patient’s recent life</td>
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<td>events &amp; acknowledgment of impact on</td>
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<td>to others, harm from others &amp;</td>
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<td>plan</td>
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<td>Promotion of realistic hope for</td>
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<td>Incorporation of coping mechanisms &amp;</td>
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<td>prior solutions</td>
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<td>Psychoeducation incorporating local</td>
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<tr>
<td>concepts &amp; terms</td>
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<td>Use of problem-solving steps</td>
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<td>Elicitation of feedback when</td>
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<tr>
<td>providing advice, suggestions &amp;</td>
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<tr>
<td>recommendations</td>
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<tr>
<td><strong>Total Number of Competencies</strong></td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>0</td>
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</tbody>
</table>

Note: DJ indicates dhami-jhankri. DR indicates Drug Retailer. JTC indicates jyotisi. N indicates not competent. Y indicates competent in the skill.
3.3 Diagnostic Approaches

Traditional healers from our studied village predominantly diagnosed illness using observation, pulse checks, gathering a history of present illness, and divination. We could not identify any relationships between specific illnesses and specific diagnostic approaches.

*Dhami-jhankri*, *lama*, and *jyotisi* reported the ability to ascertain a patient’s diagnosis through observation, although they did not specify their exact approach. *Dhami-jhankri*, *lama*, and *jyotisi* reported that they could diagnose a patient’s ailments by measuring their *naadi* (artery, can also be used for vein). Four *dhami-jhankri* took a patient’s pulse by placing their fingers on the patient’s radial artery, however other *dhami-jhankri* and *lama* varied considerably with their finger placement.

Participants described *dhami-jhankri*, *lama*, *jyotisi*, *ayurvedic healers*, *bhaidya*, naturopathic healers, *pujari*, and *jajmanj* who took a verbal history of a patient’s chief complaint by exploring the patient’s chronological history of present illness. History gathering generally lasted for no more than five minutes. Participants stressed the central diagnostic role of *jokana* (astrological divination). *Jyotisi* (astrologers) in particular drew from their strong background in astrology to make claims about their patients and the nature of their illness. One *dhami-jhankri* described astrological divination as a process by which he analyzed rice to determine the patient’s fate. This *dhami-jhankri* demonstrated his astrological divination. First, he separated the rice on a plate. He took note of whether the rice separated into odd or even amounts with odd signifying supernatural pathology and even not.
3.4 Techniques

Traditional healers from our studied village predominantly treated using altered states of consciousness, verbal rituals, non-verbal rituals, herbal medications, and social support. As with their diagnostic approaches, we could not identify any relationships between specific illnesses and specific techniques.

Traditional healers varied the length of their individual sessions from a few minutes to hours. Some treatments took place at midnight, possibly lasting overnight. Traditional healers repeated their treatments once to over a hundred times, over the course of months, depending on how long it took for the patient to receive satisfactory results. Participants attributed the amount of variability to the variable nature of disease states.
3.4.1 Chanting, Altered States, and Gods

Participants explained how dhami-jhankri, lama, and jyotisi would use advanced mantra (spoken prayer or hymns) or tantra (bodies of text or schools of thought) to facilitate laagnu (literally to be occupied or overtaken but in this context referring to a deep meditative state or trance) during which the healer would freely converse with the gods and spirits.

In the hill region, four Tamang (ethnic minority group) dhami-jhankri demonstrated their mantra and tantra on local villagers. The four dhami-jhankri congregated into one room as nearby villagers slowly arrived to witness the locally renowned healers. The four dhami-jhankri prepared a pre-ceremonial ek thaal chaamal (plate of rice grains), agar batti ko dhulo (incense powder), and different necklaces. Each dhami-jhankri successively took turns trembling, babbling, and speaking to their gods in the local Tamang dialect. The first dhami-jhankri initiated the ceremony by drawing a circle in the dirt using a knife. In doing so he separated an area specifically for meditation. He chanted using his own voice, but then his tone grew loud and thunderous indicating a possessed state by the gods. His hands noticeably shook, and he exclaimed, as though with the voice of gods, “Why did you call me? This is not important.” To which the dhami-jhankri replied in his own voice, “I’m sorry I just want to show my techniques to these people.” The other three dhami-jhankri offered similar performances.

Between dhami-jhankri and lama, both practiced similar verbal rituals with the main distinction being spoken language. Other minor distinctions separated dhami-jhankri into more frequent tantra users who could also cast mohoni (damaging love spells). Despite the wide variety in mantra, both dhami-jhankri and lama admitted to chanting several mantra interchangeably while achieving the same healing effects.

Dhami-jhankri and lama seldom offered counseling in conjunction with their mantra. However, in rare circumstances they offered suggestions on which foods to eat, which foods to
avoid, or relationship advice. Jyotisi guided patients through their astrological future. Ayurvedic healers, bhaidya, and naturopathic healers drew on non-medical processes such as energy or humors to offer advice on how to take their medicines and what diets to follow:

“I find out the cause of the interpersonal conflict, and I will give advice regarding who caused it. I will also tell my patients how we were all born and how we will all die.”

Male Baidhya; Age 48

Jajmanj and pujari performed puja rituals with patients during times of distress and guided patient Hindu practices in the days to weeks to come.
3.4.2 Healing Through Action

Participants described the non-spoken rituals of local dhami-jhankri and lama as very similar. Dhami-jhankri and lama described a very step-wise approach to their performances, with the next technique being more physically and mentally demanding and theatrical than the previous. The non-spoken rituals of dhami-jhankri and lama have evolved over time. Currently, dhami-jhankri and lama have reportedly utilized fewer household items, e.g. khorsani (red chili powder), during their ceremonies.

Dhami-jhankri, lama, and jyotisi performed several types of non-spoken rituals. Many dhami-jhankri and lama accompanied their non-spoken techniques while beating the dhangro (type of drum) or damaru (two headed hand drum). Dhami-jhankri, lama, and jyotisi most commonly practiced phuknu (air blowing).

One dhami-jhankri whispered mantra into grains of rice that he was holding and then blew them on various parts of a patient’s body. He concluded by snapping three times. Another dhami-jhankri blew mostly in the patient’s face while waving agar batti (incense) around the patient’s forehead. A dhami-jhankri, who at the time of observation was reportedly intoxicated from cannabis, swirled an incense stick around the patient’s head three times, blew on his face, and then whispered several barely audible mantra. Each of these dhami-jhankri performed two to three cycles of treatment lasting altogether for three to four minutes.

Dhami-jhankri and lama even offered food and drink which they reportedly imbued with magical qualities through the power of their mantra:

“One of the dhami-jhankri was also my relative. My wife faced difficulty conceiving, and he treated her using different techniques such as giving her pigeon blood to drink.
Currently we have two daughters. I learned my mantra from him.” Male Farmer; Age 42

*Dhami-jhankri* and *lama* used animals and items for sacrifice:

“After the first month of my son’s wedding, my daughter-in-law fainted…The next day my son called me to say she started to appear uncontrollable – at times jumping over the bed, trembling, pulling her hair, screaming, and crying…The doctor gave her an injection and she fell asleep for 12 hours. I went to the hospital and discharged her because she wasn’t getting better. Instead we took her to the *dhami-jhankri*. The *dhami-jhankri* told me to pay him 6000 Nrs (approximately 6 US dollars) so that he could treat her. He also asked for a black and white pigeon, flowers, and several other items. Afterwards he made statues made of corn flour. We then threw those statues into the river while setting loose the pigeons into the sky. The *dhami-jhankri* treated my daughter-in-law for 25 days altogether and afterwards she felt good. Now, I very much believe in *dhami-jhankri*.”

Male Farmer; Age 43

*Dhami-jhankri*, *lama*, and *jyotisi* offered their patients charms such as a *buti* (magical thread/amulet):

“My mother suffered from mental illness. First, she started trembling and roamed around at night. Because of her tension*, she developed headaches. We took our mother to the hospital and the doctor explained that the problem was related to her veins which also caused my mother’s headache. He gave her medicine for sleep, and she started to sleep at night. However, she continued to roam around, so we took her to the nearby *lama*. The
lama gave her a buti (charm amulet) to wear and only afterwards did she stop roaming around.” Female Student; Age 20 [*Note: the English word ‘tension’ was used.]

Many dhami-jhankri, lama, and jyotisi engaged patients through physical gestures such as chunu (touching) the patient’s hand or head, waving incense around their bodies, and applying korsani tika (red powder) on their forehead:

"The dhami-jhankri saved the patient by placing a rice grain in her mouth and then placing tika on her forehead. Afterwards she opened her eyes.” Male Farmer, Age 43

Other non-spoken techniques involved hitting the patient, say though kitab le hannya (hitting with books), kuccho le hannya (hitting with brooms), hitting with darshan dhunga (type of stone), and throwing akchyeta (rice grains):

“Sometimes the dhami-jhankri broke off a darshan dhunga and threw the pieces at the patient.” Male Farmer; Age 73
3.4.3 Ayurvedic Medicine

Participants described how *dhami-jhankri*, naturopathic healers, and *baidhya* prescribed more personalized and natural medications when compared to medical providers. For example, one naturopathic healer prescribed self-prepared herbal medications composed of local plants and other earthy materials, e.g. mud. Another *baidhya* prescribed homeopathic medications either self-prepared or pre-purchased.

“In rural areas people believe more in herbal medicines than they do in doctors. The medicines used to treat bigar are just herbal medicines.” Male Farmer; Age 52
3.4.4 Mobilizing Social Support

Several dhami-jhankri, lama, jyotisi, pujari, and jajmani treatment ceremonies involved both family members and friends. The invited members assisted with various preparations before and during the ceremony. Some friends and family members would even take on the work and life responsibilities of the patient to alleviate distress and allow them time to take part in the traditional healer’s treatment ceremony.
3.5 Patient Experiences of Treatment

Several villagers portrayed a sense of futility when asked to explain their experiences receiving treatment from traditional healers, often appearing confused in regard to why the researchers posed the question in the first place. Uneducated villagers more so than others often replied “upaachaar le kaam garyo” (the treatment worked) or “byakhyya garna jaruri chhaina” (it was not important to explain). However, many other patients described improvement in the context of biswas (belief), atma santushti (satisfaction in the soul), social support, transference, and symbolic narration.
3.5.1 Biswas

Villagers described how their man (local Nepali construct which can be translated to heart-mind) guided biswas (belief) in the traditional healer’s treatment, especially in the context of prior anecdotal experience:

“My man said I would be okay if I saw the dhami-jhankri, so I went and afterwards I felt okay.” Male Farmer; Age 37

“In my view people get better because of their biswas in the dhami-jhankri but not because of the treatment by the dhami-jhankri.” Female Farmer; Age 32

Villagers compared their belief to the feeling of submitting to thulo sakti (a greater power) while others described it as a form of jhuto aasha (false hope):

“Sometimes the dhami-jhankri treatment works but I don’t know how. Some dhami-jhankri create the sense of jhuto aasha by saying that they can perform any treatment.” Male Business Owner; Age 34
3.5.2 Santushti

Villagers used the term *atma santushti* (satisfaction in their soul) to describe their experience of healing:

“One time a 12-year-old girl came to me for chest pain. Although she actually suffered from kidney stones, I used my mantra to treat her, and she felt better for one week afterwards, because I gave her *atma santushti.*” Male Dhami-Jhankri; Age 42

“In this area, people used to go to the *dhami-jhankri* for medical treatment because there were no hospitals. These days those people still hold onto their old beliefs. Thus, people here attain more *atma santushti* from *dhami-jhankri* than doctors, and people will continue to seek treatment from *dhami-jhankri.*” Male Naturopathic Healer; Age 40

The *dhami-jhankri* himself may also experience satisfaction in the soul if he takes pride in his treatments:

“My patients find themselves feeling very happy after my treatments. I too gain *atma santushti* and confidence when my treatments are helpful.” Male Dhami-Jhankri; Age 56

If a traditional healer fails to treat someone’s lack of satisfaction in the soul then the patient may suffer from a multitude of ailments, most commonly anxiety and depression:

“If people cannot attain *atma santushti,* then they will suffer from tension and mental illness. Some people may even commit suicide.” Male Teacher; Age 50
However, traditional healers alone do not account for a failure in satisfaction in the soul. In reality, local patients present with complex biopsychosocial and magico-religious complaints requiring a combination of biomedical and explanatory treatments. Some patients receive medical treatment but yearn for a magico-religious explanation of their illness to alleviate mental distress. On the other hand, some patients receive traditional healer treatment but yearn for a biomedical treatment of their illness to alleviate physical distress. Tension and depression following any provider’s treatment can lead the ill patient to seek a second opinion from other providers, often shifting between biomedicine and traditional medicine until achieving a state of satisfaction in the soul. *Dhami jhankri, lama, jyotisi, pujari, jajmani, drug retailers, and community health assistants all facilitated a referral process based on the patient’s expectations for treatment. Only doctors did not refer out to traditional healers:*

"I can treat soul possession, mental illnesses such as tension, social conflicts such as low income, interpersonal conflicts between husband and wife, problem children, and small illnesses such as headache and stomachache. Only doctors can treat critical illnesses like cancer and kidney stones." - Male *Jyotisi; Age 31*
3.5.3 Influences on Biswas and Atma Santushti

Villagers reported several factors which could influence their belief and satisfaction in the soul. For instance, demographic factors could influence belief. Younger participants who spent their lives in the city reported the least belief in *dhami-jhankri*. Conversely, less educated, medically illiterate, elderly villagers who spent most of their lives in this village endorsed the greatest belief in *dhami-jhankri*, especially if the *dhami-jhankri* was related to them:

“Currently, we go to not only the *dhami-jhankri* but doctors too.” Male Farmer; Age 73

The category of illness influenced villager belief. Non-healers felt that *dhami-jhankri*, *lama*, *jyotisi*, in contrast to doctors could less proficiently treat serious conditions and *bhitrirog* (inner diseases). Serious conditions included fractures, physical trauma, and organ transplants. *Bhitrirog* included endocrine and oncologic disorders. Accordingly, traditional healers reported feeling particularly ill-equipped to treat critical illnesses such as large wounds or blunt trauma.

Participants said physicians could better treat serious conditions and *bhitrirog* because they possessed more advanced procedures and medications. These more powerful procedures and medications came at the price of more serious side effects when compared to their ayurvedic counterparts. On the other hand, participants said *dhami-jhankri* could better treat less serious conditions and non-*bhitrirog*:

*A dhami-jhankri* or *jyotisi’s* reputation can have a deep effect on patient belief and trust. Non-healers reported on several *dhami-jhankri* and *jyotisi* with off putting attributes. With respect to their personalities, villagers reported some with substance abuse and a focus on money. For instance, a *dhami-jhankri* or *jyotisi* can defame himself by exhibiting inattention, a lack of empathy, and recklessness from say frequent intoxication. These behaviors had a serious impact
on the patient’s ability to believe in the traditional healer’s abilities:

“Bad dhami-jhankri treat only for income.” Male Farmer; Age 66

“Some jyotisi are fake and just want money. These jyotisi will just at look the hand of a person and pretend to predict their future...Not all jyotisi are bad though.” Male Farmer; Age 56

A number of dhami-jhankri described themselves in relation to others, frequently discrediting the other’s authenticity while promoting their own. Among these healers, non-healer community members expressed concern about their excessive competition, condescension, and arrogance. As a result, villagers lost faith in dhami-jhankri or jyotisi who repeatedly elevated their position above others:

“Again, I did not see how he [the dhami-jhankri] could treat excess blood in her body, so I instead took my wife to the hospital. The doctor told me if I had been late then my twins might have died.” Male Farmer and Teacher; Age 53

Paradoxically, excessive competition for fame or reputation only worsens the dhami-jhankri or jyotisi’s reputation and by association his therapeutic effect. When patients must decide among several dhami-jhankri or jyotisi to treat their illness, many admitted to choosing the dhami-jhankri or jyotisi who boasted least about their abilities. Non-healer community members volunteered a similar distrust in doctors who they perceived as lacking in empathy or understanding:
"Doctors with poor behavior make me feel bad. For instance, one time I went to the hospital, and they criticized me for presenting with such a small issue…As a result I went to see a dhami-jhankri, and I felt better." Unemployed Male; Age 50

Ultimately, non-healer community members expressed an overall belief in both traditional healers and doctors framed by a diametrically opposing relationship between the two, such that as belief for one increased, the other decreased:

“If people believe more in the dhami-jhankri then the doctor will be ineffective.”

Unemployed Male; Age 73
3.5.4 The Self, the Family, and the Community

_Dhami-jhankri, lama, jyotisi, pujari, and jajmani_ mobilized social support when they encouraged family members to rally behind the patient to seek treatment. In addition, when patients adopted a culturally accepted sick role, family members often excused patients from stressful life obligations and situations. Patients who reported an involved process with friends and family also reported an improvement in their subjective well-being. However, no participants explicitly mentioned a direct relationship between the two.
3.5.5 Transference and Symbolic Narration

*Dhami-jhankri, lama, and jyotisi* made extensive use of transitional objects. For example, several villagers turned to *dhami-jhankri* after *sarpa ko tokai* (a snake bite). The typical *dhami-jhankri* would not treat the snake bite directly. Instead they would sacrifice the original snake to address the underlying magico-religious etiology. However, rarely did the *dhami-jhankri* locate the original offender. Thus, the *dhami-jhankri* would sacrifice another snake in its stead. In other instances, the *dhami-jhankri* would use a different class of transitional object, most commonly another animal or plant.
4. Conclusion

4.1 Case Study

The assessment of common therapeutic factors from the case study revealed several key findings. Ms. T expressed belief in her treating jyotisi and Dhami-Jhankri III, both of whom scored higher than the rest in the following factors: 1) non-verbal communication and active listening, 2) rapport building and self-disclosure, 3) demonstration of empathy, warmth, and genuineness, 4) collaborative goal setting and addressing patient’s expectations, and 5) psychoeducation incorporating local concepts and terms. Ms. T expressed the most improvement in her subjective well-being with Dhami-Jhankri III, suggesting that traditional healers who involve family members and other caregivers during treatment may have profound effects on patient expectations and outcomes. Interestingly, another villager’s health issues improved with Dhami-Jhankri II’s treatment, suggesting that perhaps certain common factors of psychotherapy may uniquely apply to some, but not all Nepalis. Nonetheless, we postulate that use of the common therapeutic factors may be associated with more favorable outcomes for their patients.

Overall, our case study highlighted a familiar treatment sequence in which a dhami-jhankri figuratively transfers a patient’s illness to a transitional object before treating the patient’s illness in the form of the transitional object. Interpersonal and interprofessional relationships played crucial roles throughout her narrative. First, the patient conceived of her illness in relation to a neighbor, after which she put together a diverse set of providers using the support and encouragement of her family. These providers individually addressed the physical, astrological, and spiritual aspects of her complex problem, and yet each respected the craft of the other when conceding mastery. Ultimately, the patient’s subjective well-being improved through a complex network of care that met her medical, social, mystical, and religious needs. This suggests an implicit relationship with the “other” or samaaj (social world) when understanding and treating
issues related to the “self.” Furthermore, the social world impacted not only the treatment but the patient’s perception of illness as well (Kohrt & Harper 2008). Bigar (a supernatural problem caused by other people) is commonly thought to cause inexplicable physical complaints. In the patient’s context, the social world’s effect ranges from the conception to the resolution of illness. Providers who focus too heavily on the western concept of self may miss the deeper, intersubjective issues which the patient is facing.
4.2 Thematic Analysis

Beyond the case study, our thematic analysis suggests that traditional healers tell a story by verbally and non-verbally reenacting culturally relevant imagery and magico-religious symbols (Desjarlais 1992). This entire process passively kindles the spiritual experience, and unburdens personal distress (Cassaniti & Luhrmann, 2014; Lutz & White (1986). Though passive, different patients may still experience different outcomes if they do not subscribe to the treatment’s set of symbols.

Similar to earlier work by Desjarlais (1992), the spiritual process of traditional healing weaves a complex illness state into an easy to understand and culturally relevant medical narrative. Concrete symbols form a mental scaffolding that allows the patient to reinterpret their illness outside of complex biomedical terminology, accept a disease state, cope with it, and to psychologically heal. Thus, patients perceive the most benefit from dhami-jhankri when dhami-jhankri treat less threatening, vague, difficult to conceptualize, and time-limited disease states, e.g. pain, aches.

Of note, altered states of consciousness induced by chanting or dhangro (drum) beating may add to a patient’s suggestibility, a process reminiscent of prior Nepali ethnographic research on dissociation, trance, magical flight, and ecstasy (Peters 2007). Curiously, anecdotes about altered states of consciousness from our study focused on stories about females of lower socio-economic status with little to no education. Disenfranchised populations such as these have historically suffered from stigma and socioeconomic oppression that prevented outward expression of inner conflict (March 2019). However, through altered states of consciousness, abreaction may offer unconscious access to repressed emotions (Shah 2012).

Altogether, the dhami-jhankri, lama, jyotisi, pujari, and jajmani’s unique blend of spirituality, myth, and ritual offer meaning, optimism, and identity coherence in the face of large,
existential issues such as critical illness, natural disasters, humanitarian crises, and sociological oppression. In place of despair, a tumultuous existence, and a fractured self, traditional healers tap into the innate human desire to develop a post-hoc sense of coherence. As a result, patients experience the feeling of cosmological order, psychological wish fulfillment, a measure of resilience, and the perseverance to continue on with their lives in the form of satisfaction in the soul.
4.3 Pathways to Care

To better synthesize and to visualize the connections among our findings, the relevant cultural context, and the gaps in knowledge, we hypothesized an overall pathways to care model relating traditional healers to mental health in Nepal (Figure 2). We fit our results within a broader cultural context outlined by the previous available literature and highlighted the current gaps in knowledge both below and in our model (Nortje et al. 2016; van der Watt et al. 2018):

Access to Care: The origins of Nepali mental distress may fall under biological, psychological, sociological, and/or spiritual categories. Given the cultural presence of mental health stigma, medical illiteracy, and sociological oppression, patients may self-interpret their underlying psychological and sociological distress into a culturally appropriate care seeking behavior. For instance, patients may interpret their mental distress as a less stigmatized biological or magico-religious complaint. Patients will then present either to the biomedical treatment realm (e.g. doctors), the magico-religious treatment realm (e.g. traditional healers), or both depending on the context of their environmental and illness. Few studies have investigated the specific social and economic barriers which influence patient interpretation from a primary psychological or social issue to a medical or spiritual one. Of interest may be the precise process of self-interpretation from stigmatized to less stigmatized complaints and other yet undiscovered magico-religious complaints.

Interventions: Magico-religious diagnostics include observation, divination, pulse checks, recitals, offerings, and social interpretation. Common treatments include non-verbal rituals, verbal rituals, altered states of consciousness, and herbal medications. Relationships may exist between a patient’s specific care seeking behavior and the traditional healer’s chosen intervention. Furthermore, relative to Nepal’s deep cultural diversity, the scarce available research hints at other yet undiscovered diagnostic approaches and techniques.
Perceptions of Healing: Traditional healers elicit subjective improvement through transference, symbolic narration, inducing an altered state of consciousness, mobilizing biswas (belief), atma santushti (satisfaction in the soul), social support, and simply spontaneous recovery. Relationships may exist between a traditional healer’s specific intervention and the patient’s mechanism of healing. Insufficient research has investigated the perceptions of magico-religious healing, especially with the help of objective rating scales or neurodiagnostic approaches, thus hinting at other yet undiscovered experiential phenomena.

Resolution: A patient may perceive a satisfactory resolution after their first visit to either the medical provider or the traditional healer. On the other hand, a patient may perceive an unsatisfactory resolution if they receive an intervention that lacks the biomedical or magico-religious background which they inherently desire. Scarce research has investigated the outcomes of magico-religious healing, thus hinting at relationships between a patient’s specific mechanism of healing and their satisfaction level.
Figure 2: The Pathways to Care Which Patients Take in Relation to Nepali Traditional Healers
4.4 Limitations and Future Research Recommendations

Our study’s small village within Nepal did not fully represent the country itself. We introduced neither a treatment arm nor a control arm, and by extension we did not compare our results to other biomedical treatment options. Villagers lacked any interest in participating in randomized treatment trials and had scarce access to nearby health facilities and resources. We interviewed the senior member from each household in keeping with local norms. This increased efficiency and decreased cross-talk but generally filtered key perspectives, e.g. from younger women, through older men. Thus, the research team’s interviewed population may not be representative of the overall village population. While our qualitative methodology increased bias, it also allowed us to adapt to the slow and informal pace of life in the village, where scheduling and connecting with participants was complicated by the unreliability of transportation and the needs and limitations of rural life. Thus, we were able to conduct our research slowly and within one region to allow flexible access to participants as well as enough time to accurately document how key elements of rural village life play into therapeutic practices. By allowing ourselves patience with the pace of life in the village, we documented participants on their own terms and with minimal interference. At the same time, we developed intimate relationships with our participants and recorded relevant demographics and background information to preface our results. Unfortunately, our study’s approximately 1.5-month duration fell short of most ethnographic standards, thereby preventing the richness which other previous texts have provided. To garner interest for our research project in the face of real work-life burdens, we compensated participants for their time, but this may have in turn added further bias.

To more accurately examine which common factors of psychotherapy best improve subjective well-being, future research ought to follow a similar methodology as this study and
span across Western, Central, and Eastern Nepal to capture a more comprehensive and diverse population of ages, castes, socioeconomic backgrounds, and traditional healers.

Other research should reevaluate the ENACT scale through an ethnographic lens. While we used the assessment of common therapeutic factors to measure which common factors proved most advantageous for traditional healers, the creators of this scale originally validated it for western-trained psychotherapists, making its application here somewhat problematic. For instance, our qualitative results, despite its ethnographic shallowness, highlighted many efficacious healer factors that would have fallen under the singular competency of cultural relevance. Thus, while traditional healers may overlap with psychotherapists they may also offer their own brand of healing.

Future researchers should conduct focus groups between traditional healers and medical providers to allow for the cross-pollination of ideas. Afterwards, project implementation can focus on enhancing current effective psychotherapeutic practices, generating new psychotherapeutic practices for more traditionally inclined patients, while creating effective collaborative care and referral networks.

Altogether, we propose a holistic bio-psycho-social-spiritual collaborative care model in which multi-disciplinary providers meet the needs of Nepal’s modern and traditional cultures. Biomedical providers and traditional healers should reflect on the common factors of psychotherapy found or not found among effective traditional healers, the specific factors which effective traditional healers possess and that others lack, what it means to be mentally well and “healed,” and how any treatment process may rely on trust and rapport with, as well as empathy for, a patient. In doing so, all providers may see patients as effective traditional healer’s do — not as subjects to address but rather as partners in the process. By emphasizing communication with a patient and empathy with their notion of “better,” it creates a more communally inclusive concept of healthcare.
4.5 Epilogue

Currently I am working on a similar exploratory project as part of a Fogarty Fellowship that builds upon the current study by expanding its focus to the southeastern, hilly central, and western regions of Nepal. I plan to again build upon these studies by initiating focus groups to gather ideas for future project implementation. My career trajectory is set to promote similar efforts within other understudied nations with an abundance of traditional healer utilization as a means to improve the general mental well-being of its constituents.

Beyond Nepal, global mental health studies have highlighted a high global burden of mental and substance abuse disorders amid scarcely available mental health resources that suffer from inefficient utilization and unequal distribution (“Mental Health Atlas 2017” 2018; Saxena et al. 2007). However, these estimates exclude traditional healers who may already serve disenfranchised populations through therapeutic treatment rituals.

Unfortunately, we as a scientific field lack a clear and concise understanding of who uses traditional healers and for what reasons across the world. In a Lancet Psychiatry review Gureje and others (2015) reported that psychiatric patients use complimentary and alternative medicine (CAM) at rates which vary between 20 to 80% (Gureje et al. 2015). In response to this variable range, they discussed the inherent difficulties with defining and classifying the complex enormity of CAM, a field which encompasses not just traditional healers but a plethora of other related subjects. CAM’s varying terminology and cultural meanings blurs the distinction between medical and cultural problems, and a difference in simply how one elicits information alone can change prevalence rates of CAM use.

If traditional healers have escaped estimates of care coverage, has this rippled into a broader neglect within public health and research funding? Perhaps not within high income countries (HIC), as large organizations such as the National Institute of Mental Health (NIMH)
have recognized the limitations of exclusively relying on biomedical models to assure effective care and coverage. Consider how European colonialism once suppressed Native American traditional healing practices and with it any unique therapeutic value which they may have offered (Gone 2013). By contrast, the NIMH has now initiated RISING SUN, a project which collaborates with indigenous providers from the Arctic states to help reduce the incidence of suicide. Other similar examples include the Canadian Institutes of Health Research’s Network for Aboriginal Mental Health Research and the Western Australian Association for Mental Health's Looking Forward Project.

However, despite the increased budgetary focus on CAM within HIC, less funding has reached low and middle income countries (LMIC) where patients can use traditional healers at near ubiquitous levels (Gureje et al. 2015), and report improvement at least anecdotally (Nortje et al. 2016). Instead, western medicine has rapidly expanded through LMIC, and we may see a shift away from traditional healers through marginalization and stigmatization, as we have seen in the US and other HIC. We now have a unique opportunity in history and public health transformation to study traditional healer practices while they are still widely used.

Fortunately, past research, including this study, has already provided some insight into why patients choose traditional healers within LMIC. Wagenaar and others (2013), in a study within rural Haiti, suggested that community members turn to traditional healers in pursuit of an explanation for their suffering. However, unlike trained professionals, Haitian traditional healers readily availed themselves to marginalized rural populations, offered their services in exchange for out of pocket expenses without depending on additional government subsidies to sustain their practice, and fostered cultural kinship with the patient over treatment rituals which overlapped with a shared conception of how illness works (Wagenaar et al. 2013). And perhaps like trained counselors, traditional healers use metaphor, displacement, transference, and identification as semiotic processes to organize and internalize interpersonal experience within a universal and
culturally accepted structure. As a result, other researchers have advocated for the therapeutic, yet complex, integration between traditional healing and contemporary psychotherapy (Gone 2010; Schierenbeck 2016).

However, many LMIC collaborative projects, while successful, have prioritized Western approaches over the traditional healer’s uniquely psychotherapeutic craft (Bouchard 2009; Durie 2009; Lucchetti et al. 2012; Koss 1987). One rare, though dated exception came in 1974 when medical providers consulted an African shaman to make meaning out of and alleviate psychological suffering related to Western medical treatments (Lambo 1974). Like this example, many LMIC efforts have focused on sub-Saharan Africa and South America, while many other LMIC with a rich history of traditional healers, for instance Nepal (Sidky 2008), lack the same large-scale collaborative efforts (Poudyal et al. 2005; Sharma 1996). To address the traditional healer’s potential in filling the LMIC treatment gap, the 2013–2020 WHO Mental Health Action Plan has recommended for government health programs to include traditional and faith healers as treatment resources (“WHO | Mental Health Action Plan 2013 - 2020” 2013). I plan to capitalize on the 2013–2020 WHO Mental Health Action Plan, investigate the specific relationships between traditional healers and psychotherapy, and implement flexible, collaborative models between traditional healers and biomedicine. To others planning to do the same, I can offer my own reflections and suggestions based off of my previous and current work in Nepal.

Before developing a collaborative care project within a local context, one should create a team which works the boundaries of culture, medicine, and psychiatry, and conduct a systematic review on the relationship between indigenous healing practices and mental well-being without concern for the available literature's perceived quality. Rather than trying to find one integrative theory about personhood and mental health, the research team should systematically review and organize the intracommunity cultural diversity. If at all possible, include literature written in the local context’s native language.
The research team should note that traditional healer concepts of fidelity, adherence, and manualized care do not easily translate into ways of understanding traditional healing, and much of the associated literature has suffered from unscientific study designs (Nortje et al. 2016). However, despite the inherent biases within looser methodologies, checklists and numbers can present the illusion of precision and accuracy, reduce the complexity of our social world, and miss out on deeper indigenous meanings. Thus, to capture the driving force which has naturally preserved indigenous healing practices, future researchers should marry the flexibility of looser methodologies with the the rigors of more empirical instrumentation.

Empirically measuring the psychotherapeutic factors of traditional healers in common with trained counselors can validate the traditional healer’s psychotherapeutic role within biomedicine. I recommend empirical methods that clearly define the psychotherapeutic factors in common between traditional healers and conventional psychotherapists. For example, in the current study, I measured the presence or absence of common psychotherapeutic factors using a locally validated, structured observational rating scale called ENACT (Kohrt et al. 2015).

Describing the psychotherapeutic factors of traditional healers specific to their craft can inform future culturally adapted counseling and psychotherapy. I recommend less empirical methods such as targeted ethnography to delineate the psychotherapeutic factors which separate the two.

Altogether, understanding the common and specific psychotherapeutic factors which drive traditional healing creates a system that treats biomedicine and traditional healing as disciplines which can principally learn from each other and contain elements which the other lacks. Once researchers have created a foundational knowledge base, they can then utilize the Consolidated Framework for Implementation Research (CFIR) to develop focus group discussions, educational competencies, research training programs, and finally collaborative care models between traditional healers and medical providers (Waltz et al. 2015; Padek et al. 2015;
Powell, Shahabi, and Thoresen 2003). The research team should assess these models using pre- and post semi-structured interviews, progress notes, psychometrics, and resilience biomarkers.

One should allow the collaborative care model to constantly grow and adapt with the ultimate goal of helping all providers better align with the patient, create better therapeutic alliances, and sanction treatments and improve mental well-being across culturally divergent treatment models.
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