The treatment of psychotic illness: meta-ethnographic research into the therapeutic approach and herbal medicines used in traditional interventions.

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Table of Contents

1.0 Abstract

Background

Traditional medicine (TM) is an available resource for medical research which may offer valuable therapeutic insights and herbal medicine (HM) strategies for the treatment of psychotic illness (PI).

Objectives

To conduct a meta-ethnographic study with qualitative academic journal articles which address the treatment of PI and HMs used in traditional interventions.

Methodology

18 articles were identified according to specific selection criteria and analysed using a reciprocal translation process.

Main Results & Conclusions

Traditional interventions place a greater emphasis upon social aspects that contribute to PI and intentionally involve family within the treatment process. PI is treated via regular consultation that addresses physical, mental and spiritual symptoms, supported by HM that is prescribed from a humoral and biomedical approach. This study concludes that holistic medicine practiced by medical herbalists offers a treatment approach to the multi-faceted nature of PI, which could increase the probability of successful recovery.

2.0 Introduction

This study brings together qualitative studies which have researched traditional HM and therapeutic interventions in cases of psychotic illness (PI). Meta-ethnographic research aims to determine relationships between studies so that consistencies are identified and concepts developed from the relationships identified (Atkins *et al.*, 2008; Aveyard, 2010).

This research aims to re-interpret meaning across multiple qualitative studies, in order to provide further insight for practicing medical herbalists who may encounter patients suffering from PI. It combines data from phenomenological studies, which mainly use in-depth interviews as the means of data collection and ethnographic studies, which focus upon specific communities in order to gain insight into how its members behave, with data collected mainly from first-hand observation of behaviour (Aktins *et al.,* 2008).

Researching different ways of treating a difficult illness is relevant given that many authors conclude the biomedical approach to PI has limited influence (Teuton et al., 2007; Read, 2012). This study researches therapeutic approaches and HM from TM in order to identify successful healing strategies for patients suffering from PI.

3.0 Methodology

3.1 Research Design

The research is comprised of a qualitative analysis of a literature search carried out via the University's online electronic database 'Find it at Lincoln' (FIAL), which simultaneously searches using keywords across numerous subject-specific databases (see Appendix 1). The main advantage of this method is the ability to conduct a wide search across many databases within the limited time constraints.

Keywords were identified that were appropriate to the aims of the research and used to identify appropriate articles via FIAL. The abstracts of the articles were then read and sorted into categories of similar type. Articles that met the inclusion criteria were then read in full (see section 3.2).

Following this methodology 18 articles were identified (see Appendix 2.1), which were analysed using a reciprocal translation process (see Appendix 2.2, table 1). All articles were analysed; consistent themes identified as results (in section 4.0); which are discussed (in section 5.0) and conclusions drawn (in section 6.0).

3.2 Design Specifics

3.2.1 Keywords

- 'herbal medicine' AND 'psychotic illness'
- 'herbal medicine' AND 'psychotic illness' AND 'therapeutic approach'
- 'integrative mental health' AND 'herbal medicine'

3.2.2 Inclusion Criteria

- Search results limited to full text available via FIAL
- Academic journals only
- English language only
- Years: 2000-2013
- Sorted by relevance
- Articles from traditional healing or folk medicine approach (ethnographic and phenomenological qualitative studies)

3.2.3 Exclusion Criteria

- Articles from a biomedical approach
- Articles from a Traditional Chinese Medicine or Ayurvedic approach
- Cannabinoid research

3.2.4 Bias and Limitations

This is discussed in detail in Appendix 2.2.

4.0 Results

4.1 Therapeutic Approach

4.1.1 The relevance of traditional medicine

Moodley & Sutherland (2010) discuss how there is no single worldview regarding causation of any illness or appropriateness of treatment. In terms of therapeutic approaches to healthcare, they state simplistic notions as considering one approach universally primary or superior, are no longer tolerable.

The WHO (2008) classifies between 65% and 80% of the world's care services as TM. TM is defined by Razali & Yassin (2008) as a blend of advice, solace and therapy, delivered with an understanding of the patient's background. Sodi & Bojuwoye (2011) share a similar understanding and describe how the meaning of illness (or health) to an individual is grounded in the network of meanings of an illness (or health) of that individual's culture. They describe TM as deeply rooted in the socio-cultural contexts and values of traditional communities.

Blanch (2007) considers the biomedical mental health system as having power, but lacking the wisdom which makes life sacred and meaningful. She describes the challenge to integrate wisdom and science, to make room for the sacred and practical. She defines Western civilisation as the 'master of concepts and the king of quantity' (Blanch, 2007: 251), stating it has science without wisdom, which overwhelmed cultures that had wisdom without science. However Blanch (2007) describes mounting evidence that Western culture is undergoing a shift from a strictly materialist, positivist and empiricist view towards a naturalistic understanding that acknowledges the significance of personal stories, emotions and experiences that cannot be explained purely in terms of science. She supports this with the fact that psychiatry has formally endorsed the biopsychosocial model in the DSM-IV and ICD-10 (the two psychiatric classification systems in use worldwide (Semple & Smyth, 2013)). Further differences between traditional and biomedical approaches to mental illness are discussed in Appendix 3.

4.1.2 The role of the traditional healer

Crawford & Lipsedge (2004) describe how traditional healers (THs) are highly respected members of the community, playing a fundamental role providing stability

in times of economic hardship, political strife and changing values. They define three categories of TH; the diviner, the faith healer and the herbalist (see Appendix 4).

Zulu patients frequently seek help from THs in order to gain better understanding of the underlying cause of PI, but in many cases the patient has their own idea and goes to the TH for confirmation (Crawford & Lipsedge (2004). They describe how some patients (with their families) visit many THs until they receive an explanation which was acceptable. This 'shopping around' is described as enabling the family to find a diagnosis which resonates with their own understanding of the underlying problem and ensures that they play an active part in promoting recovery. This way of seeking help is reflected in the strong distinction between diagnosis and treatment, which occur in separate consultations and command different fees.

Crawford & Lipsedge (2004) and Razali & Yassin (2008) describe how treatments expected from THs include removing or neutralising the cause of PI. Alleviation of symptoms were seen as a bonus, rather than expected outcome and patients and families often commented they were very satisfied with the treatment received, despite symptoms remaining unchanged. Biomedical health practitioners are seen as a resource for providing alleviation of physical symptoms (lack of strength, loss of energy, general body pains) and they are not expected to find out about causes of PI. Crawford & Lipsedge (2004) describe how patients talked of biomedical strength-giving injections which would give their body the ability to cope with the THs treatment, as TMs are considered powerful and work against the cause of illness and are therefore dangerous to the health of the patient in a weakened state. Zulu communities therefore use both biomedicine and THs for different aspects of their care. A summary of the role of THs in therapeutic interventions is detailed in Appendix 5.

Sorsdahl *et al.* (2010) and Kar (2008) describe how consulting a TH often results in delaying biomedical treatment, which has negative consequences in physical life-threatening problems. Kar (2008) describes the longer PI is untreated increases the probability of a worse outcome after six months in terms of total symptoms, overall functioning and quality of life and that remission is significantly less likely.

However Sorsdahl *et al.* (2010) describe the frustration expressed by African THs who complain of the disrespectful attitude of Western doctors towards them and their practices, but how they have the desire to work side-by-side with biomedical practitioners and they believe their professional body will help attain this.

Park *et al.* (2011) describe a case where instead of assuming patient's experiences were psychotic, their experiences were validated and their illness model was used as a working model and treatment approaches adapted accordingly. They described how inappropriate use of antipsychotics could have triggered side effects while the underlying illness continued. Incorporating treatment from various healthcare providers and utilising, for example, medical herbalists as an ally, not an opponent, shows empathy and emotional respect to the patient which has been shown to decrease premature termination of treatment. It does however require an organisational culture that allows non-conventional approaches to be tested. Park *et al.* (2011) also found healthcare providers who have similar values and attitudes to their patients were more effective than those who were merely ethnically similar.

Cohen (2008) describes how American Indians view suffering as part of a healer's life path (see Appendix 6.1). The Native American Indian healer (NAIH) is considered to be at the balance point, realising and accepting that life includes light and darkness, joy and sorrow, pleasure and pain. Although described as committed to a moral life, the NAIH knows that people are capable of being saints or scoundrels and because they have the courage to look at and accept both sides of themselves, they can also accept the patient. NAIHs believe there is little difference between Western physicians, whereas in contrast, no two NAIHs do the same thing (see Appendix 6.2).

4.1.3 Understanding Psychotic Illness

Sodi & Bojuwoye (2011) describe how the Hippocratic medical approach resulted in biology becoming the bedrock of all forms of illness. Illness became the result of an individual's inner processes, whereas all social and cultural layers of reality were only held as epiphenomenal. They add that from a Western perspective PI is regarded as a consequence of some malfunction within an individual's body or psychical structures; however, many THs also take into account spiritual, social and

cultural factors. How to define normality and abnormality is important in order to apply appropriate therapeutic treatment (Hsiao *et al.,* 2006). Further definitions of PI are detailed in Appendix 7.

Read (2012) describes how classically, organic mental disorders include dementia and delirium for which a clear organic pathology can be identified. She adds that functional mental disorders, which include PIs, are where an organic cause is less certain or possibly absent. However Read (2012) considers the organic / functional distinction should be discarded, as it incorrectly implies that nonorganic mental disorders do not have a biological basis.

In their study Sorsdahl *et al.* (2010) describe how THs consider PIs as the main exemplar of mental illness and that patients are only mentally ill if they displayed extreme abnormal behaviour and episodes of violence. The majority of THs interviewed believed the cause pointed to either bewitchment or severe drug abuse and was occasionally due to genetics.

Cohen (2008) argues that to label an illness, implies a uniformity in human experience, behaviours and symptoms that simply does not exist. NAIHs recognise we are all connected, yet we are all different. Since every human being has a unique body, mind and spirit, it is impossible to standardise treatments (Cohen, 2008). TAIHs believe the scientific method is established on a fundamental lie based around ‘standard conditions’ and ‘replicability’, they argue nothing in life is standard and people are different moment to moment. TAIHs use both knowledge and intuition to determine the cause and cure of mental illnesses. They listen to the story the patient tells, where it begins, where it ends, what details are included, what is left out and why. PI is seen as a loss of meaning and the cure should provide new ways of thinking, characterised by meaning and joy.

4.1.3.1 The role of Ancestors

In the African cultural model of mental illness, harmony between the individual and the ancestors is critical in maintaining good mental health. The socio-spiritual obligations to the ancestors are addressed by THs, who therapeutically aim to restore the balance between the family and the ancestors (Sodi & Bojuwoye, 2011; Crawford & Lipsedge, 2004).

Crawford & Lipsedge (2004) describe how in Zulu traditions both the source of individual distress and responsibility for its treatment is firmly located within the community which includes all members of the sufferer's family and household, both living and dead. This is in stark contrast to biomedicine which locates the source of PI within the individual, with treatment focussed at the individual level. Internal objects from the patient's inner world, which form the subject matter for psychotherapeutic theory and practice, are replaced by real people from the patient's real world, who actively co-operate in seeking a solution for their distress. Dead ancestors are likewise 'realised' by a TH; their views are canvassed and taken into account and if necessary they are appeased by suitable rituals. Establishing that external factors are responsible for abnormal behaviour over which they have no control and that there was nothing wrong in their own self; is described by Kar (2008) as giving significant relief to patients. This resulted in better readjustment and reintegration into society following the THs intervention, than after treatment from a psychiatric hospital.

Ancestors have central importance in Zulu communities and their role is to protect and support living relatives (Crawford & Lipsedge, 2004). They describe how the most powerful are the patrilineal ancestors of the preceding two generations and are thought to reside and communicate from the rafters of their descendents homestead, sometimes appearing in animal form. When angered, ancestors can cause PI and misfortune to their living relatives, however too much contact with the ancestors is also seen as damaging and can cause illness.

4.1.3.2 Supernatural causes & Sorcery

> "No sorcerer can do as much harm to you as you can do to yourself with negative thinking" Cohen (2008: 132)

In South European and Oriental cultures traditional beliefs in witchcraft, demonic forces, djinns, the evil eye or black magic are prevalent and thought to cause many PIs (Assion *et al.,* 2007). Traditional Malay belief recognises PI as arising from the work of supernatural agents; however Razali & Yassin (2008) state THs feel it is inadequate to treat a person solely on supernatural causes without considering other causative factors.

Kar (2008) describes how the majority of PI patients in Orissa believed their illness was due to supernatural causes which resulted from black magic, sorcery, angered ancestral souls, evil spirits, supernatural agents or planetary influences. Razali & Yassin (2008) describe how witchcraft or charming and possession by evil spirits are regarded as common causes of PI. Kar (2008) emphasises that such cultural explanatory models need to be considered because for example, taking tablets would not make sense to a patient who perceives their problems as lying in a religious misdemeanour. Kar (2008) describes in his study how most people believed that the person experiencing PI was a victim of external causes, without any problem in themselves; therefore TM would be of greater value than biomedicine. Belief in supernatural causes of PI was not significantly associated with age, gender, level of education or occupation; the belief that it is possible to influence the health or well-being of another person by action at distance was found to be firmly ingrained in the socio-cultural system.

Sorcery is described as a common cause of PI, which can be practiced by anyone and used when a person bears a grudge against another person (Crawford & Lipsedge, 2004). Diseases caused by sorcery, such as PI can be categorised according to the type of sorcery employed and include 'stepping over', 'eating' and 'throwing' illnesses (see Appendix 8).

A therapeutic approach that uses the attribution of sorcery by giving it a specific and limited role is described by Crawford & Lipsedge (2004). It is used as a rational tool to stimulate change, with the actual sorcery or witchcraft used marginally as an explanation. Instead the concepts are used discursively in order to pinpoint areas of conflict, which are addressed in a practical manner without recourse to supernatural solutions.

Sorsdahl *et al.* (2010) describe how THs' view PI as bewitchment and that this 'thing' must be removed in order to cure a patient. They also hold the view that biomedicine can only pacify and is unable to cure patients. The main reason given was that Western doctors do not have enough time to give the patient the attention they need. They also point out how patients are placed in rooms with numerous

other patients, with individual needs rarely being met. This is compared to THs who are available 24 hours a day, 7 days per week and frequently check on the patient and the patient's family. A PI patient is described as needing care and affection which does not happen in hospitals and that they must be treated with love which gives them hope and the ability to go on.

The use of mental and immaterial forces in socially disapproved ways, such as causing harm to another, trying to control or manipulate a person's behaviour, or using the tools of a TH in the service of ego, perhaps to gain money, material goods, sexual favours or prestige, is considered by Cohen (2008) as witchcraft and sorcery. NAIHs consider witches are people who maliciously cause a person to feel that something is lacking in their life – a person, a place, a thing or happiness itself. Just as fulfilled dreams create happiness, imposing a feeling of disappointment and loss causes mental illness.

4.1.3.3 A Fright Illness

Quinlan (2010) describes how strong emotions charge the blood with humoral heat, however cold and frightful emotions are described as freezing cold and blood-chilling, leading to tense nerves and with chronic exposure, nerve damage. West Indian ethnophysiology theorises an overload of stressful emotions (fear, panic, grieving, anguish, worry) causes a cold humoral state in which blood coagulates causing prolonged distress and increased risk of other humorally cold illnesses (for example respiratory illnesses and arthritis). PI is considered a syndrome of persistent distress, developed in the wake of traumatic events, commonly known in the English-speaking Caribbean as fright, relating back via French to shock or sudden fear. The Caribbean term fright is described as corresponding to the medical view of stress.

Quinlan (2010) describes how various world cultures associate an illness with emotional fright or trauma. Fright illnesses are described as including physical symptoms, psychological / behavioural symptoms or a period of misfortune in the sufferer's life. The illnesses share a diagnosis involving soul loss, where the distress has dislodged a sufferer's soul (or vital force) or scares the soul out of the body, as well as physical changes in blood and nerves that occur in response to trauma. Quinlan (2010) describes how Dominicans recognise two types of fright, most being

relatively acute, whereas in contrast chronic fright does not heal and ranges from recurrent fright episodes to a continuous frightened state which can be terminal (see Appendix 9). They are described as sharing similarities with post-traumatic stress disorder, anxiety and depression, all facets of PI.

4.1.3.4 A Spiritual Illness

The limited influence and apparent ineffectiveness of biomedicine in treating PI is described by Teuton *et al.* (2007) as providing a rationale for spiritual explanations and interventions. Read (2012) states psychiatry's failure to achieve a permanent cure to PI confirms its spiritual nature and therefore only THs were believed to bring about complete recovery, since only they addressed spiritual causes.

Spirit is considered the source of personality, character, disposition and intelligence in a traditional African view. It forms part of a composite self, which is complex, consisting of spirit, soul, semen from the father and blood from the mother. The spirit is the part of the person that is vulnerable to spiritual attack, for example being consumed by witches (Read, 2012).

Chiu *et al.* (2005) describe a strong need for connection within their patient's support systems and how spirituality can be experienced by helping others. In addition to connectedness, patients' spirituality brought them acceptance, forgiveness, grace, peace of mind, wisdom, gratitude, hope, strength and a driving force. Some patients were grateful for having had the experience of PI because they became aware of themselves and how family closeness helped to calm their soul and was an important resource of help.

Russinova & Cash (2007) describe how the experience of PI often precipitates some level of spiritual distress and how spirituality boosts a positive recovery (see figure 1).

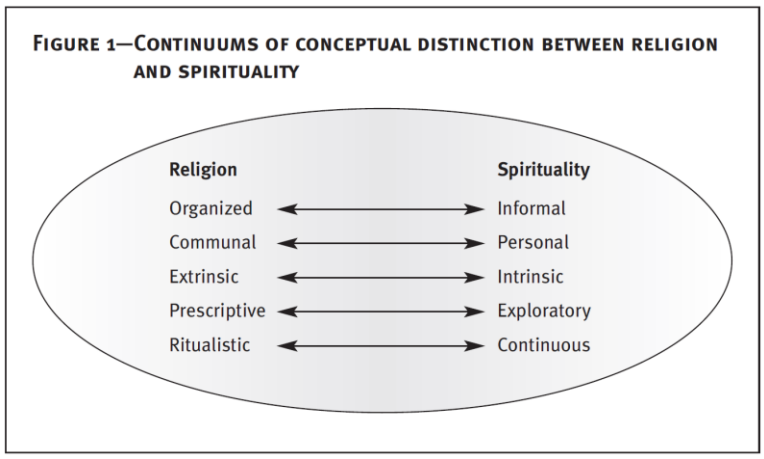

Figure 1. Source: Russinova & Cash (2007)

4.2 Traditional Herbal Medicine (THM)

Sorsdahl *et al.* (2010) report there is a lack of studies investigating the effectiveness of THMs using the 'gold standard' of double-blind, placebo-controlled trials. Evidence-based recommendations however may overlook the value of local knowledge which is harder to quantify (Read, 2012).

Razali & Yassin (2008) describe how THM is popular in Malaysia for treating conditions that are chronic, psychological and ill-defined, whereas biomedicine is preferred for the treatment of life-threatening conditions or illnesses with serious consequences or a poor prognosis. They quote research where people in rural Ecuador chose THMs for psychosomatic conditions, whereas those suffering from infectious disease and painful conditions preferred biomedicine and how in India TM is used more for common diseases than for serious illnesses.

The WHO (2008) Mental Health Gap Action Programme refers to the use of psychotropic drugs for the treatment of psychosis as well as psychoeducation, family interventions and interventions to enhance independent living and social skills. Antipsychotic drug treatment from a traditional viewpoint is discussed in Appendix 10.

Quinlan (2010) describes three herbs as treatments for fright (see Appendix 11) including THMs that act upon the respiratory system, alleviate pain and have antibiotic and antiviral actions. PI shares similarities with the description of fright and as it is seen as extremely cold, it is treated with herbs considered to be hot or

'heating'. Ingesting the medicine thaws or warms the body towards the normal warm state which serves nerve function best. Quinlan (2010) describes strong emotions as not only chilling the blood, but making it sour and caustic to the nerves, causing damage, aggravating the fright and delaying recovery. An infusion or 'bush tea' is made, regularly drunk and alternates from one herb to another.

Cohen (2008) describes how NAIHs believe the efficacy of THM is strongly influenced by the spirituality of the healer. Standardised herbal extracts cannot replicate the effects of a plant picked with prayer, used according to the wisdom and dreams of a healer and administered with positive thinking. THMs used by NAIHs are detailed in Appendix 6.5.

5.0 Discussion

Looking at TM in order to research therapeutic approaches and HMs used in the treatment of PI is relevant, especially when considering facts such as that in South Africa, there is a ratio of one traditional healer per 250 citizens compared to a ratio of one doctor per 40,000 citizens (Crawford & Lipsedge, 2004) and how in their study Sodi & Bojuwoye (2011) found African THs had greater success in treating mental health conditions when compared to physical conditions. This study's results support Edwards' (2011:344) view that TM is a 'fertile field' for medical research.

There is no global agreement regarding the cause or treatment of PI (Moodley & Sutherland, 2010), therefore looking at ways of synthesising successful treatments from different socio-cultural contexts is relevant in order to gain a deeper understanding of this type of illness and provide treatments that have a greater chance of success. Sorsdahl *et al. (*2010) describe the classical disjuncture between biomedicine and TM, which from a biomedical perspective views TM as ineffective and unsafe. Their critical view argues that biomedicine reflects just one particular way of looking at the world which is not necessarily privileged and both biomedicine and TM can have therapeutic efficacy. They also describe an integrative view which explains that both systems can influence health because they are social activities reflecting particular cultural values which act upon underlying biopsychosocial mechanisms.

Parallels can be drawn between THs and the role of medical herbalists as sources of medical advice and HM within the UK. Medical herbalists are trained holistically as in TM and taught to consider the presenting symptoms on physical, mental and social levels during the diagnosis of a patient (NIHM, 2013). Other similarities to foreign medical organisational structures can be observed, such as the expectations of African THs to be respected and work together with their biomedical counterparts, parallels the National Institute of Medical Herbalists' current campaign for statutory regulation in the UK (NIMH/2, 2013). If GP practices are 'bursting at the seams' (Soteriou, 2013), formally incorporating medical herbalists into UK primary healthcare could be an opportunity to demonstrate medical co-operation to traditional and biomedical communities across the globe, as well as open up holistic HM to patients suffering from PI.

Including families was considered by Park *et al.* (2011) as crucial for successful psychiatric treatment. They can provide emotional support, strengthen the patient's sense of belonging and purpose and provide material support such as housing and financial assistance. They can actively engage in illness management, giving information to providers, accompanying patients to clinic, assisting with medication and monitoring the effects of treatments. Involving families can therefore be seen as a means of opening up treatment opportunities. Read (2012) describes how families can be invaluable to help the person with PI maintain their social milieu, which encourages reintegration during and after recovery.

Although biopsychosocial considerations are now an accepted part of a medical consultation, the majority of diagnostic guidelines for PIs emphasise individual symptoms (ICD-10, 2004:99-109) and appear not to place as much emphasis upon social relationships as TM does. When considering that the ICD-10 (2004:86) describes PIs as 'heterogeneous and poorly understood' and that a systematic review into the incidence of psychoses in England by Kirkbride *et al.,* (2012) found that incidence varied markedly by age, sex, place and migration status over the period of 1950-2009 and that PIs have been extensively studied on an individual level, suggests more consideration of the social influence upon PI is called for. TM recognises dysfunction within social and family relationships (past and present) not only as a result of PI, but also as a cause and therefore a potential source of resolution. The results of this study have shown how patients use biomedical and THM for different aspects of their care, which along with increased involvement of the family may offer practicing medical herbalists guidance when providing treatment.

Crawford & Lipsedge (2004) describe how THs consider most illnesses as a lack of harmony between a person and their environment which include social relationships, relationship with the natural world and with their ancestors, which if out of balance can lead to physical, emotional or behavioural symptoms. An individual's relationship to their external world is therefore important to consider. Ancestral spirits can be understood as legacies and/or strong traditional values left behind by legendary ancestors, which may influence living descendants by encouraging them

to consider incorporating their exemplary behaviours and values as behavioural models or motives for decision-making (Sodi & Bojuwoye, 2011). Angry ancestral spirits could also be re-interpreted as contextual socio-economic and environmental conditions which put people in competition with one another, putting people at risk of ill-health (Sodi & Bojuwoye, 2011). This further highlights the greater emphasis THs place upon these social and environmental factors and how they influence an individual's mental health. This appears far more prominently than it does in biomedicine, whose focus is mainly on the patient themselves, with medication and therapy such as hospitalisation further isolating and emphasising the individual as the cause of their illness.

Cohen (2008) describes how NAIHs are hesitant to label any illness, even in their own language, in case the patient is hexed with negative words and *nocebo*, the power of negative expression, since to say that a patient is suffering from PI is to influence the patient to act in a way compliant with that label. A Cherokee healer uses the word *ulsgeta* (intruder) instead of the concept of *u'yugi* (illness), in case saying 'illness' will provoke it. Cohen (2008) describes how NAIHs use positive, encouraging words and focus upon the healed state that is understood to already exist already in a hidden and timeless dimension and by doing so the NAIH brings that state into existence. A NAIH intervention is detailed in Appendix 6.3. Cohen (2008) explains diagnostic categories are not considered energetically neutral and the soul is considered very delicate like glass, which risks being shattered if labelled. Shock is also considered to separate soul from body and NAIHs consider mentally ill people to show signs of 'soul loss', they appear hollow without the spark and joy of life. NAIHs consider the soul part is not repressed in the psyche, but lost in another dimension of reality which must be retrieved with the help of HM and other therapeutic practices (such as drumming). Cohen (2008) describes how many Indian words used to translate the word depression imply loneliness and absence of other people and how among many tribes, one of the worst traditional punishments is banishment since no man is considered an island and no man can survive alone. This is interesting especially when considering the isolation a patient can experience in a Western psychiatric hospital. The NAIH view of sicknesses or things that can affect people's minds or spirits are detailed in Appendix 6.4. PI is again not viewed by NAIHs as a personal problem; it is an expression of social relationships, the

physical environment and the political and economic system in which the patient lives.

Cohen (2008) describes how NAIHs view lack of meaning and purpose (which he argues is pandemic today), as the psychological root of many cases of PI. Their perspective is that every person has a life purpose, a special talent, a calling and to be happy the individual should prioritise discovering their life purpose and have the courage to live and express what is discovered. They describe how a life purpose not lived is a power that rots inside and may cause PI. Their belief that dreams shape character and encourage hope and courage is forward-looking, contrasting to the retrospective psychotherapeutic view that personality and character are a result of trauma and one's past.

This study has shown that TM does not focus upon finding a standardised approach to treat all PIs as the same and intentionally avoids placing any labels upon patients, instead urging them to identify with the healed state in order to move forward in their life. The patient's beliefs regarding the causation of the PI are discussed openly and THs suggest ways to amend behaviour and negative thinking, along with appropriate HM. Modern Western medical herbalism teaches a similar holistic approach (LincolnCollege, 2013).

Kar (2008) warns how historians of psychiatry have suggested that the witchhunts of the 16th and 17th centuries were primarily a persecution of the mentally ill and how demonological concepts of possession and witchcraft have impeded psychiatric progress for centuries. He describes how any attempt by mental health professionals to dislodge the belief in supernatural causation, stressing a medical model, may leave the patient confused, helpless and more anxious. He describes how it is important to explore the genesis and elaboration of a patient's witchcraft ideation and if possibly disentangle it from the underlying psychopathology.

Redefining PI as an opportunity for spiritual development offers another therapeutic approach and role for medical herbalists which can give the patient a valuable focus. Such holistic consultation and appropriate supportive HM offer the patient suffering

from PI an opportunity not only for genuine recovery but also deep consolation for a challenging illness.

Blanch (2007) discusses the relationship between spiritual states and psychosis and quotes studies of the biology of forgiveness which suggest that resolving issues may have a measurable impact upon brain chemistry. She describes how quantum physics suggests consciousness can be understood in terms of energy and vibration as well as anatomy and chemistry, which impacts upon how altered states of consciousness, including psychosis, can be understood and treated with therapeutic agents that intervene directly at the vibrational level (such as music, chanting and HM). Blanch (2007) comments how the deepest drives of humanity are to live with purpose and to become a decent human being. She advocates reframing PI in spiritual terms, that the end result of all the pain and hard work is envisioned as spiritual development, a worthy if difficult goal. This gives a different perspective to the consideration of 'serious mental illness', which even when viewed through the most optimistic recovery framework is usually perceived as a gloomy diagnosis. A spiritual framework can be deeply consoling and serving a purpose beyond one's self may provide meaning to the experience which can make it possible to live with what might otherwise be unbearable. However, Blanch (2007) is clear that distinguishing true spiritual encounters from more harmful and destructive psychoses is important and that practitioners who see people in severe states should be familiar with the distinctions. Spiritual information gathering is seen as a critical part of patient assessment and an expanded consultative model is advocated to medical herbalists. Blanch (2007) discusses how spiritual and mystical practices can help with recovery from PI, as many have established techniques that affect specific aspects of consciousness. She suggests a real recovery paradigm involves looking to wisdom that comes from cultural and religious systems of thought and from inner spiritual knowing and how topics that have historically been silenced may hold the keys to real recovery from PI.

The study results showed the importance of establishing a spiritual connection by emphasising integration both within the patient and in their social activities, as an important part of coping with PI. Gathering information from patients regarding their spiritual opinions during consultation could therefore help medical herbalists identify

areas of guidance and therapeutic support. Chiu *et al.* (2005) describe how patients often turn to inner resources as coping strategies and how spirituality plays an important role in the lives of female patients with PI. They cite research where people with serious mental illness use spiritual activities and meditation as the most frequently used forms of alternative therapy. The construct of spirituality is described as multidimensional in nature with several core concepts including an individual's search for meaning and purpose, sense of connectedness and relation to self, others, the environment, and God or a higher power, transcendence and existential experience (Chiu *et al.,* 2005).

Chiu *et al.* (2005) describe how spirituality can be seen as a source of healing which provides a sense of meaning to life often found lacking among people with PI. Blanch (2007) states this has been recognised in the field of mental health with amendments to the DSM-IV which no longer pathologises spiritual religious experience. This is a competent development and shows a willingness to address the spiritual dimension within biomedical mental health. However in the results it was found that it is still a relatively new concept within biomedicine to not view spiritual experiences during PIs as pathological, whereas TM has always considered it as part of the human experience, to be viewed and interpreted within social and cultural contexts and incorporated into therapeutic interventions.

In the majority of articles analysed, herbal medicine was mentioned as the TM given to PI patients, but any detail given as to what herb or type of preparation or dosage was rare. A reason for this can be attributed to the criteria within the research methodology where only articles published in the years 2000-2013 were included. Older articles may have contained more detailed information regarding THM used in the treatment of PI. This and other limitations have been discussed in Appendix 2.2. What the results have shown is that choice of HM does not need to be limited to those herbs that act upon the nervous system. The results suggest prescribing herbs using a qualitative humoral approach, such as prescribing herbs that have a warming action to address cold frightful emotions. This approach potentially opens up options for herbal treatment which may also have fewer interactions with any prescribed psychiatric drugs. Assion *et al.* (2007) describe how the use of alternative medicine is prevalent in patients with PI whether from Western Europe or

from a migrational background, therefore involving medical herbalists within psychiatric care could maximise recovery opportunities, increase safety, as well as meet patients demand for a healthcare choice.

Cowan (2004:5) describes how biomedicine has 'tyrannised the psyche' by reducing the understanding of PI to something that must be extracted, removed or eliminated, treating things we don't like as analogous to surgically removing fat through liposuction and eliminating skin wrinkles. She argues that this one-sided medical view of PIs inhibits rather than contributes to their understanding and ignores how they can often cultivate memory, deep thought, allow for insight, provide solid grounding and encompass spiritual attitude that brings a sense of significance to even the small events and experiences of life. She acknowledges how PIs are accompanied by the most intolerable of emotions and how they embody a paradox of frustration and capacity for insight. She describes how they can be the matrix of the creative state, which properly understood, appreciated and worked through, can result in valuable revelations and progress. Conflicting with biomedical ideals of health and progress, she describes how instead of being perceived as a symptom of sickness, they have the potential for wisdom and careful treatment, which could even be viewed as a partial antidote to the mania of modern Western culture. By helping a patient understand their challenging emotional states in this way, medical herbalists can help guide patients through the labyrinth of recovery.

The results of this study show medical herbalists that it is possible to help a patient recover from PI. This can be achieved by providing an individualised therapeutic plan that helps the patient disassociate from limiting definitions of illness, focusing upon what the healed state means to them, with bespoke HM that supports them onto and along that journey. TAIHs suggest that as the patient suffering from PI moves into recovery, negative emotions such as depression can be understood as negative energy leaving the body, 'the old self, the old skin..leaving slowly' (Cohen, 2008:133). By reframing aspects of PI in this way, medical herbalists can offer patients a way to understand what they are experiencing and most importantly, support the patient therapeutically with holistic consultation and HM enabling them to build a solid foundation of good mental health.

6.0 Conclusion

The results of this study have shown that THs across the globe have developed therapeutic approaches and herbal treatments that deserve to be acknowledged and studied as important strategies to treat PI. THs emphasise the social aspect of PI and how involving family in recovery is valuable and relevant. They do not believe in a standardised approach and advocate individualised treatment plans with regular consultations. TM and the results of this study encourage medical herbalists that helping patient's reframe and holistically understand these challenging psychological states is a viable therapeutic approach to PI, as is providing supportive HM which varies according to the patient's needs as they move through recovery. This qualitative meta-ethnographic study concludes that genuine holistic herbal medicine practised by Western medical herbalists offers a way to approach the multi-faceted nature of PI, which could increase the probability of successful recovery.

6560 words (excluding Appendices and Reference List)

Appendix 1

The FIAL (Find it at Lincoln) search facility searches across these databases:

Academic Search Complete, Accessible Archives, Alexander Street Press, AMED - The Allied and Complementary Medicine Database, American National Biography Online, AP NewsMonitor Collection, Aphasiology Archive, Archive of European Integration, Art Full Text (H.W. Wilson), Arts & Humanities Citation Index, arXiv, Avery Index to Architectural Periodicals, Books24x7, Britannica Online, British Library Document Supply Centre Inside Serials & Conference Proceedings, Business Source Complete, CINAHL with Full Text, Credo Reference Collections, Directory of Open Access Journals, eArticle, ECONIS, European Views of the Americas: 1493 to 1750, Food Science Source, Freedonia Focus Reports, Government Printing Office Catalog, GreenFILE, Grove Art Online, Grove Music Online, Harvard Library Bibliographic Dataset, HeinOnline, Humanities International Index, Industry Studies Working Papers, Informit Business Collection, Informit Engineering Collection, Informit Health Collection, Informit Humanities & Social Sciences Collection, Informit Indigenous Collection, Informit Literature & Culture Collection, International Bibliography of Theatre & Dance with Full Text, Japanese Periodical Index – 雑誌記事索引, J-STAGE, JSTOR Arts & Sciences I, JSTOR Arts & Sciences II, JSTOR Arts & Sciences III, JSTOR Arts & Sciences IV, JSTOR Arts & Sciences IX, JSTOR Arts & Sciences V, JSTOR Arts & Sciences VI, JSTOR Arts & Sciences VII, JSTOR Arts & Sciences VIII, JSTOR Ireland, JSTOR Life Sciences, Korean Studies Information Service System (KISS), LexisNexis Academic: Law Reviews, LexisNexis U.S. Serial Set Digital Collection, Library, Information Science & Technology Abstracts, Manuscriptorium Digital Library, MEDLINE, Mergent Annual Reports Collection, Minority Health Archive, MLA Directory of Periodicals, MLA International Bibliography, NewsBank, NewsBank - Archives, OAIster, OAPEN Library, Oxford Handbooks Online, Oxford Scholarship Online, Persée, PhilSci Archive, PsycARTICLES, PsycARTICLES, PsycBOOKS, PsycCRITIQUES, PsycINFO, Public Information Online, Publisher Provided Full Text Searching File, Regional Business News, Science Citation Index, ScienceDirect, Social Sciences Citation Index, SOFIS - Sozialwissenschaftliche Forschungsinformationen, SOLIS - Sozialwissenschaftliche Literatur, SPORTDiscus with Full Text, Supplemental Index, ABC-CLIO Social Studies Databases, School Edition, ABC-CLIO Social Studies Databases, Academic Edition, China/Asia On Demand, British Library EThOS, World Book, Airiti Library eBooks and Journals, Bridgeman Education, Marquis Biographies Online, Digital Access to Scholarship at Harvard (DASH), SSOAR – Social Science Open Access Repository, JSTOR 19th Century British Pamphlets, JSTOR Arts & Sciences X, JSTOR Arts & Sciences XI, Teacher Reference Center, The Lincoln Repository, University of Lincoln Library Catalogue.

Appendix 2

2.1 Summary of articles identified

Author(s)	Type	Number of participants	Location	Brief Description
Assion *et al.* (2007)	qualitative study of ethnographic interviews	167	Germany	explores use of unconventional medicine of psychiatric in-patients with vs. without a background of migration
Atkins *et al.* (2006)	academic article	n/a	South Africa	explores meta-ethnography of qualitative literature
Blanch (2007)	academic article	n/a	USA	Reviews the historical tension concerning integration of religion and the science of mental health, explore current social trends, discuss strategies for integration
Chiu *et al.* (2005)	qualitative study of ethnographic interviews	30	Canada	explores views of South & East Asian women with serious mental illness with regard to treatment choices and spirituality
Cohen (2008)	academic article	n/a	Netherlands	explores depression in American Indian Culture
Crawford & Lipsedge (2004)	qualitative study of ethnographic interviews	36	South Africa	explores role of traditional healers, interactions between traditional and western health care, how patients and their families cope with mental illness
Edwards (2011)	academic article	n/a	South Africa	explores the psychology of traditional medicine
Hsio *et al.* (2006)	qualitative study of ethnographic interviews	28+caregivers	Australia	explores concepts of mental illness and current social and cultural knowledge about mental illness and how it influences Chinese-Australian patients and caregivers
Kar (2008)	qualitative study of ethnographic interviews	76	India	explores belief and utilisation of traditional medicine, its implications and associated socio-cultural factors on psychiatric inpatients in India
Moodley & Sutherland (2009)	academic article	n/a	Canada	explores traditional and cultural healers and healing in non-Western countries and their practices.
Park *et al.* (2011)	interpretive phenomenological study	20	USA	explores how mental health workers adapt their practice to meet unique needs of Asian Americans
Quinlan (2010)	qualitative study of ethnographic interviews	106	Dominica	explores fright as a psychiatric syndrome
Razali & Yassin (2008)	qualitative study of ethnographic interviews	120	Malaysia	explores use of CAM & traditional medicine among psychotic patients in Malay
Read (2012)	qualitative study of ethnographic interviews	40	West African	explores views of treatment with antipsychotics by people with mental illness, role of traditional medicine
Russinova & Cash (2007)	qualitative study of ethnographic interviews	40	USA	explores the various meanings patients with serious mental illness attribute to concepts of spirituality
Sodi & Bojuwoye (2011)	academic article with case examples	n/a	South Africa	explores influence of culture upon conceptualisations about illness, health and healthcare, argues Western healthcare has limited success when applied to non-Western cultures and key challenges to integrating traditional medicine
Sorsdahl *et al.* (2010)	qualitative study of ethnographic interviews	24	South Africa	explores data from focus groups with traditional healers with regard to referal practices for patients with mental illness
Teuton *et al.* (2007)	qualitative study of ethnographic interviews	20	Uganda	explores relationships between various healers caring for psychotic patients

2.2 Bias and Limitations

As in all research there are threats to the reliability and validity of the investigation, which include bias and errors in the conceptualisation of the research idea, the design and process of the study, which can lead to systematic deviation from the true value (Bowling, 2011), especially when combining results of studies such as in a meta-ethnography. The qualitative studies analysed in this research, are subject to various different types of bias, which according to Bowling (2011) include:

- Design bias
- Evaluation apprehension
- Interviewer bias
- Measurement decay
- Mood bias
- Non-response bias
- Observer bias
- Publication bias
- Reactive effects
- Recall bias
- Reporting bias
- Response style bias
- Sampling bias
- Selection bias
- Social desirability bias.

Atkins *et al.* (2008) discuss how the application of quality criteria to qualitative research is widely debated and that there is no consensus on whether criteria should be applied, which criteria to use and how to apply them. Over-rigorous application of criteria was considered counterproductive, especially considering the lack of use of a recognised approach within much qualitative research.

Context is important in qualitative research in order to lend credibility and weight and a synthesis should aim to retain the rich context of the data (Atkins *et al.,* 2008). However, to systematically explore the influence of various contextual factors, such as the socio-economic status of the study populations and their geographic location along with the findings of the synthesis, is beyond the remit of this work by an individual researcher and furthermore would be difficult due to poor reporting of contextual information in many studies (lack of context descriptions or impact of context upon findings). This is therefore highlighted as a limitation to the research and a potential source of bias in the results and subsequent discussion, albeit unavoidable within the time and resource constraints of this research.

...continued overleaf...

A further limitation to the research can be identified within the analysis process. Published examples of meta-ethnographies make use of the notion of first-, second- and third-order constructs (Atkins *et al.,* 2008) within the analysis process (see table 1).

Table 1: Definitions (Atkins *et al.,* 2008)

1st order construct	Constructs that reflect the participants' understandings, as reported in the included studies (usually found in the results section of an article)
2nd order construct	Interpretations of a participants' understandings made by authors of these studies (and usually found in the discussion and conclusion section of an article)
3rd order construct	The synthesis of both first and second order constructs into a new model or theory about a phenomenon
Reciprocal translation	The comparison of themes across papers and an attempt to 'match' themes form one paper with themes from another, ensuring that a key theme captures similar themes from different papers.

Accessing first order constructs, or participant views or beliefs are problematic within this meta-ethnography since the data extracts included in the articles have already been selected from the full dataset by the study authors, the extracts therefore do not reflect the totality of participant experiences. Author, or second order, interpretations, provide more insight by offering an explanation of the observed phenomena, but the level of interpretation offered in articles was minimal, many of the articles were highly descriptive in nature and difficult to distinguish first- from second-order interpretations or to decipher to what extent the authors' interpretations were influenced by their own background or theoretical standpoint. In agreement with Atkins *et al.* (2008) the usefulness of this categorisation in a meta-ethnography is unclear and so the analysis was undertaken using a reciprocal translation process.

Other limitations to the research are acknowledged as follows:

- Whilst investigating the reference lists of the articles identified, it was noted that there were a significant number of articles published earlier than 2000, which may have contained relevant material. Not to include older relevant articles is therefore a limitation of the research, however a necessary one, in order to complete the research within the time constraints.
- The limitations of undertaking meta-ethnographic research by a sole novice researcher are acknowledged. A novice researcher is disadvantaged due to time constraints and lack of resources (as opposed to for example, a team of experienced researchers).
- Only sources were used that could be read in their original form. Any references to other works within the articles found that were either unlocatable via FIAL or were within the exclusion criteria, were not incorporated.

Appendix 3

Differences between Biomedical and Traditional Medical Approaches to Mental Illness

In American and European societies there is a greater tendency to use individuated psychological types of explanatory constructs in describing social behaviour, *eg.* an individual as a bounded and complete universe that is unable to cope with a number of psychological stressors. This compares to non-Western societies that tend to conceptualise reality holistically and dynamically in terms of its material and spiritual dimensions, eg. a traditional healer may interact with the ancestors by means of dreams to help him/her understand a patient. Such sources of knowledge relating to health and illness are not considered legitimate in biomedicine (Sodi & Bojuwoye, 2011).

Polite criticisms about traditional healthcare practices are that they are harmful, unhygienic and unscientific and African traditional healers are also criticised for their inability to keep patient history and records of assessment (Sodi & Bojuwoye, 2011). But such challenges described as being characteristic of traditional medicine are also not uncommon with biomedical systems, for example,

- At any time, over 1.4 million people worldwide suffer from infections complications acquired in hospital (Sodi & Bojuwoye, 2011)
- Hospital-acquired (nosocomical) infections occur in 5-10% of patients admitted to US hospitals (Sodi & Bojuwoye, 2011)
- According to WHO (2002) nosocomical infections are promoted by many factors including invasive procedures, crowded hospital populations and poor infection control practices.

Of course there is evidence of potentially dangerous assessment and treatment procedures used by traditional healers, but the many good practices of non-Western traditional medicine, such as the standard practice by African traditional healers in the use of community and participatory approaches to the treatment of psychiatric patients, should not be ignored because of them (Sodi & Bojuwoye, 2011). Excesses, abuses and malpractices are not peculiar to non-Western traditional healthcare practices, as they are also happening in Western-orientated practices.

Sodi & Bojuwoye (2011) suggest that both traditional healthcare and Western-orientated practitioners need training in finding modern truths in ancient wisdom, reassessment, re-interpretation and reconstruction of concepts, principles and processes. Additionally Kar (2008) challenges medical scientists to support the concept of ‘healing the whole person’ and to develop a greater awareness of ‘unknown factors’ working in recoveries of patients beyond normal medical expectations.

Appendix 4

Categories of Zulu traditional healer, according to Crawford & Lipsedge (2004)

- Diviners
    - Choose or 'are chosen' by ancestors.
    - In latter case falls ill and recovers after starting training.
    - Method of being chosen is well recognised.
    - *Example* Diviner 'Gwala':
        - diagnostic sessions 2 days/week, treatment sessions 2 days/week
        - Format: talk to patient, pray to ancestors for advice, often received in form of dreams. Treatments include herbal medicines, performance of ritual sacrifices and general advice and reassurance.
        - Common: relationship problems. Always encourages married couples to stay together however severe the problem.
        - Feels that doctors can treat illness but cannot identify the cause.
        - Alcohol problems are referred to hospital, believes little can be done to help.
        - Most important characteristic is being able to talk to people and give correct treatment.
        - Sometimes takes a long time to put a patient at ease and encourage them to talk, but this part should never be hurried. A number of consultations to explain their concern may be necessary.
- Faith Healers
    - 'one who prays for people'.
    - Usually women who belong to a church.
    - Diagnosis through communication with god, although ancestral help is recognised.
    - Treatment is via herbal medicine, holy symbols and practical advice.
    - *Example* Faith Healer 'MaGema':
        - Asks for advice in prayer, receives God's reply in visions, a spoken voice only she can hear. Ancestors seen as subordinate to God.
        - Treatment format: patients seen at healer's homestead. Brief description given, part of the consultation is spent praying, detailed account of cause of illness given.

...continued overleaf...

- Herbalist
    - Usually male. Often educated and has another job.
    - Learns by apprenticeship and attends training courses.
    - Specialises in herbal cures.
    - Often specialise in a particular disease such as snakebite or mental disturbance.
    - *Example* Herbalist 'Mr Y':
        - Often would see 20 patients in one day.
        - Format: asks detailed questions about symptoms, enquires about diet, family relationships. No physical examination undertaken but makes physical observations such as gait or skin colour.
        - Diagnosis based upon previous experience.
        - Consult text books in difficult cases.
        - Often sees patients that have been to hospital and have been prescribed Western medication.
        - Believes hospital medicines work differently to herbal medicines, therefore asks patients to stop taking hospital medication while they were being treated by him.
        - Treats many cases of 'mental confusion'
        - He believes the most common causes are anaemia and possession by demons.

Appendix 5

Therapeutic interventions by traditional healers (THs) (Crawford & Lipsedge, 2004)

- Promoting discussion and active collaboration within the family.
- Strategies designed to strengthen existing social ties and increase family's sense of cohesion and capacity to work together (eg by joining together in a task of preparing and carrying out a task, the meaning and purpose of which has been decided beforehand through open discussion).
- THs concentrate on interventions in the social arena, 'curing' distressed patients by bringing about significant change within their social environment. This contrasts with biomedical approach which generally emphasizes treating and promoting change within the individual alone.
- Herbal medicines are used widely and have therapeutic effects, but may also be harmful or lethal. Biomedical doctors are aware of dangerous aspects of interventions by traditional healers but have far less exposure to and knowledge of the indigenous healers' skilled and sophisticated non-pharmacological interventions.

Traditional healers believe they have the capacity to cure all mental illnesses, which they understand as being when the patient does not need any medication and is free of symptoms (Sorsdahl *et al.,* 2010).

Ritual therapeutic approach

Rituals are viewed as procedures used for modifying human behaviour, procedures for facilitating and encouraging people to rethink human relationships from being competitive to being collaborative and as sources of support and avenues for learning new human relationships and coping skills (Sodi & Bojuwoye, 2011).

Rituals have two critical functions to perform, whether by a Western medicine practitioner or traditional healer – first an attempt must be made to identify the particular phenomenon experienced by the patient and second they must link the patient's idiosyncratic experience with a culturally meaningful theory, which will enable them to integrate the patient back into the cultural mainstream (Sodi & Bojuwoye, 2011).

Edwards (2004) contends that non-Western traditional healthcare providers are skilled and experienced in psychotherapeutic practices using procedures, methods and materials surprisingly resembling contemporary psychotherapies including establishing trusting relationships with patients, diagnosis of problems, use of imagery, dream interpretation, self-regulation and group support.

Appendix 6

6.1 Suffering and melancholy is considered by American Indians as part of a healer's life path (Cohen, 2008)

- "I suffer in order to learn, I suffer so I can heal others".
- *Empathy*: healers are better equipped to understand the epidemic of sadness in the world if they experience it themselves. The most important quality of the healer is empathy, being able to feel what the patient feels. If healers can weather a storm in life, then it is easier to help others navigate it, and patients are more likely to trust their advice.
- *Testing*: spirits may test a person to see what he is made of, to see if even in the midst of pain, he holds to his spiritual values rather than succumbing to bitterness or immoral and destructive behaviour. To fail this test means that spirit will withhold the gift of medicine power. Suffering also teaches us that human beings are limited. Some things are beyond our control and we must ultimately rely on a power beyond ourselves, the Great Mystery, the Creator. A common saying consistent with Indian philosophy: "Man's extremity is God's opportunity".
- *Initiation*: Shamanic and indigenous cultures the world over recognise that illness may be a calling to a new way of life, an initiation. The medicine person is 'the wounded healer'. Spirit powers sometimes initiate a shaman by inducing a temporary state of psychological disorientation, agitation, and/or melancholy. Variously called spirit illness, Indian sickness or simply suffering, initiates literally cry out in agony.
- Two candles are described on the TH ceremonial alter – one symbolises our strengths and the part of ourselves that lives in a world of light and joy. The other symbolises our weaknesses, our shadow side, and how the light of wisdom can illuminate it.

Differences Between Western and Traditional American Indian Mental Health Workers

Western	American Indian
Focus on disease and diagnostic categories	Focus on health and positive words
Therapist practices a profession learned through books, academic study, and internship	Counseling ability may be an inborn gift, may be conferred through initiation and ceremony, developed in dreams and visions, or learned by observing or apprenticing to noted healers
Hierarchical view: therapist is an expert and authority; transference is common	Egalitarian view: all people have challenges; transference is uncommon
Oversight by licensing boards	Oversight by community
Interventions generally have a serious tone	Humor is common
Healing accomplished through insight, interpretation, and/or medication	Healing accomplished through insight, interpretation, plant medicine, prayer, ceremony, and transpersonal help from spiritual powers; therapist may acquire new skills or power to help a particular patient
Therapy practiced in an office	Therapy practiced in nature or in a sanctified space
Advertising, marketing, and networking are keys to success	Therapist has no shingle, advertising and marketing may be considered unethical Patient finds therapist by word-of-mouth and by being in the right place at the right time
Fixed fee for services	No fees, flexible fees, or donation are common; selfless generosity of healer and patient promotes successful outcome
Sessions have fixed length	Sessions have no fixed length; may last minutes or hours
Treatment may be prolonged, continuing weekly for years	One to four sessions, generally on successive days, are often sufficient
Therapist never touches the patient	Massage, laying on of hands, or other physical gestures may be part of the treatment
Focus on coping with, managing, or curing mental disease	Focus on returning to a state of confidence, balance, beauty, well-being, and harmonious family and community relations

Source: Cohen (2008:132)

6.2 American Indian Counselling Style (Cohen, 2008)

- The four winds, the power and spirit of East, South, West and North are the basis for a unique method of American Indian counselling. They represent aspects of psychological and spiritual balance and wholeness. Four winds philosophy is ubiquitous among American Indians.
    - Let us discuss your gifts from the east, the direction of the rising sun, of hope, of inspiration and joy.
    - How can the south wind heal your heart and teach you about compassion and love?
    - The west where the sun sets, what parts of yourself are hidden below the horizon. How can the west teach you to keep your dreams alive and to have the courage to look within?
    - Can you find the cool detachment of the north and the freedom of clear thinking?
- Storytelling and humour is used as a way to educate the patient and reinforce healing attitudes.
- Self-deprecating humour may imply the healer shares with the patient and the rest of humanity common vulnerabilities and challenges. A humourous attitude helps the patient develop mental flexibility, alternate viewpoints and the ability to see options.
- Most important reason to use humour in treatment of mental illness, is that used appropriately, it lessens the patient's preoccupation with himself/herself.
- The secret to banishing negative traits, emotions or thoughts is to remember words have power. If you want to get rid of negativity, say good-bye to it and then replace the old habitual thought patterns with new and positive expressions. To complete the cure, sign songs of peace and share a peaceful, loving and joyous spirit with others.
- In a sacred space, say good-bye to depression. Don't just think it, say it out loud. And ask for forgiveness, especially of yourself. If you are depressed because you have made mistakes, then forgive yourself, determine not to repeat the mistake and stop dwelling on / in the past. Replace negative scripts with positive ones. Celebrate joy of life with positive words, song, poetry or art.
- Enhance positive thinking and behaviour by 'entering into the silence'.
    - In a solitary place in nature, dig a small circular hold about six inches deep and a foot in diameter. Lie on stomach with face in the hole and talk to the earth, seeking counselling with mother earth, the wisest of women. Speak frankly about the problem about which seeking help. Very importantly, express gratitude that these problems have already been resolved. 'Thank you mother earth for healing my depression. I am so grateful that I have purpose, meaning, energy and joy of life'.
    - Important principle – that healing already exists although the patient may be unaware of it. Invite your healed self to be present by expressing gratitude that is has already arrived.

  - After speaking with the earth, fill the hole back up and then sprinkle some tobacco on the ground. Enjoy a feeling of peace and unity with the earth, you have entered the silent sanctuary of nature.

- The practice of inner silence is universally acknowledged as a key to mental health. A silent mind is less likely to dwell on depressive thoughts or to repeat self-destructive behaviours.
- Silence is the opposite of nihilism, it creates openness to the beauty of the world.
- Healers are advised to 'empty yourself' to prepare for a ceremony.

6.3 American Indian Traditional Healing Intervention / Treatment Approach (Cohen, 2008).

- Healer prays to the spirit of forgiveness to give the patient the power to let go of the past and completely forgive themselves. (Not only to animals, trees and plants have spirits in Indian cultures, so do love, fear, kindness, sadness and other emotions).
- After the prayer is finished, the disease is 'sucked out' with the intent of extracting all aspects of the disease: physical, emotional, mental and spiritual.
- Sanctified water is then blown on the patient.
- A combination of sweat lodge, prayers and the above intervention is considered sufficient to cure the disease.

6.4 American Indian views of the sicknesses or things that can be wrong with people's minds or spirits (Cohen, 2008).

- Worry sickness (mood swings, loss of self-control, worry, insomnia, loss of appetite. Chemical depression, bipolar disorder)
- Unhappiness (worry, cognitive disorientation, limited memory loss. May be transitory state brought on by grief)
- Heartbroken (situational depression, broken romance, child ignored by mother, perplexing or sudden emotional disappointment. Loss of sleep and physical exhaustion)
- Drunkenlike craziness with or without alcohol (includes agitation and anger, consequence of alcoholism or psychotic hallucinations)
- Disappointment, pouting, 'turning ones face to the wall' (state of disappointment, characterised by loneliness, withdrawal and suicidal thoughts).

6.5 Ceremonial and plant medicine (Cohen, 2008)

- The sweat lodge is considered a purification ritual that cleanses both body and mind and a way to commune with higher powers.
- No healer can guarantee an outcome no matter how talented or what method applied.
- The decision whether or not healing or cure occurs is not up to the TH. However a healer can strongly shift the odds in a patient's favour, influence the outcome in direct proportion to her degree of love, reverence and connection with the creator.
- Efficacy of herbal medicine is strongly influenced by the spirituality of the healer.

- Standardised herbal extract cannot replicate the effects of a plant picked with prayer, used according to the wisdom and dreams of a healer and administered with positive thinking.
- The patient also has a role to play, medicine is more potent if the patient is calm and open minded, just as positive thinking can empower a medicine, negative thinking can neutralise it.
- Treatment of depression is challenging, requires a TH to combine modalities, counselling, laying on of hands, prayer and herbs.
- Timing is also critical, is it the right time in the patient's life to receive healing, or are there more life lessons to be learned first?
- Traditional herbs used:
    - Eastern white pine *Pinus strobes*
    - Swamp white oak *Quercus bicolour*
    - Wild bergamot *Monarda fistulosa*
    - General tonic and preventative effect – *Panax quinqufolius, Valeriana officinalis*.
    - Smudge away psychological problems by bathing in the smoke of a purifying plant such as wormwood leaves or pine needles.
- Many kinds of mental illness can be treated by taking a walk or run in nature, by bathing or swimming, or by seeking comfort from sunlight, spring breezes, the sight of wildflowers, and the strength of pine trees.
- On the surface these practices are healing because they involve outdoor activities or exercise. Exercise and light therapy have been shown as effective for many types of mental illness. But American Indian tradition maintains that nature is healing because nature is a healer. A stone is a powerful elder. A star is a wise ancestor.
- Nature is one of the sources of Indian healing wisdom and is always available to one who approaches her with respect, humility and an open mind.

Native Indians believe that every recovering individual needs to have a dream (ie a vision and a plan) that lays out a pathway to their better future. The dreams grow as people go further on their healing journey (Cohen, 2008). Cohen (2008) states how there cannot be a standardised reference for dream symbols or archetypes, for example, a wolf may represent fear to a European, or family values to an American Indian.

Appendix 7

Table 3: Understanding Psychotic Illness

Sodi & Bojuwoye (2011)	Psychotic features including hysteria and suicidal tendencies explained in terms of spirit possession. Spirits are not simply relics of the past but archetypes of the collective unconscious of individuals.
Read (2012)	Severe disruption of social functioning and behaviour such as talking nonsensically, acting aggressively, roaming around and dressing in dirty clothing is characteristic of psychotic illness.
Sorsdahl *et al.* (2010)	A psychotic patient is identified by traditional healers through extremely abnormal behaviour and episodes of violence with other common behaviours including wandering away from home, eating or smearing faeces, laughing at inappropriate times and impaired self-care such as not washing or eating dirty food.
Razali & Yassin (2008)	Malaysian traditional medicine ascribes psychotic illness to physical and supernatural causes: • Physical: certain foods, heat and cold, physical trauma, tiny particles, brain impairment, inner wind • Supernatural: activities of a wide variety of spirits, witchcraft and the wrath of God • Treatments: holy water, herbal remedies, ceremonial rites, incantation, trancework, exorcism, talisman, examining horoscope, body massage. Despite different backgrounds and training, traditional Malay healers do not see their approach as conflicting with modern medicine. Malay healers also hold the common view that Western treatments are effective in curing medical (physical) illnesses but are powerless against black magic or supernatural causal agents and consequently psychiatrists do not have the expertise to deal with supernatural powers.
Hsiao *et al.* (2006)	Chinese-Australian & Western medicine share commonly expressed psychotic symptoms: violent behaviour, disturbed behaviour, disorganised speed, talking to oneself, irritated emotions, inappropriate affects, social & occupation dysfunction. In comparison to the Western term 'psychotic illness', the Chinese have many descriptions including: insanity (which can be further classified as elegant insanity (talks about something illogically) or violent insanity (attacks people and is aggressive), mad-anxious, crazy, stupid insanity, nerve derangement and nerve illness. Negative emotions are also further classified, for example, if they emerge from experiencing a 'bad situation', these emotions are regarded as normal and part of human life, whereas amoral or impersonal causes are considered 'an illness'. Hsiao *et al.* compare this to Western medicine, where all of these problems are called mental disorders.
Cohen (2008)	Depression is seen as negative energy leaving the body – the old self, old skin, old spirit leaving slowly. A healthy person is one with 'great silence'.

Appendix 8

‘Stepping over’, ‘eating’ and ‘throwing’ illnesses, according to Crawford & Lipsedge, (2004)

- ‘Stepping over’ illnesses are thought to be caused by the perpetrator putting the illness in the path of the victim. Symptoms caused include loss of strength, loss of appetite, joint pains, headaches, abdominal pains, loss of enthusiasm. Less commonly a stepping over illness may cause insomnia, hypersomnia, bad dreams, memory loss, poor concentration, trembling, dizziness and sweating. Victims may also become suicidal.
- ‘Eating’ illnesses are caused by putting medicine in the victim’s food. Symptoms depend on where the ‘medicine’ lodges in the body. It can cause problems in the throat, the stomach or kidneys and causes associated pain and discomfort.
- ‘Throwing’ illnesses are believed to occur while the victim is asleep and dreaming. These illnesses are particularly feared by the Zulu community because the perpetrator can cause the illness even when far away from the victim. The perpetrator prepares a special medicine and then undertakes a ritual whereby the illness is transmitted to the victim without any direct physical contact between the victim and the medicine. Perpetrators are able to ensure the illness affects the correct individual simply by knowing the name of the proposed victim. This form of illness leads to serious and sometimes fatal illness and can only be stopped by identifying the perpetrator and sending the illness back to him. Only a skilled traditional healer has sufficient powers to do this. The throwing illness can cause mental disturbances.

Appendix 9

Understanding acute and chronic forms of fright (Quinlan, 2010).

Acute

- Defined as a shocking event that leaves a person stunned
- Symptoms include frequent recollections or dreams about a traumatic event
- Difficulty concentrating
- Persistent anxiety or arousal
- Hypersensitivity (including exaggerated startle responses)
- Outbursts of anger or grief
- Lasts 2 – 14 months, up to 2 years
- Highly comparable to post-traumatic stress disorder precipitated by an emotional trauma

Chronic

- Continuing acute symptoms
- But no longer persistently aroused or hypersensitive
- Becomes dull, frequently sad, tired
- Not really stupid, but foolish like the brain is lazy
- In extreme cases
    - Permanently depressed (without any happy moment)
    - Cannot eat
    - Cannot sleep or sleeps all the time
    - Some psychotic events
    - These people will ‘die of fright’
- Best matches major depression

The Dominican view is that anyone bombarded with enough stress may develop a fright illness but the severity and if they become ill at all depends upon the ‘strength’ of the individual’s ‘God-given nerves’.

Dominican treatment includes:

- Bush teas
- Prayer
- Exercise is mentioned as the best treatment for fright and any kind of stress and that one should ‘burst a good sweat’ to ‘warm out the fright’. This is concurrent with biomedical thinking that alarm reactions trigger endocrine responses which prepare the body to cope with threats through ‘fight or flight’ and hence physical exercise ‘ventilates’ the stress response.

Appendix 10

Treatment with antipsychotic medication

A study by Read (2012) described how Ghanaian psychiatric patients valued a reduction of perceptual experiences less than a return to social function. The failure of antipsychotics to achieve a permanent cure is described as casting doubt on their efficacy and strengthened their suspicions that psychotic illness is a spiritual illness which resists medical treatment.

Unpleasant side effects of antipsychotic treatment such as feelings of weakness and prolonged drowsiness conflicted with notions of health as strength and were seen to reduce the ability to work as well as impact significantly upon patient's willingness to take them (Read, 2012). Short-term benefits of antipsychotics that were highly valued were in calming acute behavioural disturbances, but long-term use was considered intolerable because they interfered with the perception of wellbeing (Read, 2012). Antipsychotics were highly valued for inducing sleep, since getting good sleep was associated with good health and equilibrium, but continued use resulted in excessive sleeping and drowsiness (Read, 2012).

The sedative effect of antipsychotics fit with the understanding of psychotic illness as a 'hot' condition which required cooling (Read, 2012). States of heightened emotion such as anxiety, anger and grief as well as argumentativeness and aggression are considered hot and some patients with psychotic illness complained that 'the head is burning'.

Read (2012) describes how in Ghana bodily strength equates with health and healing and is understood as a return to productivity. She adds that a return to social roles is valued above symptom control and how such 'social healing' is precisely where antipsychotics have least impact. Hallucinations and delusions are seen as 'positive' compared to the impact upon a person's ability to participate in work and family life. Being able to work is a principle measure of recovery, bringing the person back from a sense of uselessness and failure.

Appendix 11

Herbs used in the treatment of psychotic illness (Quinlan, 2010)

***Gossypium barbadense* L.** – 'kouton nue'

- Malvaceae family
- Most used treatment for fright, white cotton 'kouton blan' also used
- Commercially important cotton species
- Common names: extra long staple, pima, south American, creole, sea island, Egyptian cottons
- Red-tinged leaves
- Three servings from boiling one lobe from one leaf torn up for three minutes
- Drink one cup once or twice a day until fright subsides
- Ethnographic info on medicinal use of this plant (apart from cotton fibre) is scanty but most uses relate to relieving pain or treating coughs and respiratory trouble
- North American Indians use roots to make a tea to ease childbirth
- Decoction of bark from the roots an official US drug from 1863-1950, to stimulate menstrual flow and aid contractions during labour
- North Peruvians use it topically for wounds
- Jamacians use it for haemorrhoids
- Yucatan Maya and people of St. Kitts drip juice of the flower bud into the ear for earaches
- Venezuelans, Jamaicans, people of St. Kitts and Nevis drink an infusion of leaves and flowers for bronchial and pulmonary problems and colds and flus
- Cubans boil the seeds to make a decoction for bronchial trouble
- South Carolinians and ancient Maya used the roots for asthma
- Mexican maya use for snakebite, grind seeds for a headache poultice
- Trinidadians favour a treatment of cotton seeds for deworming dogs
- Guiana shield – use leaves for backache
- French Guianese and native Guiana boil leaves to treat high blood pressure and pain and apply macerated leaves to control itching. Treats pain and stress as Dominican use for fright.
- Abundant lab research on agricultural use of cotton, pharmacological research pales in comparison
- Gossypol, produced in seeds, is highly toxic to fungi that are pathogenic to animals; it is particularly effective against the trypanosomosis disease including African Sleeping sickness and South American Chagas Disease. It is cytotoxic to tumor cells. Functions as a contraceptive for men – antispermatogenic, reducing total sperm count and sperm motility and velocity. Infertility may be an unwanted side effect.

***Lippia micromera* Schauer** – 'ti dite'

- Common names: "small tine", false thyme, Spanish thyme, oregano del pais
- Thyme-scented shrub, 2m high
- A seasoning in Northern South America, Central America and Caribbean that people especially tend to eat with meat in soup and gravy

- 'calming and warms the blood'
- Other cultures use: for upset stomach, infusion for colds, influenza, sort throat, antispasmodic, respiratory disorders, stomach problems, sedatives, insomnia, relaxing remedy
- Haitians use thymus vulgaris for similar condition as fright which may be false thyme
- Thymol is main constituent in both varieties, two plants therefore somewhat comparable
- European use of thyme corresponds to Caribbean use for fright – in England 'most important reason for drinking thyme tea has been to calm the nerves, the plant is a well-known sedative'. Scots and English in Suffolk used it to prevent bad dreams.
- Lippia mircomera exhibits bioactivity, highly potent antimicrobial activity against bacteria, moulds, fungi and yeast.
- High in cavacrol – inhibits gastrointestinal spasms and contractions, renders bacteria non-infective (by affecting flagellin to become nonmotile and unable to adhere to epithelial cells)
- High in thymol – spasmolytic, muscle-relaxant, antibacterial, antimycotic and antioxidative properties
- Thyme oil formerly prescribed for dyspepsia, dysmenorrhea, headache, to 'relieve hysteria' and 'exhausting diseases', as soporific, antiseptic, intestinal parasites, particularly hookworm. But can irritate gastric mucosa. In terms of fright, thymol inhibits neurotransmission in CNS (has GABAergic activity) and thus regulates excitability and has general anesthetic properties (similar to propofol).

***Plectranthus [Coleus] amboinicus [Loureiro]* Sprengel** – 'go dite'

- "sea moss"
- Common names: Cuban oregano, Mexican mint, Indian borage, Spanish thyme, French thyme
- Everyday cooking herb
- Used for fright, induce menstruation and labour, after childbirth.
- Two average stalks (about 24 leaves) to one litre water. Boil for few minutes or infuse few minutes.
- Calming melting effects felt immediately
- Acute fright – one cup can cure. Chronic fright – one cup a day or a few a week, alternating with other 2 herbs
- Other cultures use for: digestive problems, skin conditions, burns, wounds and allergies. Topically to treat skin ulcers, urinary diseases, fevers, bronchodilator and cold and respiratory remedy. Epilepsy, convulsions, earaches, stiff necks and backache, chronic cough, asthma, epilepsy, convulsions, intoxicating effect
- Related species has psychoactive properties, significant divinatory use
- Relaxant, antispasmodic, treats pain.
- Antimicrobial activity, antiviral against vesicular stomatitis, herpes simplex virus, inhibits HIV activity
- Action similar to tricyclic antidepressants

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