TENDENCY OF PATIENTS TOWARDS MEDICAL TREATMENT AND TRADITIONAL HEALING IN SUDAN

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ABSTRACT

Patients' treatment dilemma and their instability under one health system in Sudan is a serious problem that influences and hampers the effectiveness of treatment and delays patients' recovery and, furthermore, that may threaten the sustainability of the medical health system. Health is the backbone of individual life. Although the medical health system has been developed to provide health and good life for all health seekers, along with the general goals in psychiatric medicine, in all its myriad forms, which is to change behaviours or feelings, or both, of those who come for treatment, adoption of the psychiatric health system in Sudan is not widespread enough. Many patients have abandoned this health sector and turn to the traditional healing system. Therefore, the main questions are: What can we learn with respect to the patients' tendencies and factors influencing them as well as in relation to other contributing factors that result in patients' switching between/within the health care systems? And how can the mental health system be improved to offer the required benefits to the patients as well as to all the community?

This study was planned mainly to investigate the tendency of patients towards the two health systems in Sudan, namely the psychiatric health system and the traditional healing system. The latter system includes three types of healing for the purpose of the study, and these are: Quran healing, Sufi healing and Zar healing methods. It aims mainly to identify the factors that originate from the patients' tendency towards traditional healing and its relation to the effectiveness of these healing methods, also to identify the other factors that influence a patient's first decision of adopting one of the two health systems and, furthermore, the reasons that led the patient switch the first chosen treatment and turn to the other one. Moreover, the study attempted to underline theories and models of mental disorders with regard to psychiatric medicine and traditional healing in general and in Sudan particularly through direct contact with the two types of practitioners. Nevertheless, the study neither ignores nor underestimates the importance of the collaboration between the two health systems, "the psychiatric system and the traditional one".

This research was conducted in the northern part of Sudan, namely Khartoum city - the capital - and its surroundings. This study covered carefully three selected hospitals and five selected healing centres, representing the most important involved areas of mental health care in Sudan. Random sampling is decided upon as a method of survey. Primary and secondary data, necessary to achieve the objectives of the study, were generated through field survey and review of literature. In addition to a preliminary survey of ten patients, the data collection procedure involved a combination of methods that includes the relevant clues obtained through systematic observation and casual discussions carried out by the author during the survey, a documented video-tape concerning the way of four healing methods in Sudan, and two major surveys: (1) an interview questionnaire survey with a sample of 50 patients who were exposed to the two health systems (two groups: patients under psychiatric treatment and patients under traditional healing). (2) An interview questionnaire survey with a sample of 16 practitioners in the field of mental health care (two groups: psychiatric doctors and traditional healers). An intensive analysis was used to analyse the survey data in addition to a suitable statistical package 'SPSS'.

The conclusions of the general findings of this study are that most of the sampled patients have a positive tendency towards traditional healing, particularly the female patients. This tendency was assumed to be influenced by patients' belief in the abilities of traditional healers and their healing methods that generated from their religious and cultural

background. In addition to that, this tendency has a positive effect on the treatment/healing success and the healers who assume the patient's belief in the healing methods "spirituality" is the base of healing success are supporting this dimension. However, educational level and patient's conception of health and illness have no significant effect on health plan decisions.

To simplify the mental health problem in Sudan, the situation in Khartoum shows that mentally ill patients were unstable in one treatment system and from that results the patient's treatment dilemma. The factors influence the patients' decision of changing the treatment are that the personal experience with the treatment and the duration under treatment without resulting in better effects in patients' health, also the influence of the extended family, socio-cultural factors and last not least the general economic situation.

Finally, the result has revealed some similarities between traditional healers and psychiatric doctors as it's reflecting the importance of a relationship "rapport" between healers and their clients particularly for spiritual healing. This result declares that traditional healers and some of their healing methods give benefits over a long time and help patients to get rid of their illness and to solve their problems. For other people who are not possessed these methods are considered a protection from all troubles. Almost all Sudanese people in the area of mental health depend largely on traditional healers and their methods. Some of these methods are unfortunately subject to a lot of harmfulness. As a result, considerations should be made regarding collaboration between the two health systems (psychiatric medicine and traditional healing) in Sudan.

The study suggests a set of recommendations based on methodology, areas for further research and policy interventions. Policy recommendations were made to remedy the situation of patients' uncertainty towards health plans and their negative consequences. Based on the above findings, improvement of people's awareness towards health and illness as well as the risk of extended family interfere in such issues and stands as an essential component of the health system policy. Concerning the medical health system, improvement of the socio-economic environment, qualification of physicians and recommendations on technology development will be needed. Improvement of healers' education and knowledge about general health and illness subjects in the field of medicine is urgently required as well as deep investigation about methods of traditional healing particularly the harmful ones. The study recommends collaboration between psychiatric doctors and traditional healers and, furthermore, it invites us "as academic researchers in the field of health and social psychology" to look for "a new science" that involves and integrates the spiritual dimension to the science of psychology as well as considers the role this dimension plays, particularly when we plan to study human events or to investigate the other social and psychological phenomena.
This study and its results bring a lot of hidden facts and findings to the light of science as it gives more deeply meanings at every time that we go through it.

Dedications

This work is dedicated to my late mother Nafisa and my late sister Dr. Alam.
"*May almighty God rest their soul in Eternal Peace, Amen*"
To my father, Abbas and my husband, Essam.
"*May God bless them*"

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Last, I would like to say that the responsibility for any errors and/or omissions in this thesis is entirely the author's, while all the good outcomes are conferred to everyone with great pleasure.

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Afaf Gadh Eldam

1. INTRODUCTION AND RESEARCH FOCUS

1.1 Background to traditional medicine

The World Health Organisation (WHO 2000) estimates that 80% of the population living in rural areas in developing countries depend on traditional medicine for their health care needs. WHO defines traditional medicine as "the total combination of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental or social diseases and which may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing".
In Africa traditional medical knowledge has been handed down from generation to generation mostly by oral tradition. Traditional healing is therefore, the management of patients by traditional health practitioners using traditional methods of medicine.
A traditional health practitioner "traditional healer" is defined by WHO as a person recognised by the community in which he lives as competent to provide health care using plants, animals or mineral products, or using any religious or social methods acceptable by the population in the community where he lives.

The global situation of traditional medicine is such that in the last decade there has been a global upsurge in the use of traditional medicine and complementary/alternative medicine in both developed and developing countries. It plays an increasingly important role in health care and health sector reform globally. In Africa, up to 80% and, in India 65% of the population in rural areas use traditional medicine to meet their primary health care needs. This is because Like Sudan, in many African countries traditional medicine is accessible, affordable, socially and culturally accepted by the population. Elsewhere in Asia, and in Latin America, historical circumstances and cultural beliefs mean that populations continue to use traditional medicine. In China, traditional medicine accounts for around 40% of all health care delivered. In Latin America, 71% of the population, and in Chile 40% of the population have used traditional and complementary/alternative medicine. Meanwhile, in many developed countries, complementary/alternative medicine is becoming more and more popular. During the last decade, the percentage of the population which has used complementary/alternative medicine at least once is 48% in Australia, 42% in the USA, 31% in Belgium, 49 % in France and 70% in Canada (WHO 2001).

Despite the limited research data on efficacy and safety, the impact is that complementary/alternative medicine is used for the full spectrum of diseases from self-limited to life-threatening illnesses. For example, WHO Roll Back Malaria Programme (2000) reported that in Ghana, Mali, Nigeria and Zambia, herbal medicine is the first line of treatment for more than 60% of children with high fever. Worldwide, the surveys show that over three-quarters people living with HIV/AIDS, either in poor African countries or in rich industrialised countries, such as North America and Europe, uses traditional or complementary medicine. Also its used for various symptoms and/or conditions. Complementary/alternative medicine is often used to treat chronic pain and to improve the quality of life of those suffering from incurable diseases. For example, in 1998, in United

States of America, a national expert panel made consensus conclusion there is clear evidence that needle acupuncture treatment is effective for postoperative, pregnancy and chemotherapy nausea vomiting and dental pain with extremely low side effects than conventional treatments. In Germany, 70% and in the United Kingdom, 90% of pain clinics use acupuncture.
It is for the wide use and recognition of the role of traditional and complementary/alternative medicine that the Alma-Ata Declaration of 1978 and the relevant recommendations of WHO governing bodies (the World Health Assembly, the Who Regional Committees and the Executive Board) underscore the importance of traditional medicine and its practitioners in primary health care. Apart WHO and other organisations such as the Organisation of African Union, United National International Development Agency Organisation, the African Development Bank, the Works Bank, the International Development Research Corporation and others, have also been stressing the importance of traditional medicine. On its part, the African Summit of Heads of State declared in Abuja, Nigeria in April 2001 that traditional medicine research should be a priority and in Lusaka in July 2001 that the period 2001-2010 should be a decade for African Traditional Medicine. A plan of action for implementation of the decade has been adopted and will be endorsed by the African Heads of States in this year July 2003.

Despite these policy orientations, Africa is facing a number of challenges including the varying degree with which governments in the continent recognise traditional medicine; few countries have put in place regulation or registration procedures for herbal products, although this figure is increasing rapidly at present. There is a lack of co-operation and information sharing regarding market control between the ministries of health among the countries. Important data related to safety, efficacy and quality control are often insufficient. In most countries, either no safety monitoring system exists or the existing safety monitoring system excludes many types of traditional medicines. Due to lack of regulation on quality control and lack of the proper use by consumers as well as some harmful methods practice, cases for misuse of harmful methods, wrong species and misuse in taking high dosages have been reported, there is lack of qualification schemes which makes difficult for national authorities and consumers to recognise the qualified providers of traditional and complementary/alternative medicine. All of these factors impact on the safety, efficacy and quality of traditional and complementary/alternative medicine. In addition, Africa is facing difficulties in ensuring equitable access to health care and only about half of the population in Africa have access to formal health services. However, this traditional medicine maintains its popularity for historic and cultural reasons.

1.2 Background of the study

Due to this background of the situation of traditional medicine in Africa, that this thesis on "Tendency of patients towards medical treatment and traditional healing in Sudan" was undertaken. Most of the population in developing countries are facing problems in the mental health field. In Sudan psychiatric medicine has decreased almost steadily, the conditions of health facilities, equipment, drugs and supplies are poor. The picture is further complicated by the brain drain to western world and rich Arabian Gulf countries

where over 75% of skilled doctors work (Sudanese Medical Society 2003). For example currently, many people in urban areas seek help of psychiatrists and traditional healers. However, in rural areas traditional healing is the most prevalent method for the treatment of mentally sick people due to the meagre economic resources, inaccessibility of medical services, lack of awareness among the population and the high prices of service (Elsafi 1994). Moreover there has been a steady shift and switch between health systems as patients move from the more fragile health service of psychiatric medicine to the relatively better service of traditional healing. Following the risk that accompanying negative consequences in their health.

Traditional healers in Sudan perform many valuable services and social benefits to mankind. Nevertheless, traditional healing is not formally institutionalised, as there is no responsible government entity that guide and supervise the delivery of traditional healing services. Therefore, getting accurate figures/numbers of traditional healers and their speciality is extremely difficult and generally most of the data available concerning psychiatric health system in Sudan are largely based on estimates. This explains why in recent years traditional healers and their healing methods, particularly the spiritual one have attracted widespread concern throughout the developing world, and among the development community in general. Although some of these healing methods have a negative consequences concerning a patient's health such as skin damage and malnutrition. The number of traditional healers with their different healing methods in developing countries is increasing and the rate of people with psychosocial disorders is still alarming.
It is tempting to conclude that such emotional mal-adjustment is linked to something in today's world-rapid technological change, perhaps, or a decline in religious, community, family, or other support systems. Although the special pressures of modern life probably do contribute to psychological dysfunctioning, they are hardly its primary cause. Every society, past and present, has contended with psychological abnormality. Perhaps, then, the proper place to begin our examination of abnormal behaviour and treatment is in the past (Comer 1998, 9)

As we look back, we can ask what features remain constant in human societies, and which vary from place to place and from time to time. We can look at how each society has struggled to understand and treat psychological problems, and see that many present-day ideas and treatment can be traced to the past. The importance of traditional healing methods in developing countries cannot be underestimated and it is generally perceived as part of the prevailing religion and belief system. Literature have highlighted that traditional healers are often seen as the primary agents of psychosocial problems in developing countries; estimates of their share service range as high as 45% to 60% (WHO 1992). Several research efforts have been devoted to compare medical and traditional health systems in different cultural contexts. These studies gave evidence of some controversial findings; partly this is due to the differing methods of traditional healing across various cultures. However, no attention was paid to patients' tendency towards the health system and the factors influencing their tendency. In fact, the factors that influence the patients' tendency towards traditional healing and even their health decisions are complex and rarely known with any precision. In practice, it is difficult to identify a single underlying reason for patient's health decision and his/her switching between/within these two health systems, as many of them have an unavoidable link with each other.

This study aims to compare the similarities and differences between medical and traditional health systems in the Sudanese culture. It also attempts to fill the existing gap in literature by putting special focus on the patients' tendency towards the health plan and the socio-cultural factors influencing their tendency. Moreover, the study highlights an important and un-addressed phenomenon, which is the patients' treatment dilemma and their switching between/within the two health systems. Based on the findings of the study several recommendations were given aiming to improve the mental health system in Sudan and suggesting potential collaboration opportunities between the traditional and medical health systems for the benefit of the patients' health. Patients are a part of our community and may paralyse the developmental wheel.

1.3 Research question

The main questions of this study are therefore: (1) What can we learn with respect to the patients' tendency and factors influencing it as well as to other contributing factors that result in the patients switching between/within the two health systems? (2) How can mental health systems be improved and give the required benefits to the patients?

The researcher expects specific socio-cultural factors to influence the patients' tendency in choosing their health plan. These are: general perception on health and illness, personal beliefs generated from religion and culture, gender and educational level. An important question in this study is that the treatment success plays a major role in patients' decision of switching between/within the health systems. Mentally ill patients in developing countries are typically constrained by limited resources and access to both psychiatric hospitals and medicine. They depend mainly on traditional healers and their healing methods as the most accessible and less demanding in terms of financial obligations. Therefore, there is a special need to study the traditional health system, its methods, and patient's tendency with the ultimate aim of comparing it with the psychiatric health system.

1.4 Problem statement

Based on the background information, two research problems emerge. The first research problem relates to mentally ill patients and the need to improve their health awareness. The second research problem is associated with the existing situation of mental health in Sudan. Mentally ill patients in Sudan are confronted with many problems, which result in the observed different types of health systems and patients switching between these systems. This behavioural change is facilitated by a personal sense of control. Conner & Norman (1996, 165) stated that adopting health-promoting behaviours and refraining from health-impairing behaviours is difficult. Most people have a hard time making the decision to change and, later on, maintaining the adopted changes when they face temptations.

Moreover, methods of psychiatric health system for mentally ill patients in Sudan in many cases have little effect in improving the patient's health and they appeared not to meet the

standard of medical health services (Bassher 1984). Therefore, patients and their families have to look for treatment that satisfies the patient's health needs through different traditional healing methods ranging from mind, soul and body curing. The holistic approach of traditional healing might lead to long-term stability of health, this might explain why in many cases patients would prefer this approach than other techniques that result in short-term relief of symptoms.

It is well known that psychiatric illness requires a long duration under treatment and many ill persons are impatient and look for fast recovery. This results in the patients' instability under one treatment and their switching between/within different health systems. Therefore, due attention is given to understand the patients' tendency and their decision making in regard to choosing a mental health plan.

The problem is complicated by the extend methods emerging from the Islamic religion and cultural beliefs and that are followed by traditional healers. Despite the fact that traditional healing methods are widely accepted by the Sudanese people as it is based on *Quran* verses and other cultural and religious methods, in many cases certain methods of traditional healing instead of curing the sick extravate the patient's health problem, e.g. skin damage, worsening the nutrition of the patient. Studying the above-mentioned problems necessitates having a sample of patients that are exposed to both medical and traditional treatment.

To summarize the main premise of this research is to investigate which factors influence the patients' tendency and to what extent these factors affect their decision of switching between health systems. As already pointed out, very little is known regarding patients' tendency and their decision making for a health plan as well as the factors lead them to switch between psychiatric medicine and traditional healing.

1.5 Objective of the research

The broad objective of this research is: To establish an understanding of patients' tendency and perception towards mental health and illness, its effect on making health plan decisions as well as its relationship with the personal beliefs, duration of stay under treatment and other socio-cultural factors.

In order to achieve the objectives of the study the author first reviewed the available literature and relevant information in the field of mental health, which is presented in chapter two. In addition, the interviews conducted with the practitioners of the two health systems concerning their concepts and the methodologies of treatment are summarized and discussed in chapter five as well as the observation during the survey regarding the patients' instability under one treatment method. The specific research objectives therefore are:

* To investigate the tendency of the patients towards the medical and traditional treatment, according to their general perceptions and causes of mental illness.

* To determine the effects of culture, religion, experience and level of education on the patients' tendency towards the type of treatment.

* To study the relation between the patients' belief and the treatment continuation as well as the treatment success.

* To investigate the role played by the experience gained from duration under treatment and its effect on changing patients' perception and tendency towards both health systems.

* Based on the findings of the study the author suggests recommendations that will help to improve general perception and awareness about mental health and the effectiveness of the existing treatment methods.

1.6 Hypotheses of the research

The five hypotheses of this study are:

1) The patients in Sudan have a positive tendency towards traditional healing.

2) The tendency of the patients towards the type of treatment depends on their thinking about health and illness.
3) The differences in the patients' level of education and the duration they spend under the treatment influence their tendency towards the traditional healing.

4) Belief in traditional healing affects the success of the treatment.

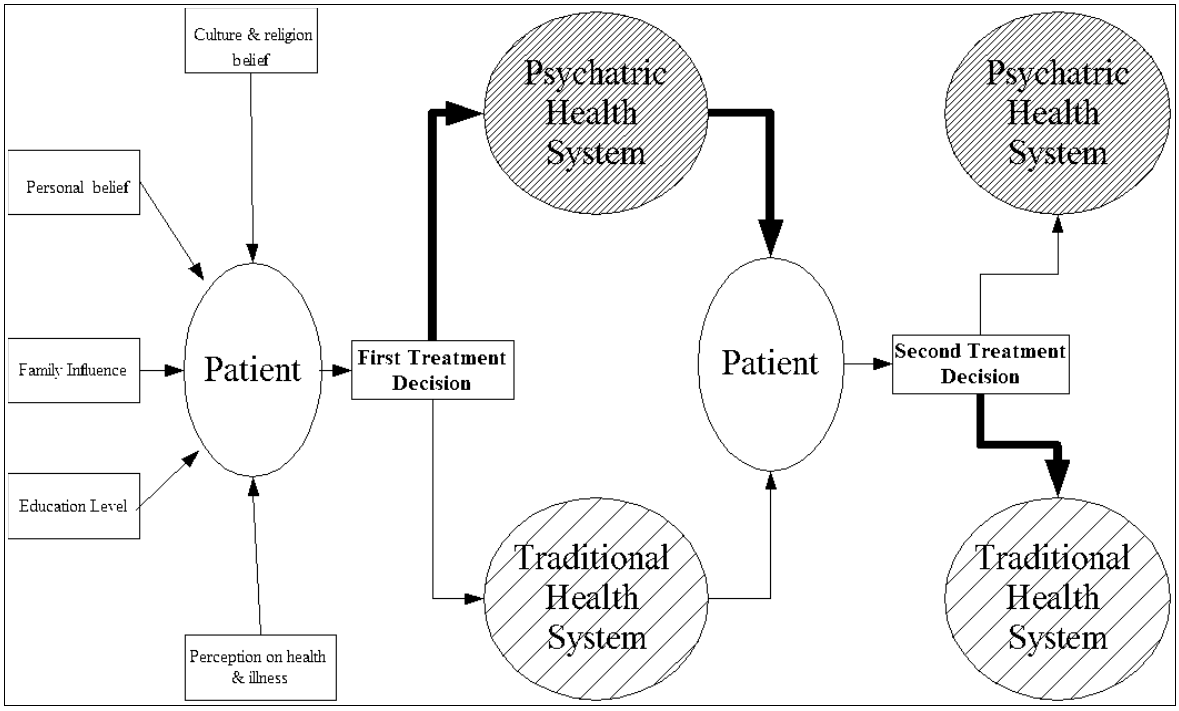
5) There are differences between the male and the female patients in their tendencies towards the traditional healing; female patients are expected to be more responsive to traditional healing than male patients.

1.7 Focus of the research

We are studying the above objectives and hypotheses within our research issue **"Tendency of patients towards medical and traditional treatment in Sudan**". Following the description of tendency, medical and traditional systems in the field of mental health, a general remark can be made regarding the approach of the present research. Since there appears to be no consensus regarding the definition of tendency in the health field there is a need for defining/elaborating this term in the context of this research. Tendency is viewed as statement of mind and feelings in which individual patients perceive outcomes to a particular health action. It is related to patients' awareness and their perception about health and illness in general as well as the socio-cultural surrounding. This tendency plays an important role in the individual behaviour orientation, especially with patients who accept the treatment according to their own views and beliefs of causes behind their illness. It has been found that a strong sense of personal efficacy is related to better health, higher

achievement and more social integration. This concept has been applied to such diverse areas as school achievement, emotional disorders, mental and physical health, career choice and socio-political change. It has become a key variable in clinical, educational, social, developmental, health and personality psychology (Bandura 1977, 1986, 1991, 1992, 1997; Conner & Norman 1996, 163). The present study refers to its influence on the adoption, initiation and maintenance of health behaviour. (See the following model, figure 1.1) that used to analyse the factors influencing patients' tendency towards the medical treatment and traditional healing, as well as affecting the patients' decision of switching between these two health systems in Sudan.

Figure 1.1. A framework of different variables affects the patients' tendency towards the two health systems of care, and later decision of switching between them

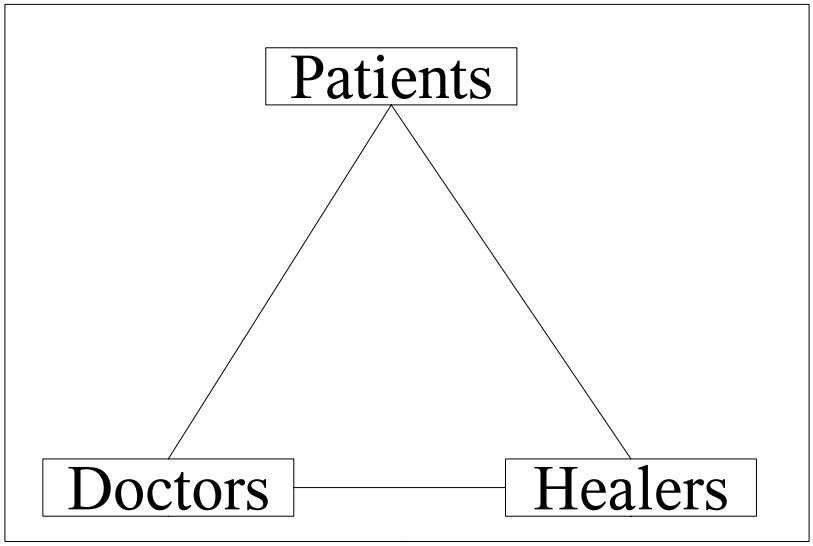


The research therefore focuses on understanding the factors that influence mentally ill patients' tendency towards the medical and traditional health systems and their decision making in health plan taking Khartoum the capital of Sudan and its neighbourhood as a case study. The choice of Khartoum area, among others is due to the existence of various health treatment methods. In addition, Khartoum residents were came from almost all the cultural and tribal background in Sudan. Nevertheless, the information gathered from this research and its findings are expected to be useful for all parts of Sudan as well as other African countries, which have similar cultural background and facing similar problems in the field of mental ill health.

The research also advocated to study separately (a) theories and models of mental health systems and (b) patients' perception on mental health systems in order to have a clear understanding of these concepts in daily practice. This distinction was found to be useful because recommendations can be made separately and thus enlarges the options for improving mental health situation.

In order to develop the mental health system in Sudan there is need to focus on a triangle approach (Figure 1.2) considering three areas of mental health care: patients, traditional healers and psychiatric doctors, rather than making prior assumptions and deliver recommendations regarding patients' mental health problems. This approach is appealing in the sense that one gets first hand information by the way how patients perceive and react to mental ill-health systems and from their own point of view and relate these to concepts and methods of treatment by both kinds of practitioners. The sample size of the practitioners was 16 and consists of 8 healers and 8 psychiatrists. A relatively small sample was chosen because translation of the local terms (in Arabic and other local languages) used by traditional healers is time consuming and also it is difficult to find the exact interpretation and rendering in English. However, due to time and financial constraints the practitioners' measurement procedures were taken only once.

Figure1.2: A triangle approach of studying patient's treatment dilemma.



To ensure reliability of measurement procedures, the patients' sample was exposed to the two health systems (psychiatric treatment and traditional healing). So it can present the factors that influence their tendency towards the first health system adopted, as well as factors that influence their decision to switch between/within types of treatment. In addition a pre-test of the survey questionnaire (Appendix 1) was carried out before applying it to the sampled patients in order to ensure reliability and validity of the research measurement. Moreover the author used a tap recorder during all the interview phases. Another problem that was observed during the interview process is that patients and

families may not always see the side effects of their switching within/between the health systems.

Data analysis was done using SPSS software package as regards the patients' interviews as well as an intensive analysis for the practitioners' interviews. Moreover the Chi-square test and cross tabulation of variables were applied to test the significance of the research hypothesis

1.8 Set-up of the thesis

This report is subdivided into six chapters, the first being the introduction and presenting the research focus. Chapter 2 offers review of the literature on psychiatric history as general and current status of mental health systems in Sudan. It also reviews traditional healers, their social status and their methods in connection with the prevalent belief systems in Sudan and the associated cultural dimensions. The experience of other countries in regard to collaboration approaches between psychiatrist doctors and traditional healers is also presented in this chapter.

Chapter 3 presents the methodology used in this research. First the definition and specification of qualitative methods related to the empirical measurement is presented. Following this, a justification for the choice of the research area is given, also a detailed description of mental health locations (hospitals and massed[*]) where the samples were selected, and it's surrounding in Sudan is presented with emphasis on the characteristics of psychiatrists and healers. To meet the objectives of the study a sampling procedure is followed for both the patients and the practitioners. A random purpose sampling procedure is used to select the respondents focusing on patients who are exposed to the two health systems (one group under psychiatric treatment and the other group under traditional healing). Whereas for the practitioners an interview was carried out with the heads of hospitals/*masseds* and their assistants in case he/she is available. A structured questionnaire constructed according to Rolf Schwarzer's model in "Self-efficacy and Health Behaviours" is used for the patients' sample (Sozial-kognitives Prozessmodell gesundheiten Handelns, Schwarzer 1992). The practitioners' questionnaire was based on five major categories: aetiology and causes of mental disorder, classification, diagnosis, treatment method and attitudes towards collaboration with their counterparts. Finally, the chapter gives the linkage between research objectives, concepts, questions and the methods of data analysis.

Chapter 4 consists of three parts. The first part presents the results obtained from analysing the data collected from the psychiatrists with reference to the above-mentioned categories in addition to their individual characteristics. Part two presents the results of analysing the traditional healers' interviews as well as their individual characteristics. The method of analysis followed in both parts is an intensive analysis technique.
Part three discusses and interprets the results of the two types of practitioners (psychiatrists and traditional healers) as well as the relevant clues obtained through systematic observation and casual discussions carried out by the author during the survey. It also

[*] Massed is a place where a healer use to meet and to heal the patients and also where they live.

compares the results of the two practitioners in terms of their similarities and differences. Summary and conclusion present the major findings in a systematic way.

Chapter 5 presents and discusses the results obtained from analysing patients' data, more specifically it discusses the patients' tendency towards medical and traditional treatment identifying the factors that influence their tendency towards the two health systems in addition to the factors that influence their decision of switching between these two health systems. The first section presents the results and the discussion of patients' tendency towards traditional healing and the difference in the tendency between the two patient groups using the items/statements included in the structured questionnaire.
The second section gives the results and discussion of factors that are expected to influence the patient decision towards health systems which are: patients' perception on symptoms, patients' perceived illness name, patients' perception on causes of illness and patients' perception on the illness origin (Is it hereditary? Is it a result of general weakness in the body? Is it fate?). The third section presents the results and the discussion of factors that expected to influence the patient decision on switching between the two health systems and explains the patient treatment dilemma with reference to the patient education level and patient experience with the health system and his/her duration of stay under the treatment.
The forth section presents the results and the discussion of the relationship between patient personal belief and the effectiveness of traditional healing methods, an attention was paid to patients' view on the abilities of the traditional healers, patients' perception on religion origin of traditional healing and patients' perception on cultural origin of traditional healing. The final section gives the results and the discussion of gender and its influence on patient's tendency towards the chosen types of treatment. The chapter also presents the results and the discussion of patients' socio-cultural factors and characteristics that might influence patients' tendency towards the two health systems and their decision of switching between these systems.

Chapter 6 presents the general discussion, conclusions and recommendations. It starts with some reflections on the research approaches and assumptions as well as the research methodology and the results of this research. The discussion centres on specific limitations and strengths of the research in trying to validate the results. Conclusions and recommendations regarding the results, methods used policy implications and on future research needs are also presented.
Finally, the chapter presents the references and the appendix that includes questionnaires, tables and figures.

2. Literature review

Introduction

Mental illness passes through many changes, through different periods of time, and the treatment follows these changes. Furthermore, mental illness is since long time known as an illness of possession by spirits. Different established techniques make the body an inhabitable place for the evil.

Day-to-day there is a process of dramatic changes in the understanding of mental illness. In the sixteenth century special institutions for the mentally disturbed were established in different parts of the world. However, the conditions in these hospitals often were bad.
The movement towards humanitarian and moral treatment of patients received its first great support from the works of Phillip Pinel (1745-1826) 'who argued that the patients were sick people whose mental illnesses should be treated with and kindness rather than with chains and beating' in France, Turke and Dix in England (1802-1887). Their efforts resulted in the opening of two hospitals in the US, as well as in other countries. By the end of the nineteenth century, the mental hospital had become a familiar landmark in the world, and the twentieth century witnessed a number of scientific advances. For example, the successful results of biochemical methods were applied to disorders, and scientific research progressed into the biological and psychological roots of mental disorder (Coleman 1984; Comer 1998,15).

Psychiatry has to a large extent been reintegrated into the main stream of the general hospital development. In many countries, psychiatric wards were integrated to regional and major province hospitals' development. This has been a great advantage for the patients as well as the staff and has contributed to break down prejudice and discrimination against psychiatric patients, at least, to some degree (Nimb 1980, 108).
This part of chapter two intends to outline the historical background of the psychiatric and disease's theories.

2.1 History of psychiatry

Medicine as a humanitarian institution has a long past but a short history. However, like other social institutions, medicine cannot stand suddenly and independently, but only within combination of other factors that paved the way. The medicines became requested and the human conscience was awakened, then wisdom grew and the light of science and knowledge spread out.

It is suitable to start by mental health and it's concept. Mental health has a terminological change in its concept and meaning today. The first historical mentions of mental health in its context include the same ideas that are close to those included today. This comes from the geographic and historical succession, beginning with the social aspect for its importance. That will enable the researchers to follow its origins, its supporting elements and consequences and to adopt a technical approach, which has no relation with time.

Baasher (1984) stated: ”The concept of mental illness or mental disorder has gone through different stages of historical development, and before the modern conception of mental illness existed, mental disorder was attributed to possession of mind and body by demons; the invisible powers that were assumed to cause the evil, pain and suffering that were everywhere evident. He defined mental health as the ability of the individual to adjust to his/her living circumstances effectively, and to interact with others positively. In many instances people fall subject to mental and psychological disorders”.

The widespread social and intellectual changes have occurred with the developing science of neurology, which separates body from spirit; therefore, mental disturbance is attributed to disease rather than to demons. Another perspective of defining mental illness is on the basis of the sociological point of view; that is, the mental disturbances are here classified as deviant. However, deviant can be defined statistically simply as an expression of degree of deviation from the population average. Furthermore, the term deviant implies that an individual is different in kind from ordinary people and that there is no area of his/her problem (Zimbardo 1980). Comer (1998, 3) argued that abnormal behaviour, thoughts, and emotions are those that violate a society’s ideas about proper functioning. Each society establishes **norms** – explicit and implicit rules for appropriate conduct. Behaviour that violates legal norms is called criminal. Behaviour, thoughts, and emotions that violate norms of psychological functioning are called abnormal. Typically, the norms of psychological functioning focus on conduct that is common in a society, such as our society’s expectations that people will remember important events in their lives. Sometimes, however, a society may value certain psychological deviations, such as superior intelligence and extreme selflessness, and may include these forms of functioning within its norms. Consequently, each society defines itself negatively by pointing out what is not appropriate rather than what is appropriate behaviour. This view supported by many researchers like (Foster & Anderson 1978; Helman 1986; Helman 2000). However one clinical theorist, Thomas Szasz (1997, 1987, 1961) places such emphasis on society’s role that he finds the whole concept of mental illness to be invalid, a myth of sorts. According to Szasz, the deviations that society calls abnormal are simply “problems in living” not signs of something inherently wrong within the person. Societies, he is convinced, invent the concept of mental illness to justify their efforts to control or change people whose unusual patterns of functioning threaten the social order. In extreme cases the category even serves to justify the removal of those individuals from society (Comer 1998, 5).

This focus on social values as a yardstick for measuring deviance suggests that judgments of abnormality vary from society to society. A society’s norms emerge from its particular culture – its history, values, institutions, habits, skills, technology, and arts. Mental health professionals function as agents of the society, so the view that what is healthy can make deviants of mental illness, which appear to be universal manifestations of affection that are not negative to particular cultural settings. Thus, the word insanity refers to a pattern of related behaviour, beliefs and the person's mind over which he/she has lost control (Helman 1986, 43; Comer 1998, 3).

In all cultures mental disorders disturb all the levels of the person’s functioning: physical, psychological and spiritual. The whole world of the sufferer is then disrupted. This may include his ethical value, self-image and relation with others. The severity and degree of disruption is determined by the combination of different interrelated factors. Those include, among other things, the personality of the sick person and the culture in which he lives. A therapist should always bear in mind that the person coming for help has his unique problems coloured by the culture in which he lives (Badri 1979, 39; Eric 2001, 37).

The way people conceive the notion of health varies subject to time and place. Tracing the historical changes of the diagnosis and treatment of mental health, from one phase to another, may endow us with fruitful concepts, which might otherwise appear chaotic (Elsafi & Baasher 1981).

The early writings of ancient Chinese, Egyptians, Hebrews and Greeks on mental health show that all of them attributed abnormalities to demons that had taken possession of the individual. Thus our knowledge of how ancient societies viewed and treated people with mental disturbances is limited. Historians have concluded that prehistoric societies probably viewed abnormal behaviour as the work of evil spirits. People in these early societies apparently explained the phenomena around and within them as resulting from the actions of magical, sometimes sinister beings that shaped and controlled the world. In particular, they viewed the human body and mind as sites of battle between external forces, and they viewed behaviour, both normal and abnormal, as the outcome of battles between good and evil spirits, positive forces and demons or good and bad gods. Evil spirits often interpreted abnormal behaviour as a victory, and the cure for such behaviour was to force the spirits to leave the person's body (comer 1998,10). This implies that ancient theories of disease had a good deal in common between them irrespective of geographical disparity. This is not surprising when we remember that "good" and "bad" spirits were widely used to explain lightning, thunder, earth quake, storm, fire, sickness and other occurrences that otherwise seemed incomprehensible. It was probably a very simple and logical step to extend this theory to peculiar and incomprehensible behaviour as well (Weber 1920; Davison & Neale 1974, 7).

Taylor (1976) suggested that the concept of disease causation through object intrusion had spread from one area by diffusion. Clements (1932) supported this view suggesting that the concept spread firstly across Asia and Europe, and then crossed over to America. He added that there were only three basic explanations of disease causation in the ancient world: loss of vital substance from the body (soul loss), introduction of foreign and harmful substance in the body (spirit intrusion or possession) and violation of taboos and witchcraft (Kiev 1964, 53).

Weber (1920) stated that; "Demonology is the doctrine that a devil or any other spirit is able to control the body and the mind of the person". The decision as to whether the "possession" involved good spirits or evil spirits usually depended on the individual's symptoms. If speech or behaviour appeared to have a religious or mystical significance, it was usually thought that a good sprit or god possessed the person, such individuals were often treated with consideration and respect, it was thought that they had supernatural powers. Most possession, however, were considered to be the work of an angry god or of evil sprits, particularly when the individual become excited and overactive and engaged in behaviour contrary to religious teaching. Among the ancient Hebrews, for example, such possessions were thought to represent the wrath and punishment of God. Moses is quoted in the Bible as saying "The Lord shall smite with madness". Apparently this was thought to involve primarily withdrawal of God's protection and the abandonment of the individual unto the forces of evil (Davison & Neale 1974, 7-10).

These above mentioned possessing spirits were then divided into two types: good and evil spirits. Good spirits were associated with mystical and religious functions. People who were possessed by good spirits were treated with respect and awe for they were believed to

have supernatural powers. The common mystic notion of *budalah*[*] throughout the Muslim world is supportive of this concept. Evil spirits, on the other hand were associated with excitement, overactive and irreligious behaviour. The method of treatment for the latter type of possession was exorcism, which included various techniques for the casting of the evil spirit out of the patient's body. They included prayers, noise making, and use of bad tasting substances. In extreme cases, severe measures such as flogging were used in an attempt to make the body of the patient a too unpleasant place for the spirit to stay. And indeed, the skulls of some patients were cut open to allow the spirit to escape through this opening (Coleman 1984). Such treatment was originally in the hands of shamans but eventually was taken over in Greece and Egypt, by priests. A priest was a mixture of a minister, a physician, a psychologist and a magician. The priests themselves were the makers of the concepts of disease and the authors of the etiological cause, symptoms and disease entities. However, this concept of demonology was criticised by Hippocrates (460-377 B.C.), the father of modern medicine. He denied the intervention of demons in the development of disease and insisted that mental disorders had natural causes rather than metaphysical ones. He saw abnormal behaviour as a disease caused by internal physical problems rather than by conflicts between gods or spirits. Specifically, he believed that some form of brain pathology was the culprit, and that it resulted-like all other forms of disease, in his view-from an imbalance of four fluids, or humours, that flowed through the body: yellow bile, black bile, blood, and phlegm. An excess of yellow bile, for example, caused mania; an excess of black bile was the source of melancholia. To treat psychological dysfunctioning, Hippocrates sought to correct the underlying physical pathology. He believed, for instance, that the excess of black bile underlying melancholia could be reduced by a quiet life, a vegetable diet, temperance, exercise, celibacy, and even bleeding. He emphasised that the brain is the central organ of intellectual activity and that mental disorders are due to brain pathology (Comer 1998, 11; Jakobsen 1999, 13-43).

Hippocrates' focus on internal causes for abnormal behaviour was shared by great Greek philosophers Plato (427-347 B.C.) and Aristotle (384-322 B.C.) and later was extended by influential Greek and Roman physicians. The physician Aretaeus (A.D. 50-130), for example, suggested that emotional problems could also cause abnormal behaviour. The physician Galen (A.D. 130-200) systematically distinguished emotional causes, such as financial worries and loss of love, from medical ones, such as head injuries and alcohol abuse. These theories led Greek and Roman physicians to treat mental illnesses with a mixture of physical and psychological techniques. Before resorting to such extreme methods as bleeding patients or restraining them with mechanical devices, many Greek physicians first prescribed a warm and supportive atmosphere, music, massage, exercise, and baths. Roman physicians were even more emphatic about the need to soothe and comfort patients who had mental disorders (Comer 1998, 11).

The Greek medical aspect was mostly developed in Arabia and throughout the entire Islamic empire. The first mental hospital was established in Baghdad (729 A.D.) and was soon followed by others in Damascus and other Islamic cities. In these hospitals, the mentally disturbed received far more humane treatment than they did in the contemporary asylums of Europe, where patients were treated as if they were criminals (Coleman 1984, 36). The out standing figure in Islamic medicine was Ibn Senia (A.D. 980-1077) who was a brilliant example of how Islamic physicians have considered the Greek medical heritage

[*]Budalah: Divine people of a higher rank in the classification of Sufis. They are of supernatural knowledge, which extends to the unseen world. It is believed that they shoulder the burden of saving people in cases of threatening crises.

and have contributed substantially to the advancement of medical wisdom in psychiatry. Many researchers appreciated this point by narrating the famous story of the delusional Prince treated by Abn Senia* (Coleman 1984, 36).

Hakim (1992) noted that during the Middle Ages, (about A. D. 500-1500), there was a tremendous revival of the more ancient concepts of demonology. Mental disorders were frequent throughout the middle ages and their incidences seemed to have increased toward the end of the period as medieval institutions began to collapse. Rossen (1967) suggested that the medieval world began to come apart in the 14th century with ever increasing degree of disintegration. The tremendous social change in this century included institutional structures and beliefs. That period evidenced, beside rural and urban unrest, wars and plagues. No wonder then that the general feeling of insecurity generated by such socio-cultural turmoil precipitated many psychological disorders. As such, the last half of the middle ages in Europe saw a peculiar trend of abnormal behaviour. It was famous for the occurrence of group mental disorders, which seemed to be cases of hysteria. Whole groups of people were affected at the same time.

Throughout the Middle Ages in the years from A.D 500 to 1350, treatment of the mentally disturbed was left largely to the clergy. During the early part of the medieval period the mentally disturbed were treated with much kindness. Prevailing techniques include prayers, holy water, the breath or spittle of the priest, visits to holy places and gently laying-on of hands, or the holy touch. Comer (1998, 12) mentioned that religious beliefs-themselves highly superstitious and demonological at this time-came to dominate all aspects of life. Personal experience and conduct were often interpreted as a conflict between good and evil, God and the devil; and deviant behaviour, particularly mental dysfunctioning, was seen as evidence of an association with Satan. Although some scientists and physicians still argued for medical explanations and treatments, their views carried little weight in an atmosphere of rigid religious doctrine. Later on, however treatment of such patients became harsher. This is reminiscent of the development of healing practices during the Greek era in which gentle treatment eventually gave way to severer punishment as treatment of patients. Thus again, the belief that the mentally ill are possessed, made healers resort to trying to drive the demons by more unpleasant methods. These included flogging, starvation, chains, immersion in hot water, and other horrible techniques.

Even in the later part of the 15th century the concept of demon possession also prevailed. It was generally believed that possessions were of two main types: possession in which the victim was unwillingly seized by the devil, as punishment by God for past sins and possession in which the individual was in complete agreement with the devil. In the latter type of possession the individuals were believed to have a commission with the devil approved by signing in blood a book presented to them by Satan. In that commission such individuals were believed to have give supernatural powers, which could be utilised in harming or serving other people (Coleman 1984). The general public did not only hold such beliefs, but also they were held and elaborated upon by most of the important clergymen at that time. Even Luther 'a German theologian and leader of reformation who held the belief common to his time that mentally disturbed were possessed by the evil (1484-1546), states: "Men are possessed by the devil in two ways: physically and spiritually. Those whom he possessed corporal as mad people, he has permission from God to vex and agitate but he has no power over their souls". Here again we see the concept of

* The prince, in his disease, came to believe that he was a cow longing for being slaughtered for his flesh. He refused his food. Abn Senia persuaded him to take his meals by associating the fulfilment of his desire by his being fattened. When he ate eagerly for that purpose he gained his strength and got rid of his delusion.

the *budalah* in the Islamic culture, which is still prevailing up to the present time (Coleman 1984; Comer 1998, 10).

The unwillingly possessed individuals were treated with the prevailing techniques of exorcism. These milder forms of exorcism were sometimes supplemented by torture in the form of starvation, whipping, scalding, or stretching. The gap between these two types was gradually lessening till the end of the 15th century when the mentally ill came to be considered in general as harmful witches who must be got rid of. They had to be tortured till confession was obtained. A victim had to confess all his past sins otherwise he had to face the penalty of conviction because of witchcraft. To be convicted because of witchcraft was not an easy matter. The penalty usually followed one of three forms: those who were strangled before being burned, those who were burned alive and those who were mutilated before being burned (Coleman 1984; Comer 1998, 14; Isak 1997, 17). The suffering of the mentally disturbed in this period of history is illustrated in the following case: ”In Kingbory in 1663, a man thought he was God, the Father. He claimed that all the angels, the devils and the Son of God recognised his power. He was convicted. His tongue was cut, his head was cut off and his body was burned”. Needless to say that this poor fellow was obviously suffering from some sort of psychosis characterised by grandeur (Zilborg & Henry 1941,113).

There seemed to have been little distinction between the Roman and the Reformed churches in their attitudes toward the so-called witchcraft. Large numbers of people were put to death in that period. A French judge boasted that he had burned 800 women within 16 years. The process of burning of patients was originally started by the Church of Rome and was carried along by the protestant churches of Britain and Germany. In protestant Geneva 500 persons were burned in 1515 (Bromberg 1937; Davison & Neal 1974, 9). In such cases, every effort was made to rid the person of the evil spirit, Jesus reportedly cured a man with an "unclean spirit" by transferring the dust (demons) that played to him a herd of swine who, in turn, became possessed and ran voluntarily down a steep coast into the sea.

Another type of treatment for demonical possession was exorcism. This included various techniques for casting the evil spirit out of the body. These techniques varied considerably but typically included the following:
Magic: It is art of controlling events by the pretended use of super natural forces, which is owned by individual. Senior men try to acquire a few of the principal and well-established medicines and out sick these people who are given medicine appropriate to their special pursuits. A man may, however, obtain actual ownership of medicine and become the magician himself who operates them (Elguhary 1992, 15). Magic is a seldom and essential part of the social activity. Magical rites are usually described relative to economic and social activity. Most of the magicians are males, they are usually middle-aged or old, and they pass on their knowledge to one of their sons so that he learns the secrets of the trade. As Elguhary mentioned that Reichard (1963) described magic as giving power and is monopolised by men as seekers of power while women use it to be protected from its evil and sorcery. This early interpretation is susceptible now with socio-economic changes in the status of women (Elguhary 1992, 33; Gafour 1997, 28).

Prayer: It is a form of worship to God after ”giving thanks” by bringing some gift or money to the Shaman or priest, you ask him then in return for your favour that you recover from your illness. Davison & Neale (1974, 10) noted that the treatment of mental illness during the Middle Ages was generally in the hands of priests, who would pray and sprinkle

the afflict with holy water. In their Zeal and well-intentioned attempts to strike a fatal blow to Satan's pride, however, they often shouted obscene epithets as well. As time went on, terrible tortures took the place of prayers, for the devil within had been punished and the body harbouring him made inhabitable.

Certain plants and herbs: They are a certain kind of tree roots from deserts used for curing illnesses and for psychological relief. There are other methods of healing, e.g., noise making and the use of various horrible tasting concoctions, such as purgatives made from sheep's dung and wine, are also used. In extreme cases, even more severe measures are used, such as that of starving (suffer from hunger until near to die), or of flogging (beating/whipping and hitting), were sometimes used in an attempt to make the body of the possessed person an unpleasant place to the evil spirit and it would/could then be driven out. The popularity of movies and books on possession and exorcising suggests that these primitive ideas still have a wide appeal today (Coleman 1972; 1980; 1988).

The task of exorcising was originally in the hands of Shamans, but was eventually taken over in Egypt and Greece by the Priests, who were apparently an interesting mixture of priest, physician, psychologist and magician, whereby the cures still remained based on magical rites. Although these priests mainly believed in demonology and used established exorcist practices, many made a beginning in the more human treatment of mental disturbances. For example, in the temples of the god Asclepiad in ancient Greece, the priests had patients sleep in the temple, they assumed that the dreams they had would reveal what they needed to do to get better. The priests supplemented prayer and incantation with kindness suggestions and recessional measures, such as acting, riding, walking, and harmonious music (Hakim 1992).

Ahmed & Amin (1990, 67) argued that any criticism or questioning of the doctrine of witchcraft and the demonology of the Middle Ages was made at the risk of life itself. That was the case in the Western world of the Middle Ages. Nevertheless, the concept of demon possession was and is still prevailing in the Islamic world. Perhaps the main difference is that mental disorders are not associated with volitional possession of evil spirits. Indeed an insane, here, is considered as an innocent person. The prophet of Islam was reported to have said that three classes of people are not accountable for their misdeeds; namely, children before puberty, the insane, and people during their sleep. Ibn El Gheyem (1993) gave another clear illustration when he wrote that in the statement of the prophet Mohamed, it stated that *Rughyeah*[*] could cure all types of disease, mental or physical.

Coleman (1984) noted that a short time later insisted that mental disorder was not a possession but a form of disease and that it should be treated as such (Zilboorg & Henry 1941). The true founder of modern psychotherapy was Johann Weyer (1515-1588), who is a German physician and specialised in mental disorders. The scenes of harsh imprisonment, torture and burning of innocent people convicted of witchcraft distressed Weyer. He made a careful study of the entire problem of witchcraft. About 1563 he published his book, "The Deception of Demons", in which he argued that all of the victims of his time were actually sick in mind or in body and believed that the mind was as susceptible to sickness as the body. He added that great wrongs were being committed against innocents. The other investigator was Reginald Scott (1538-1599), who worked hard to explain the fallacies of witchcraft and demonology. Scott convincingly denied the

[*] A ritual where the breath or spittle of the Sheikh is directed to a client while the Sheikh recites certain *Quran* verses.

existence of devils, demons and evil spirits as the cause of mental disorders. He argued that the so-called witchcraft women were but diseased wretches suffering from melancholy and that their behavioural abnormalities were but reflections of their sick brains (Comer 1998, 14).

Faced by such daring attacks, which continued through the next two centuries, demonology was forced to give way and gradually pave the way for modern experimental and clinical approaches through reasoning and observation. Finally, at the beginning of the 18th century the doctrine of demonology was completely abandoned and patients were kept in mental hospitals instead of being burned. However, treatment in many monasteries or asylums was still inhumane. Comer (1998, 15) mentioned that Selling (1940) has described the treatment of the chronic insane in la Bicetre Hospital in Paris. The methods of treatment he described included tying patients to the walls of their cells, by the so-called iron collars, disallowing their movements. Iron hoops around the waists of patients were also very common. Conceived of being animals, patients were not adequately fed. They were put in cells furnished only with straw, with no reasonable sanitation and no visits were allowed. Even as late as (1830) newly admitted patients had their heads shaved, were compelled to swallow some more drugs, but were also permitted to exercise on hospital's ground and kindness was extended to the poor victims. The results were almost miraculous. Selling then wrote: "The whole discipline was marked with regularity and kindness and had the most favourable influence on the insane rendering even the most furious more tractable" (See Davison & Neale 1974; Comer 1998,15; Isak 1997, 24)

The success of Pinel encouraged the establishment of ten other similar hospitals in France. William Tuke (1732-1819) founded a similar successful institution in England. He established *The York Retreats* in 1796, a pleasant country house where mentally ill patients lived, worked and rested in a kind religious atmosphere. Similar hospitals were then seen in England and other Western countries. The "medical" cures developed for use in asylums during this period were themselves misguided and unintentionally cruel. Comer (1995,15) mentioned that in the eighteenth century, no less a figure than Benjamin Rush (1745-1813), often called the father of American psychiatry, treated some patients by drawing blood from their bodies, a technique also used at that time to treat bodily illnesses. This treatment was meant to lower an excessively high level of blood in the brain, which Rush believed was causing the patient's abnormal behaviour (Farina 1976). Thus suspicious, ignorance, and erroneous medical theory conspired to keep people with mental disorders a shameful form of care until the late eighteenth century.

As 1800 approached, the treatment began to change for the better once again. Thus moral therapy in mental hospitals became widely spread. This approach stemmed largely from the works of Pinel (1745-1826), who named the chief physician in France and Tuke (1732-1819) in England. The methods espoused by Pinel and Tuke, called "moral treatment" by their contemporaries because of their emphasis on moral guidance and on humane and respectful intervention, caught on throughout Europe and the United States. Increasingly, patients with psychological disorders were perceived not as possessed, but as human beings whose mental functioning had broken down and who had lost their reasoning as a result of being exposed to severe psychological and social stresses. Such stresses were known as moral causes of insanity. Moral treatment aimed at relieving such a patient through friendly exploration of all his problems (Comer 1998, 16). Moral therapy such as discussions of patients' problems, individualized care, constructive activities, work, companionship, and quiet was no doubt effective and indeed it may be fruitful even today though anti-psychotic drugs are so prevalent. It may be tempting to the author to suggest that moral therapy has

many parallels with the religious healers (Sheikhs) techniques of the Sudan as well as with Glaser's Modern Techniques of Reality Therapy.

Despite its effectiveness, moral therapy declined and was nearly abandoned by the end of the 19th century. Worse noting is that Europeans in the 18th century even after abolishing the concept of demonology and possession still viewed mental patients as beasts and criminals. Dorothea Dix (1802-1887) who made humane cares a public and political concern in the United States. She told the Congress of the United States that mental ill people across the country were still being "bound with galling chains, bowed beneath fetters and heavy iron balls attached to drag chains, lacerated with ropes, scourged with rods and terrified beneath storms of execration and cruel blows" (Zilboorg & Henry 1941, 583-584. In Comer 1998, 17).

As we have observed, the treatment of abnormality has followed a crooked path. Over and over again, relative progress has been followed by serious decline. Viewed in this context, the decline of moral treatment in the late nineteenth century is disappointing but not surprising because of several factors contributed to this decline (see Bockoven 1963; Comer 1998, 17) Gradually, by the early twentieth century, strides were made in changing the attitude of the public toward mental patients. Clifford Beers (1876-1943) followed up the work of the American pioneer and ex-school teacher Dix in educating the public about mental disorder. Beers (1908) in his famous book, "A Mind that Found Itself", described his own mental collapse, the terrible treatment he received, and how he recovered in the house of a friendly attendant (Comer 1998, 17). Therefore, through these efforts of devoted volunteers, contemporary mental health care came into being. Gradually there was better public understanding of mental disorders, of the necessity of the development of mental health programmes and facilities and toward the concept of comprehensive health.

The late nineteenth century also saw a dramatic resurgence of the somatogenic perspective, the view that the abnormal psychological functioning has physical causes. Here it appears that the revolt against demonology and similar paradigms has led psychiatrists to overemphasise the involvement of an organic origin in the aetiology of mental disorders. In fact the involvement of organic factors was not altogether unfamiliar to European thinking if one takes into account the tradition of the Greek physician, Hippocrates who noticed, "abnormal behaviour resulted from brain maladies and an imbalance of humours, or bodily fluids", yet it had never before been so widely accepted.

Two factors were responsible for this recovery. One was the work of Emil Kraepelin (1856-1926), a German researcher who took particular interest in the relation between abnormal psychological functioning and such physical factors as fatigue, and who measured the effects of various drugs on abnormal behaviour. In 1883 Kraepelin published an influential textbook, expounding the view that physical factors are responsible for mental dysfunctioning. Later he constructed the first "modern" system for classifying abnormal behaviour, listed their organic causes, and discussed their expected course (Jablensky 1995). Another important trend to unfold in the late nineteenth century was the emergence of the psychogenic perspective, the view that the chief causes of abnormal functioning are psychological. The Roman statesman and orator Cicero held that the psychological disturbances could cause bodily ailments, and the Greek physician Galen believed that many mental disorders are caused by fear, disappointment in love and other psychological events.

However in modern times the concept of organic aetiology of mental disease acquired sound sophistication and later on, research at the molecular level of neural functions. As early as 1775, Elbrecht van Haller emphasised the role of the brain in psychic functions and started to examine the brains of some insane by post-mortem dissection. In 1792 an improvement was made for treating these people. Furthermore Griesinger (1845) insisted that all mental disorders could be explained in terms of brain pathology. In the beginning of the twentieth century 1905 that a great advance was made in medicine and psychology (Comer 1998, 18).

To conclude the social views of mental illness, there are both universal aspects of mental disorder as well as specific cultural aspects. In addition to cultural aspects, there are cultural bound and situational relevant dimensions of mental illness in a given culture. Such view leads to the conclusion that each psychotherapeutic setting should consider the cultural elements in each society (Zimbardo 1980, 167).
The treatment of mental disorder due to scientific theories depends mainly into two types of treatment: biological therapies and psychotherapies.

a) Biological therapy: Biological and anatomical discoveries also spurred the rise of the somatogenic perspective. One of the most important discoveries was that an organic disease, syphilis, led to general paresis, an irreversible, progressive disorder with both physical and mental symptoms, including paralysis and delusions of grandeur. The organic basis of this partly mental disorder had been suspected as early as the mid-nineteenth century, but concrete evidence did not emerge until decades later.

Comer (1998, 18) mentioned that the work of Kraepelin and the new understanding of general paresis led many researchers and practitioners to suspect that organic factors were responsible for many mental disorders, perhaps all of them. Despite the general optimism, the biological approach yielded largely disappointing results throughout the first half of the twentieth century. True, many medical treatments were developed for patients in mental hospitals during that time, but most of the techniques proved ineffectual. The biological approach domain, considers changes in behaviour through manipulations of the brain, psychological and chemical processes. Biological therapy however, includes electro therapy, psychosurgery and psychoactive drug treatment, a method, which has proved to be dramatically effective in helping alleviate the symptoms of many people with emotional disturbances. Each of these biological therapy methods has its positive and negative aspects. For instance, the psychoactive drugs used in treatment are classified into four categories: major tranquillisers for psychotic symptoms, minor tranquillisers for anxiety, antidepressants, and stimulants. All of them can produce undesirable side effects, and some make physically addictive. When a patient stops taking the medication, symptoms usually return. Until the 1950s, when a number of effective medications were finally discovered, did the somatogenic perspective truly begin to pay off for patients with mental disorders. For example, psychoactive drugs have made it possible for many who previously could not be reached by psychotherapy to benefit from psychological as well as biological treatment (Sadock & Kaplan 1996, 399).

b) Psychotherapies: This approach has long history, actually dates back to 1778 when it use as a means of treating psychological disorders. Friedrich Anton Mesmer (1734-1815) established a clinic in Paris where he employed an unusual treatment for patients with hysterical disorders, mysterious bodily ailments that had no apparent physical basis. Comer (1995, 19) noted that “Mesmer’s patients would sit in a darkened room filled with music. In the centre of the room, a tub held bottles of chemicals from which iron rods protruded.

Suddenly Mesmer would appear in a flamboyant costume, with draw the rods, and touch them to the troubled area of each patient's body". He argued that a surprising number of patients did seem to be helped by this treatment. Their pain, numbness, or paralysis disappeared. Mesmer's treatment, at first called '*mesmerism*' and several scientists believed that Mesmer was inducing a trancelike state in his patients, and that this state caused their symptoms to disappear. In later years this technique was developed further and relabelled *neurohypnotism*, later shorted to *hypnotism*[*] and that is the inducing of a trancelike mental state in which a person becomes extremely suggestible.

By the late nineteenth century, two competing views had emerged. That a technique that enhanced the power of suggestion could alleviate hysterical ailments indicated to one group of scientists that hysterical disorders must be caused by the power of suggestion-that is, by the mind- in the first place. Another group of scientists believed that hysterical disorders had subtle physiological causes. Comer (1998, 19-20) argued that the later experiments showed that hysterical disorders could actually be induced in other wise normal subjects while they were under the influence of hypnosis. That is, they could make normal people experience deafness, paralysis, blindness, or numbness by means of hypnotic suggestion and they could remove these artificially induced symptoms by the same means. In short, they established that a mental process-hypnotic suggestion-could both cause and cure a physical dysfunction.

Josef Breuer (1842-1925) "a Viennese doctor who studied the effects of hypnostism on hysterical disorders" discovered that his hypnotized patients sometimes awoke free of hysterical symptoms after speaking freely about past traumas under hypnosis. During the 1890s Breuer was joined in his work by another Viennese physician, Sigmund Freud (1856-1939). Freud's work eventually led him to develop the theory of psychoanalysis, which hold that many forms of abnormal and normal psychological functioning are psychogenic. He believed that conflict between powerful psychological processes operating at an unconscious level is the source of much abnormal psychological functioning. Freud also developed the technique of psychoanalysis, a form of discussion in which psychotherapists help troubled people acquire insight into heir psychological conflicts. Such insight, he believed, would help the patients overcome their psychological problems. Comer (1998, 20) argued that to many observers, Freud's psychogenic perspective seemed the antithesis of the increasingly influential somatogenic view of mental dysfunctioning.

Thus his ideas were initially criticized and rejected. Freud persevered, however, and by the early twentieth century psychoanalytic theory and treatment were widely accepted throughout the Western world. Indeed, it would be difficult to name another school of thought that has had greater influence on Western culture. Therefore this technique of psychological treatment depends on various schools of psychology. Each is based on a certain philosophical concept. Examples of that are psychotherapies, psychoanalysis behaviour and cognitive therapy. A variety of approaches to therapy have been developed because human adaptation is complex and there are many views about how best to help an individual. So still another type of psychotherapy and cognitive therapy, which is concerned about the cultural element of societies, emerged and developed, the traditional psychotherapy. Freud who rejected what had been essentially a static model of a suffering individual as a passive victim of demon diseases, and his followers applied the psychoanalytic treatment approach primarily to patients with relatively modest mental disorders, problems of anxiety or depression that did not require hospitalisation. These

[*] Hypnotism from hypnos, the Greek word for sleep.

patients visited psychoanalytic therapists in their offices for sessions of approximately an hour and then went about their daily activities-a form of treatment now known as outpatient therapy. Psychoanalytic therapy's major goal for change is to restructure personality: id, ego, and super ego. A client's difficulties assumed to be caused by problems in his/her id, ego, and super ego personality structure. Altering those structures should help the patient function more effectively. Psychoanalysis has used dream interpretation, hypnosis and projective tests. Psychoanalysis does not work effectively at all times and in all situations because it requires levels of clarity, insight, and verbal skill beyond the capabilities of most such patients. Moreover, psychoanalysis often takes years to be effective, and the overcrowded and understaffed public mental hospitals could not accommodate such a leisurely pace (Comer 1998, 21; Sadock & Kaplan 1995, 375).

Behaviour therapy is a contrast to psychoanalysis. Unlike psychoanalysis many practitioners of behaviour therapy minimise the importance of the relationship between therapist and patient; instead, it emphasises impersonal techniques for treatment. Behaviour therapy makes use of all the learning techniques (classical, operant, condition, modelling, observational and cognitive restricting). Many types of behaviour therapy are used for treating the different psychological disturbances: systematic desensitisation, impulsive therapy and version therapy. The major goal is still to help people change their overt behaviour by using principles of learning (Grasha 1980). In other words, it tends to help people focus on increasing awareness, changing their beliefs or thinking pattern rather than dealing with underlying mental components of a problem. Behaviour therapy helps in decreasing anxiety quite dramatically, but it functions less well in questions of long-range benefits.

Cognitive psychotherapy, a concept of thoughts, beliefs and images, gained increased popularity with many psychologists in 1960. Albert Ellis and Joseph Wolpe recognised the basic roles these processes contributed in adjustment and competence. Researchers demonstrated that thoughts and beliefs affect behaviour quite powerfully. Consequently, therapists began using these observations to help patients. Cognitive behaviour therapists help identify and then modify thinking patterns that affect overt actions (improve moods or change habits). The positive elements of cognitive therapy is that it requires less time and trouble, it deals with relatively mild problems of living and helps in preventing problems from occurring.

Concerning the current trends of psychiatry, Comer (1998) argued that it would hardly be accurate to say that we now live in a period of widespread enlightenment or dependable treatment. Indeed, a relatively recent survey found that 43 percent of respondents believe that people bring on mental disorders themselves, and 35 percent consider the disorders to be caused by sinful behaviour (Murray 1993). "In some ways the study and treatment of mental disorders have made great strides, but in other respects, clinical scientists and practitioners are still struggling to make a difference. The current era of abnormal psychology can be said to have begun in the 1950s" (Comer 1995, 22).

Thus the contemporary advance of modern psychiatry, in which the concepts of organic origin of the aetiology of mental disease gained credence in present Europe as an alternative to the absurd earlier Western ideas of demonology. However, modern psychiatry as it stands has not equally changed the concept of possession in the Muslim world. The concept of possession in Islamic countries was quite different throughout the middle ages and has thus survived the centuries because it is not associated with illogical diagnosis and cruel treatment. That is perhaps why still in many Muslim countries,

including the Sudan, native and traditional healing exist side by side with modern psychiatry (Bassher & Abd Al-azayem 1980) (see chapter 4).

2.2 History of psychiatry in Sudan

The psychotherapy came to Sudan with Islam. The society itself became the most important factor in health. There was the spread of mosques and *Khalwas*. The Sheikh plays a great role in religious teaching and traditional treatment, which stem from *Quran.* In Sudan there were some religious institutions established for psychotherapy in *Kadabas* and *Umdawanban* using religious treatment. Such traditional treatment played a role in caring for patients (El Safi 1984)

The establishment of psychiatric services in Sudan is a fascinating experiment in a developing country. Prior to World War II there were hardly any organised psychiatric services for the care of mental patients. After World War II, modern psychiatry in Sudan began by efforts of the late professor Dr. Eltigani Elmahi, born in 1911. He was considered to be the father of psychiatry in Sudan as well as in Africa. Dr. Eltigani worked when psychiatric treatment was not very much appreciated by his medical colleagues. Baasher (1995, 14-20) mentioned that the mental health services in the Sudan were inaugurated in 1950, prior to that there had been no mental health institutions of any kind in the country in that year. A community clinic for neuroses disorder, Khartoum North, was opened with the object of (1) assessing the extent and type of psychiatric morbidity in the country, (2) of developing the methodology and techniques appropriate to the socio-economic-cultural background, and (3) the purpose of eventually acting as spear head for future mental health development. The work is now on a purely extra-mural basis, the staff consists of two professional psychiatrists assisted by two medical assistants with extensive training, locally supplemented by extended visits and experience in mental health work in reputable middle east institution nursing personnel who were recruited from the ranks of general hospitals, were similarly subjected to intensive training on an apprenticeship basis. The number of cases attended every year amounts roughly to 5000 patients, of which about one-third are new cases, balance being outpatients (Ministry of Health, report 2000). The Kober Institution was built to cater to 200 patients. This was followed by the establishment of four psychiatric units in provincial capitals at Wad Medani Teaching Hospital, containing 30 beds; Portsudan, containing 24 beds; El Obeid, containing 14 beds; and Atbara in 1964, containing 22 beds. A 30-bed psychiatric ward was built in Khartoum General Hospital. Finally in 1971, plans were laid to start work in Omdurman psychiatric hospital, the first to establish psychiatric units with close links with medical institutions and broad connection with community agencies. More recently, a modern hospital in Omdurman, bearing the name of the Sudanese pioneer Dr. Eltigani Elmahi, opened in 1973, contains 128 beds and admits 1500 patients per year. This hospital is specialised in treatment and research work in the field of mental health. With regard to the manpower throughout Sudan, there are only 28 psychiatrists, 78 psychiatry medical assistants, 80 clinical psychologists, and 54 psychological social workers (Ministry of Health, report 1994).

Statistical records of Health Ministry in Sudan for the year 1994 showed the total admission to all hospitals equals 650,680 patients, 0,05% (3120) due to psychiatric disorders. Also they formed 0,05% (19750) of the outpatients' attendance that was estimated to be 35423541 in total. Still those figures can't give the right estimation of the

morbidity of psychiatric illness, because many patients prefer to consult sheikhs as the author noticed during her visits to the famous traditional healer's centres.
Baasher statd: "The psychiatric model has moved to be flexible made it possible for psychiatric boundaries to open up into various activities and gave initial coverage to remote areas in different countries". The current status of psychotherapy is not very developed in Sudan. The beginning of this time of therapy was widely used by professor Malik Badri (1982) who criticised the Freudian school of psychotherapy. Badri was against psychoanalysis, so the Sudanese school was influenced by his thought. He practised the behavioural psychotherapy with apt patients. He encouraged cognitive therapy and supportive therapy.

When we look in the history of other countries we find that they were dealing with the same development in the history of psychiatry.

2.3 Traditional medicine

There are numerous terms that are commonly used when referring to traditional treatment such as native, ethnic folk medicine and tribal. Furthermore traditional medicine may be generally used to refer to home remedies or to other alternative methods of medicine, such as homeopathy. The fact that there are varieties of traditional systems of medicine with different historical background may make it rather difficult to group them under one specific term because of the wide range of activities and practices. Chinese system of medicine, for example, has a basic philosophy and applies established methods and techniques, which are essentially different from other Asian or African traditional practices.

Traditional medicine is an integral part of culture, which represents a sum up of beliefs, attitudes, customs, methods, established practices of traditional societies. Knowledge and skills may have been recorded or may have been directly transmitted and acquired from one generation to another. However, it is important to note that there are certain overlaps between traditional medicine and modern health sciences. Acupuncture, meditation therapy, Yoga, medicinal plants, which have their roots firmly established in traditional techniques have been increasingly incorporated also in the modern medicine in industrialised countries (WHO 2001).

This art of healing has been practised over the world for centuries. It includes different techniques and beliefs according to cultures. The official policy towards this art of medicine varies from country to country, depending on cultural heritage, historical background of health services, political system and socio-economic condition. In the majority of the concerning countries traditional medicine is not officially recognised, not legally prohibited in general and suffering neglect and isolation. There are a few countries such as China who regulate and promote traditional medicine (Baasher 1994).
This section intends to discuss the history of traditional medicine, and traditional medicine as a system of health care, the main traditional systems of medicine in some parts of the world, and the concept of traditional healers. Special focus is given to traditional religious healers in Sudan. The last part presents some of the country's experiences and official policies towards traditional medicine.

2.3.1 History of traditional medicine in Islamic countries

Traditional treatment has been established for more than 200 years, and gained fame long before the development of modern psychiatric services (Badin 1983, 3). When we talk about the traditional healers especially in Islamic country, is very important to mention the African folklore, in general, though the African 'Folk' have been and still are to a great extent utilising and applying their traditional knowledge in various spheres of their daily life from time to time. Most of this knowledge is in the form of Folklore. When we look closely at African Folklore, including oral literature and the performing arts, which are capable of sustaining interest through their native methods alone, we find out that they are deliberately applied to serve specific goals. In many parts of African countries, still widely used in education, medicine is to illustrate this phenomenon. So, African folklore medicine consists of the general knowledge which every individual is supposed to have in simple matters, the layman can look after himself by using preventive and curative remedies. He/she may always have the assistance of an elder with in the family. The specialists are scattered throughout the African content with different names, functions and curing abilities. These include holistic, bone or blood letters, diviners, *Kujurs, Zikir* and *Zar*. They apply their traditional knowledge to physiological and psychiatric ailments with different degrees of success (See Sayied 1983; Kenyon 1992, 59; Riordan 1999).

We find that in the past the traditional treatment is differing from now. As Bassher (1994) noted “After Islam the view of treatment was changed by prophet Mohamed (Peace be upon him)”. As we know the Islam involve and direct all the Muslim behaviour. In Islam and in the other religions there was a relationship between religions and medicine. Before Islam, people believed that the reasons of disease are spirit and devil due to the patient's qualities or errors. When this spirit involves the person, Doctor and *Kahin* give a drug to the patient, this drug is sour, so as, to prevent the spirit of body. In Islam this was changed and concentrated on the importance of the relation between people and God, and in *Quran* it contains the holy of Muslim behaviour as we said and direct behaviour towards the straight way. *Quran* becomes the basic element of traditional treatment used by El Sheikh, there are expressions in the *Quran* about devils regarded as evil forces that harmed people and intervened with normal behaviour to over-come the influence of those evils and spirits. An application was made to the medical point of views a number of this sayings and traditions as well as religious regulations constituted guidelines for remedies. Later, the sayings entraining to medical problems were called separately and came to be known as the medicine of the prophet (El-Zahay 1974, 22). An attempt was made to focus on the psycho-medical aspects of the prophets' teaching.

Generally speaking, they point out early Islamic concepts, and out line the basis of religious therapy, which has influenced traditional healing to the present day. As a fundamental principle, the prophet stressed to his followers that for every disease there is a cure. Similar meaningful statements were reiterated in due cause. The importance of such saying can be gathered by the fact that Badin (1983, 112) believes who referred to the prophet were often undecided whether to resort to the treatment or to become resigned to their fate. His precept gave strong psychological impetus for a great hope for recovery and persuaded people to seek treatment. Of particular importance was the emphasis put by the prophet on the relationship between psychological factors and some disease. This was demonstrated clearly in his saying that ”who is overcome by worries will have a sick body”. He added that such teaching had great influence expounding on this in some disorders. He pointed out that fear, sadness and the like diminish bodily energies accentuate disease should be

present and lead them if they are absent. Anxiety and unhappiness were among the most severe psychiatric symptoms and both were greatly damaging to the body.

Baashar (1994) noted "The Sudanese society noted different views regarding mental illness in the common man. Mental disorders are the work of evil spirits or evil eye, a view not different from that held by primitive societies".
The source of the traditional medicine in the Sudan begins with tracing the sources of the Arabic medicine from Egypt. The Arab had been greatly influenced by Babylon, Greece and some other countries of the Middle East, which enabled them to be creative in this medical field.
There are two main factors which play an important role in the development of traditional medical knowledge and treatment ways in every society: The endemic diseases, on the one hand, and the healing experience with plants, herbs and minerals used an experimental basis for the medical treatment desired, on the other hand. In Northern Sudan the traditional medicine has been influenced by pharisaic methods. West African healing traditions influenced the west of the Sudan.

The early Islamic influence (*Daauah*), infiltrated through the northern part of the Sudan since the middle of the seventeenth century by the Muslim traders and Arab immigrants who came across three main routes, the Down the Nile, was the most important one, the second one was across the red sea from Hijas (Saudi Arabia); the third from Morocco across the centre of the Sudan especially by the influence of Golam Allah Bin Aaccl, the famous Yemeni Sheikh, had strongly contributed in spreading Islam in the country. From the sixteenth century. Sheikh Hamed Abu Donana founded the *Alshazalia* Order (*Attriga Alshazalia*) in the Sudan. From that time on, endeavours were exerted to concentrate the religious rights specifically on *Quran* reading (*Tajweid*), recitation (*Tilawa*) and *Quran* writing. This Islamic consciousness had been accompanied by a wide concern of collecting and making available religious books (Fadol 1995, 53).

The majority of the Sudanese were Islamic mysticism followers (*Murideen*, see below). Islamic mysticism (Sufis) was actually meant for the elites of Muslims. The mystic dervish order (*Altariga Al-sufi*) spread over the entire Islamic world and become a great power in the Islam culture in different parts of Asia and Africa as well.

The historical, political, social and religious states of the Sudan are closely connected with the history of Islamic mysticism. Mystic schools were founded in the early years of the sixteenth century, the beginning of Blue Sultanate. The Sufis built mosques for Islamic praying, worshipping and Islamic law schools, besides spreading Islamic teaching among pagans. Tag Eldin Elbukhari, who came from Baghdad, became the leader of the *Murideen* (Sufi followers) and associated with the advent of *Algadria* order in Sudan in 1577 A.D.

The *Shazalia* order was introduced to the Sudan before the birth of the Funge Kingdom in Sudan (15.4.1821), while El Sheikh Ahmed Elteib Ibin Elbeshier established the *Samania* order in 1792. The early Sufis who had come to the Sudan aimed at spreading and strengthening the principles of the Islamic belief in simple ways through advising the followers to follow special moral and spiritual methods like *zikir* and prayers. The degree of successful influence of the sheikhs on the people depended on religious morals and knowledge, piety (*wara*), asceticism (*zuhd*), working miracles (*karamat*) and spiritual power (Fadol 1995, 48; Riordan 1999).

2.3.2 Traditional medicine and its different types

Traditional treatment is an ancient form of health care, practised long before the appearance of modern scientific medicine and is still practised today in many parts of the world. It is an integral part of a native culture. As mentioned before, traditional medicine has been defined by a group of experts from African Region convened by the WHO Regional Office for Africans, that met in Brazzaville, 1976, as follows: "the sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or writing". "Traditional medicine might also be considered as a solid amalgamation of dynamic medical know-how and ancestral experience". "Traditional African medicine might also be considered to be the sum total of practices, measures, ingredients and procedures of all kinds, whether material or not, which from time immemorial had enabled the African to guard against disease, to alleviate his sufferings and to cure himself" (WHO 1976, 1994, 2001).

Another definition introduced by Baasher (1994). He noted, “In brief, traditional medicine is an integral part of culture and represents a sum up of beliefs, attitudes, customs, methods and established practices of traditional societies. Such knowledge and skills may have been recorded, such as in the case of Chinese, *Ayurvedia* and Greece-Arab medicine; or may have been orally transmitted and acquired from one generation to another similar to what is generally observed in Africa. However, it is important to note that there are certain overlaps between traditional medicine and modern health services. Acupuncture, mediation therapy, Yoga and a variety of medicinal plants, which have their roots firmly established in traditional techniques have been increasingly incorporated in modern medicine in industrialised countries”.

The above definitions describe traditional medicine as an integral part of all human cultures. Traditional medicine is a primary health care for the majority of the population in developing countries especially in rural areas, where there is a lack in modern health facilities. Sudan is no exception. It is increasingly recognised that in order to achieve health for all, the all-available resources should be utilised effectively including traditional medicine. The WHO (2000) stresses the importance of traditional medicine as a primary provider and health care for the majority of population in developing countries. It encourages the Governments to move from restriction and antagonism against traditional medicine and traditional healers toward efforts to recognise and incorporate them into primary health care. WHO policy statements on traditional healing have received support from the health planners in most developing countries. One recent undertaking is initiation of programmes in several African countries to investigate the pharmacological properties of medicinal plants and to standardise their dosages. Given their widespread use, systematic study of herbal medication is essential to the better understanding of traditional healing.

There are different systems of traditional medicine according to the differences in cultures. As a matter of fact these different traditional systems of medicine have a common goal of providing health and health care, despite the different setting in place, time and culture. Some of the traditional systems of medicine will be discussed below in brief to show this similar trend.

Here the famous traditional systems of medicine in different parts of the world are discussed. Many of them come from ancient great civilisations like those of China, India, Africa, Arabia and West Europe. Many of these ancient systems have been used and enjoyed considerable success and have been increasingly incorporated into modern medicine. Acupuncture for example has been used for many centuries. Now it has been developed and used for the treatment of a wide range of diseases. Acupuncture is a famous traditional Chinese system of medicine. It has been applied as a therapeutic medical technique in China for at least 2000 years. It is used in order to draw off fluids or to relieve pain. The word acupuncture literally means to puncture with a needle. Acupuncture is based on the principal that there is a connection between the internal organs of the body and the body surfaces. Therefore a channel of healing to organs can be opened by careful placement of needles on the skin. The Chinese have described many acupuncture points distributed all over the body. A cup-pressure, on the other hand, uses the same points but applies pressure rather than needles. Acupuncture is used for a wide range of diseases. It is especially useful for muscular pain, headaches, migraine, asthma and for anaesthesia (David 1999). Acupuncture as medical system has been developed not only in China, but also in neighbouring countries, namely Japan, Korea and Vietnam. It is currently widely used by Western practitioners in treating certain pains.

Acupuncture could be compared to cupping and cauterisation methods of healing that recommended by prophet Mohamed (Peace be upon Him) and used by religious healers in Sudan. For example in the case of jaundice disease, the traditional healers believe that certain points in body surfaces are connected with the internal affected bladder. Therefore a channel of healing to organ can be opened by cauterising, these particular points in the body surfaces by hot needle, so as to get the yellow fluid out of the patient's body (see chapter 4, part 2).

In India, there is a famous traditional system of medicine known as *Ayurvedia* medicine. *Ayur* means life and *vedia* means science. *Ayurvedia* is considered as an integral part of Indian culture. It originated and has been practised in India and in neighbouring countries for 3000 years and is still practised today. It is estimated that about 80% of the population living in the rural areas of India and neighbouring countries have confidence in and use the *Ayurvedia* system.

Ayurvedia medicine equated health with balance. It recognises the existence of three humours, phlegm, bile, and wind or flatulence. Hence health is a result of an optimal balance of these humours, and illness results from excess or deficiency of one or more of these humours. An imbalance of humours may result from a variety of sources not only in a sick person's body, but also in those social and environmental context, e.g. eating too much, hot food or from eliminate or from excessive or immoral sexual activity. Treatment is to rebalance the three body humours, the phlegm, the bile and the wind, through appropriate diets and herbs. *Ayurvedia* and Yoga are now widely adopted through Government policy in India and they are included in curricula of several institutions of learning in universities and colleges of medicine and secondary and primary schools as well as in centres for the training of diverse types of health personnel.

Humoral theory has its roots in ancient China and India. Hippocrates who was a Greek physician, born in 460 BC, elaborated this theory into a system of medicine. Hippocrates' theory is that the body contained four liquids or humours: blood, phlegm, yellow bile and black bile. Health is a state in which these four humours are in optimal proportion to one another. Health is then proper balance of the body's humours. Ill health occurs from an

excess or deficiency of one of the body's humors. Ill health is then a state of imbalance of the body's humours. These four body humours - blood, phlegm, yellow bile and black bile -, correspond to four elements: air, being hot and moisten in nature; water, being cold and moist in nature; fire, being hot and dry in nature; and earth, being cold and dry, respectively. The balance of the four body's humours could be affected by different factors such as diet, environment and climate, to restore health is to restore the natural balance of the body humours. This was done by removing the excess by bleeding, purging, vomiting, starvation or by replacing the deficiency by using special diet and medicine. Cure, in same cases, requires treatment by opposite. For example remedies such as drugs, herbs and food are categorised by their inherent humoral qualities. Diarrhoea a hot condition is treated with cold substances. Hippocrates was supported and further elaborated by Galen, a Greek physician. Then the ancient system of humoral medicine, proposed by Hippocrates and Galen, was transferred and spread to the Arabic Islamic world. It is worth saying that the Arabs not only translated the Greek's work, but they also developed it by popularising it and commenting upon it, and so that is known as Greco-Arab medicine or Arab medicine. It is worth mentioning that Hippocrates set the stage for the development of modern scientific medicine. He is most famous for the Hippocratic oath, which stands as the cornerstone of the contemporary medical ethics (See Hakim 1992; David 1999; Jakobsen 1999).

Yoga is a personal self-help system of health care and spiritual development. It originated in India and it has been practised by a large number of people all over the world. The word Yoga means union. Yoga is a system of exercises that increase control over mind and body. Yoga practice includes postural exercises, breathing exercises and some types of mediation. By continuous practice of Yoga a perfect union of body, mind and soul can be attained leading to tranquillity and peace. Regular practice leads to better physical health and great self-confidence and a decrease in tension and stress.

With Islam came a new system of medicine, which was based on the teaching of the Prophet Mohamed (Peace be upon Him) in *Quran* and *Sunna*. This system of medicine is known as *Al-Tib Al-Nabawi* (Prophetic medicine). The Prophetic medicine includes both preventive and curative measures. Prophet Mohamed (Peace be upon Him) gave specific instructions on various aspects of health. He considered the human well-being in its totality, the spiritual, the psychological and physical within the context of the social milieu. It is said that Muslims are fatalistic and hence they do not take care of their health, believing that health is to be in God's hand. This of course is an obvious mistake. Health and health care are the basic elements that Islam seeks to achieve. The Prophet Mohamed (Peace be upon Him) gave great attention to the care of the body, diet, purity, sexuality and care of sickness. The Prophet Mohamed (Peace be upon Him) encouraged the sick man to seek treatment. It was reported that a Bedouin asked the Prophet Mohamed (Peace be upon Him) if they could seek treatment when sick. The Prophet said, "You can, for God has not created a single disease, without creating a treatment for it, except for one and that is death" (Elsafi & Baasher 1981, Bassher 1994).

The methods of treatment that were mentioned by the Prophet are divided into three main categories; honey, cupping and coterie. Elsafi (1994, 33) stated that: "Prophet Mohamed has limited the principal methods of treatment to three; the administration of honey, cupping and the actual coterie and he recommends his followers to avoid or make sparing use of the latter".

El-gwahry (1988), noted, “Herbal medicine is an ancient worldwide system of medicine. It uses natural herbs and plants to prevent and cure diseases. Evidence from all over the world shows that animals are naturally drawn to certain plants and herbs when they are sick. Herbal medicine is used for a variety of diseases such as asthma, bronchitis, digestive troubles, migraine, heart conditions, urinary infections and hormonal problems”. There are three ways to use herbs as treatment. Some herbs are applied to the skin, others are ingested in form of a drink and some herbs are inhaled. Herbal medicine is considered as most valuable therapy and is still practised today in Africa, Asia, America and Europe. Our country Sudan is very rich with medical herbs and plants. A large number of people in Sudan depend on herbal remedies for treatment. They know the secret of herbs and plants and use them in treating a wide range of diseases. However, the use of herbal remedies for digestive troubles in general, such as *Hargal, Mahareb, Shamar* and for diarrhoea in particular such herbs as *Helba, Yanson, Gongoles*, and *Seder* are well rooted in Sudan. It is well known that most of the common and simple illnesses are diagnosed and treated at home. This type of traditional treatment is known as home remedies. In every society one can easily find a family that has at least one old member who is able to give advice about health care, and who has a store of simple remedies. His or her credential is due to his or her wide experiences and skills rather than to his or her education. Home remedies are useful for a variety of illnesses such as digestive troubles, cold, headaches, and especially useful for children's diseases in cases of fever, diarrhoea, cold and cough (Institute of Herbal Medicine in Sudan, reports 1990, 1995).

The art of healing through interpersonal relationship and personal characteristics of the healer is very old indeed. Perhaps the most famous traditional systems of interpersonal healing is the spirit healing, which is very wide spread in Africa, and the spiritual healing, which is found in West Europe (See Jakobsen 1999; Parker 2001; Brownes 2002).

Al-Issa (2000) stated, “Spirit healing is an ancient form of healing. It is based on the principle of making contact with supernatural forces such as with devils and evil spirits”. The spirit healers claim that they make such contact with these supernatural forces either to ask for their help or to command them to leave the patient's body. They claim that they have the power over these spirits because they know their names, secrets and weakness. A variety of techniques are used to make such contact. Some spirit healers pronounce certain words known as words of power or they pronounce the name of the spirits or spells invocation. Other healers perform ceremonies and rituals. Some healers claim they are able to make such contact during dreams. It is in dreams they say that direct relationships with spirits, God, and ancestral souls are established. An example of spirit healing in Sudan is the *zar* healing method.

El-zar is found in northern and western Sudan. The term zar refers to a ceremony and a class of spirits known as *Zar, Dastur* or *Rih-ahmar* ”red wind”. According to Al-Nagar (1987): "*zar*, *Dastur* or *Rihahmar* are words used interchangeably in Sudan to refer to healing practices and rituals centred on the belief in the existence of powers or spirits which possess people through whom they make certain demands. Symptoms which are attributed to possession may be psychological such as depression, agitation, feelings of persecution and migraines, or physical such as bleeding, miscarriages and fevers”. Boddy (1989) stated ”*zar* is a form of spirit possession in which actions of a person are interpreted as evidence of control of his behaviour by a spirit normally external to him. Some times known as women heal women because it is used by women as the explanation of diseases in certain contexts but more significantly it is a social phenomenon representing important aspects of the society”.

El Mahie (1944) defines *zar* as "a part of psychic disorder that characterises the oriental women and that arises from a group of social diseases that affected women and not men. In short the *zar* is taken to mean both spirit possession and folk medical practice". Any woman can be affected with the *zar* spirit; but those who approach the *zar* Sheikh for treatment are those women who suffer from illnesses, which fail to respond to medical treatment, and are said to be associated with the *zar* spirits (Khater & Abd Elgalel 1990, 127).

The old belief about *zar* that is depicted as a class of Jinn who remained out of control of the prophet Sulaiman, who is believed to have all the Jinn under his sway. One of these variants goes as follows: The prophet Sulaiman had every thing under his control, however one Jinni, hid in the seventh sky and thus stayed away of the prophet's sway. One day while the prophet Sulaiman was saying his prayers, this Jinni descended from the sky and appeared before him. On seeing the Jinni he queried and after a while addressed the Jinni and said 'who and what are you?' The Jinni responded, 'I am a merry Jinni who would appear at the end of time and seduce every body'. The Jinni then disappeared.

A more elaborate version mentioned by Al-Nagar (1987) that one day while the prophet Sulaiman was saying his prayers, all of a sudden he saw before him a huge and ugly creature. Prophet Sulaiman taken by the sudden appearance of this creature addressed him and said: I ask you in the name of God to tell me who are you, for I have had all humans and Jinn under my sway and no one is spared. Where have you been hiding, so that you stayed out of my control?' The Jinni answered that he had been hiding between earth and space and added 'I have now come to tell you that I will appear at the end of time and possess both men and women'. The prophet Sulaiman then asked the Jinni of how the cure of those possessed by him would be. The Jinni answered, 'I would never be exorcised, but I have certain demands to be fulfilled, these demands are dance, music and perfumes.

A third variant of the myth of origin of *zar* tells that the *zar* spirit is one out of the groups of spirits under the sway of the prophet Sulaiman. They appeared to him and when he ordered them to descend to earth they refused. They said however, that they would be pleased to come down by the smell of incense and sound of drums. They identified themselves as troublesome spirits who might trouble people and possess them. A condition for their propitiation is dancing, singing and luxurious things (*Zar* Workshop, Khartoum Jan. 11-13, 1998).

The *zar* basic concept regarding supernatural powers has been subjected to certain transformations to conform to community beliefs and traditional practices. Hence among Christian and Muslim communities one notices that beside the possession by evil spirits, there is the tendency to associate the *zar* manifestations with the power of divine spirits. Consequently when a Sudanese patient, for example, who believes that she was suffering from *zar*, is asked what type of *zar* she had, then she may mention the name of one of the well known holy men such as Sheikh Abdel Elgadir Elgeilani. Similarly in Egypt famous holy men particularly *Elsayed* Elbadawi, Mursi Abu Elabbas are often involved. Collectively, they are addressed as the masters (*El Sayed*) and they are given a central role in the *zar* phenomenon. In this respect one can see two characteristic elements of the *zar* phenomenon, the belief in spiritual possession and the appeal to divine powers invested in holy men to deal with the adverse effect of *zar*. The identification of these holy men closely represents the socio-cultural background and esteemed images of these prestigious personalities.

Beside the propitiation of certain spirits and the invocation of holy men, some patients identify themselves with images of a variety of archetypal models and prototypes. Among the common models are the *Habbashi* 'Ethiopian', the *Hadandawy* 'big tribe in East Sudan', the *Hakeem Pasha* 'the senior medical officer', the commander in chief, and many others. These models are characteristically representative of the socio-cultural background and are subjected to changes and modifications with changes in time and place. Some of these models are usually picked up as part of social learning and close acquaintance with the *zar* healing practice. However, in essence some of these archetypal models are seen to signify a subconscious psychosocial need and a symbolic identification with certain characters or authoritative powers, being capable of resolving the patients' emotional conflict or fulfilling their wishes. (See Boddy 1989; Al-Nagar 1987, 77).

Hence, the study of these archetypal models and prototype characters can be very interesting and helpful in the identification of the patients' inner conflicts and in the assessment of psychosocial problems. When someone falls ill and does not find a clear cause for his/her illness, he/she resorts to the help of *a zar* healer who is known as the *Sheikha* or *Kodia*. The *zar* practice is essentially a traditional psychosocial therapy on a system of patient/healer relationship, group interaction, vigorous drumming, psycho-dramatic expression of emotional feelings and the observation of ritualistic behaviour. Some of the patients dance till they collapse (Al-Nagar 1987). Sheikh *El-zar* is a leader of the *zar* ceremony. She has an understanding with the spirits and she knows the special songs and beats of the summoning spirits (see the video tape). Al-Nagar has mentioned this fact, when she stated that: "The leadership of the Sheikh stems from the fact that she can diagnose possession by *zar* spirits. She knows the techniques by which the *zar* spirits are propitiated to withdrew their affliction".

Baashar (Zar Workshop 1998), in a paper, emphasised the importance of the *zar Sheikha* (leader) as a healer and explained: I prefer her to social workers as the attention that the social worker gives to her patient is very limited and the atmosphere in which the meetings take place is formal and the time is limited, while the *Sheikha* is more sympathetic, generous in reception and has no limited working hours. It is particularly linked to the belief in the Jinn (demons), which is quite dominant in contemporary Sudanese folk culture that is mostly based on the Holy *Quran*.

O' Riordan (1999) argued that the spiritual healers see the spiritual healing as a gift that comes from God and they regard themselves as channels for this healing power and they feel compelled to use it to help sick people. There are various ways of conducting spirituals according to cultures. In west Europe the most common ways are: hands on healing or lay on of hands. In this case the spirituals healers use their hands to touch their patients on the head or in the troubled areas so that the healing power can be transmitted from them to their patients. The healer usually relaxes himself, tries to remain passive and thinking deeply about the part that needs help, so that the healing power can be active through him. Harry Edward the world famous English spiritual healer claimed that he failed to heal only twenty percent of those who came to him.

Wilson describes his method of healing as follows: "My own method is usually to begin with a short time of silent meditation after giving the person a constructive thought to hold in his mind about the love and good purpose of God to heal. Short, simple prayer is then said, asking God to heal. After this, I stand in front of the person who is kneeling and lay my right hand on the forepart of the head and my left on the back of the head. After a few moments, in which I try to realise that I am only the instrument by which our Lord is

himself laying on his hands, I say, 'Our Lord Jesus Christ who gave authority to His disciples that they should lay hands upon the sick that they might recover, have mercy upon you and strengthen you in spirit, soul and body, and give you faith in His power to heal. And by His authority committed unto me, I lay my hands upon you that you might recover your full health and strength, in the name of the Father and of the Son and of the Holy Ghost. After this, I give a blessing and then remain for some time in silent thanksgiving'. He said, 'I always tell the person that, though sometimes a person is healed almost at once, in most cases the healing comes gradually and not very quickly. I also warn him not be continually thinking of his symptoms and not to be disappointed if he is better one day and not so well the next; but to be confident that God is at work and that in time he will see what great things God will do (Weatherhead 1968, 82). (See Bruno Gröning - Freundeskreises 2000)

Weatherhead (1968) mentioned that the practice of the laying on of hands is only resorted to when all else has failed. In such cases this practice also often fails. Nor is this surprising. If disease is understood and the remedy is obvious, no other treatment is resorted to, certainly not the laying on of hands.
The patient's acceptance of the rite would mean his recognition of those purposes and the effect would be to turn the patient's mind away from his illness to God. The patient should not think of the rite as in the same category as the treatment by the doctor, he would be tough to think of the laying on of hands as an act of worship. In that act God comes near to the patient, and the patient responds to God. The touching by the Priest is the symbol of the divine love making contact with the human soul.

Similar to hand healing or lay on of hands as a type of spiritual healing is the *Azima* method by religious healers in Sudan. *Azima* usually performed by the Sheikh or *Faki* (a religious healer). The *Faki* puts his hand on the patient's head and reads certain verses of holy *Quran,* at every phrase or sentence he spits or puffs. It is not necessary that any moisture should reach the patient's body; it is the power of the holy *Quranic* words that are directed at the patient. Certain verses of holy *Quran* are believed to have a power to ward off the influence of the evil supernatural forces (see chapter four, part two).

Also Weatherhead mentioned the second way of conducting spiritual healing in West Europe, which is the absent or distant healing and is restored to when the patient is not present. Easthope has described absent healing that takes place in Harry Edwards spiritual centre at Burrows Lea-England. He states, "Absent healing intercessions commence from the time the necessary request is made to the healer, usually by way of a letter, which gives the healer a mind picture of the patient's needs. Every healing request receives individual attention, and each patient is interceded for individually. Thus every letter is answered personally" (Weatherhead 1968).

It is clear from the above that despite the obvious differences between traditional systems of medicine, they all have a common goal of providing health care and spiritual development for the population.

2.3.3 Traditional healers

Traditional healers can be defined as those who are active within the traditional systems of medicine or in other words those who are practising or are claiming to practice traditional healing outside the boundaries of scientific medicine. Most of their knowledge, skills had not been learned from books or colleges, but they had developed out of centuries of experience. Comprehensive definition has been adopted by the African Regional Office Experts Group (WHO 2000) that a traditional healer is: "a person who is recognised by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability".

WHO evaluation is that traditional healers are not quacks as some people believe but they are vital sources of health manpower especially in rural areas. They can provide a high level of available, accessible and affordable health care, and the Government should recognise and incorporate them within the health system.

There are different forms of specialisation of traditional healers, ranging from secular such as bonesetters, traditional midwives, herbalists and religious healers, such as shamans, priests and *Faki*/Sheikhs in Sudan. Between these two extremes, there are other healers occupying different places. A bonesetter may be defined as a wise native doctor, who sets bones skilfully and manipulates joints. A midwife is defined as a woman who assists the mother at childbirth, a female who specialises in treatment of all problems associated with pregnancy and delivery. In Sudan a traditional midwife, *Dyat Elhabil,* literally means midwife of the rope. Elhakim, stated that: "In Sudan, untrained Training Birth Attendants (TBAS) are called *Dyat Elhabil* (midwives of the rope), literal descriptive name derived from the traditional method of delivery in which the woman in labour takes a squatting position, supporting herself by a rope (*Habil*) suspended from the ceiling, while the midwife (*Dyat*) squats between her legs to deliver the baby. Traditionally, untrained TBAS not only deliver babies but act as consultants on disease of women, perform and try to repair the damage of paranoiac circumcision, assist women in abortion and provide advice on traditional methods of contraception or, where called for, on methods of increasing fertility" (Algwahri 1988, 23-37).

It is clear from the above that the role of the *Dyats* is particularly important and significant. They are an integral part of the local community. It is worth mentioning that the traditional midwife was forbidden in Sudan by law to practise midwifery. However, they do practise in poor remote rural areas. The first Sudanese school for the Training of Birth Attendants was opened in Omdrman in 1921. Since then many schools for the training have been opened in different parts of the country. Nevertheless, the prevalence of midwives is limited and that is why current efforts are taken to train TBAS to promote their knowledge and skills rather than isolate them (Ministry of Health report, Sudan 1995).

An herbalist can be described as a traditional healer, whose specialisation lies on the use of herbs to treat various diseases. He is expected to be highly knowledgeable in the efficacy of toxicity, dosage and compounding of herbs. We may refer him as a traditional pharmacist (Oberender 1982). These three types of traditional healers are nearly found in all societies.

They usually acquire their knowledge and skills from their own families or from wiser traditional healers.

Spirit healers, on the other hand, usually mix up magic with religion. They usually stress that they can make contact with supernatural forces either to ask for their help or to recommend them to cast the spirit out from the patient's body. A common belief exists especially in Africa that most illness is caused by the invading of supernatural forces such as witchcraft sorcery, evil spirit and evil eye. One of the famous ways to attack the evil spirit and cast it out from the patient's body has been described by Easthope when he stated that: "For being watchmen, the healers torment the invader so that the invading spirit or witch abandons the person because life becomes too uncomfortable for it. The healer exorcises the demon". He added that the emphasis is upon an attack on the invader and the individual who has been involved is relatively unimportant, while spiritual healers believe that healing is a gift.

Harry Edwards, a world famous English spiritualist, has stated that: "You see healing is a gift. You don't learn it by going on a course of study. It is largely dependent on a person's character and on his genetic abilities. Healers are invariably those who are generous in their nature, people who will support causes and fight for causes even without getting a result or a reward". (Abd Elhalim 1994, 42; Al-Issa 2000; Petrie 2000).

Religious healers, on the other hand, see healing as a power that comes from God and is granted to individuals or places. These individuals or places are channels through which healing power flows. Most of the religious healers claim that a cure is from God. Religious healers have different ways of healing according to culture. In Sudan, the native religious healers throughout Northern Sudan are known as the Sheikh/*Faki*. Many terms have been used to translate this term. Al-Issa (2000) stated that: "A few remarks may be interpolated here on the meaning of the word *Faki*. It is generally rendered in English as a holy-man or religious leader and is used differently to describe the head of a religious sect, big or small, the guardian of a holy tomb, a man of well known piety who has no particular diocese or religious function, a curare and a school master of *a Khalwa* or *Quran* School". Abd Elhalim (1994, 14) translates the term *Faki*/Sheikh as a native doctor or *Basir,* while El Tayeb (1982), translates the term as local religious Sheikh.

The *Faki* or Sheikh in Sudan is usually associated with Islamic religion. Before that all over the world, the empirical sciences discovered that people depend on witches to face the natural phenomena. During Christianity the people used to go to Church seeking cure and forgiveness. In short, all these practices were a method of cure for man and were means of protection from natural disaster.

When the Sudanese adopted Islamic religion, its instructions rejected all sorts of witch and sorcery and people used to get relieved through *Quran's* verses. The Sheikh phenomenon emerged as a leader for teaching and curing. Usually a Sheikh settles in a village and begins as a *Quran's* teacher, leading people during prayers, and being responsible for marriages in the village, a leader during deaths, farming and harvest. The *Faki* or Sheikh is the most important person in small communities in most parts of Sudan (EL Safi 1994).

Furthermore, some of those *Fakis* who came from East Africa were concerned with magical rites beside the *Quran*. They used books to verify their talents and experiments. Folk medicine related to certain plants and herbs, mentioned in the *Quran,* was also used for cure of illness and psychological relief. The position of the *Faki* became prominent as a

social figure that decides on community problems, he leads discussions and sometimes issues instructions. Every village had one *Faki*/Sheikh, sometimes two, but rarely. Usually the elder son inherited the work (Al-Tayeb 1982).

2.4. Therapeutic options

Helman (1986, 42) stated, "In most societies a person suffering from physical discomfort or emotional distress has a number of ways of helping his self, or of seeking help from other people. He may, for example, decide to rest or to take a home remedy, or ask advice from a friend, relative or neighbour, or consult a local Sheikh "folk healer", or "wise person" or decide to consult a doctor, provided that one is available. He may follow all of these steps, or perhaps only one or two of them, and may follow them in any order. The larger and more complex the society in which the person is living, the more of these therapeutic options are likely to be available. Within these societies there are many groups or individuals, each offering the patient their own particulars of explaining, diagnosing and treating ill–health. Although these therapeutic models co-exist, they are often based on entirely different premises, and may even originate in other cultures, such as Western medicine, religious medicine, African medicine, or Chinese acupuncture. To some people, however, the origin of these treatments is less important than their efficacy in relieving from the suffering".

2.4.1 Social and cultural aspects of medical systems

Anthropologists have pointed out that any society's medical system couldn't be studied in isolation from other aspects of that society; especially its social, religious, political and economic organisation. It is linked with these, and is based on the same assumptions, values and views of the world. Landy (1977, 129) points out that medical systems have two inter-related aspects: a cultural aspect, which includes certain basic concepts, theories, normative practices and shared modes of perception; and social aspects including its organisation into certain specified roles (such as 'patient' and 'doctor'), and rules governing relationships between these roles in specialised settings (such as a hospital or a doctor's office). In most societies, one form of health care, such as modern medicine in Sudan, is encouraged by the scientific and Western medicine. Beside this 'official' medical system, there are usually smaller, alternative systems, such as homeopathy, herbal medicine, and spiritual healing in Sudan, which might be termed traditional healing. Each has its own way of explaining and treating ill-health, and the healers in each group are organised under a professional name, with rules of entry, codes of conduct and ways of relating to patients. Traditional healing may be indigenous to the society, such as religious healing "*Quran* and Sufi healing methods", or it may be imported from elsewhere; in many cases, immigrants to a society bring their folk healers along with them, to deal with their ill health in a culturally familiar way. In Sudan, an example of this is the *zar* healing. *Zar* is widespread in Ethiopian and Egypt (both are Sudan land neighbours). Considering medical systems, wherever they occur, it is important to examine both the cultural and social aspects of the types of health care available to the individual patient. Concerning this issue, this study will examine the pluralistic health care system of one of the complex societies, the Sudan, in order to illustrate (1) the range of the therapeutic options available in these

societies, and (2) how and why choices are made between the various options. The medical system in Sudan and its implications for the maintenance of health care will be also discussed.

2.4.2 Health care systems

Kleinman (1980, 49-70) has suggested that, in looking at any complex society, one can identify three overlapping sectors of health care: (1) the popular health care, (2) the folk health care, and (3) the professional health care. Each system has its own ways of explaining and treating ill health, defining who is the healer and who is the patient, and specifying how healer and patient should interact in their therapeutic encounter.

2.4.2.1 The popular health care system

This is the 'lay, non-professional, non-specialist' domain of society, where ill health is first recognised and defined, and health care activities are initiated. It includes all the therapeutic options that people utilise, without consulting either folk healers or medical practitioners. Among these options are: self treatment or self medication; advice or treatment given by a relative, friend, neighbour or work-mate; healing and mutual care activities in a church, cult or self-help group; or consulting with another lay person who has a special experience of a particular disorder or of the treatment of a physical state. In this system the main arena of health care is the family; here most ill health is recognised and then treated. It is the real site of primary health care in any society. In the family, as Chrisman (1977, 351) points out, the main providers of heath care are women, usually mothers or grandmothers, who 'tend to diagnose common illnesses and treat them with material at hand'. Kleinman and his colleagues (1978, 251) estimate that about 70-90% of health care takes place within this system, in both Western and non-Western societies.

People who become ill, typically follow a 'hierarchy of resort' ranging from self-medication to consultation with others. Self-treatment is based on lay beliefs about the structure and function of the body, and the origin and the nature of the ill health. It includes a variety of substances such as patent medicines, traditional folk remedies or old wives' tales as well as changes in diet or behaviour. Food can be used as a form of 'medicine' in folk illness such as 'high blood' in the southern United States, acid or astringent foods, lemon juice, olives, pickles, vinegar or sauerkraut are used to reduce or 'cut' the excess volume of blood, which is believed to cause the condition. In Latin America, certain foods are used to counteract 'hot' or 'cold' illness and restore the body to equilibrium. In Britain, self-prescribed 'bitters' and 'tonics' are commonly used to restore health when one is 'feeling low'. The changes in behaviour that accompany ill-heath range from special prayers, rituals, confession or fasting to resting in a warm bed for a 'chill' or a 'cold'.

The popular system usually includes a set of beliefs about health maintenance. These are usually series of guidelines that are specific to each cultural group; about the 'correct' behaviour for preventing ill health in oneself, and in others. They include beliefs about the 'healthy' way to eat, drink, sleep, dress, work, pray and, in general, conduct one's life. In some societies, health is also maintained by the use of charms, amulets, and religious medallions to ward off 'bad luck', including unexpected illness, and to attract 'good luck' and good health (Foster & Andersen 1978).

Most health care in this sector takes place between people already linked to each other by ties or kinship, co-residence or membership of work or religious organisations. As Chrisman (1977, 351-377) points out, this means that both patient and healer share similar assumptions about health and illness, and misunderstandings between the two are comparatively rare. The sector is made up of a series of informal healing relationships, of variable duration, which occur within the sufferer's own social network, particularly his family. These therapeutic encounters occur without fix rules governing behaviour or setting; at a later date the roles may be reversed, with today's patient becoming tomorrow's healer. There are certain individuals who tend to act as a source of health advice more often than others. These include: (1) those with long experience or a particular illness, or type of treatment, (2) those with extensive experience of certain life events, such as women who have raised several children; (3) the paramedical professions (such as nurses, pharmacists, physiotherapist or doctor's receptionists) who are consulted informally about health problems; (4) doctor's wives or husbands, who share some of their spouses' experience, if not training; (5) individuals such as chiropodists, hairdressers, or eventually bank managers who interact frequently with the public, and sometimes act as lay confessors or psychotherapists; (6) the organisers of self-help group; and (7) the members of the officiates of certain healing cult or churches. All of these people may consider resources of advice and assistance on health matters, by their friends or families. Their credentials are mainly their own experience rather than education, social status or special occult power. A woman who has had several pregnancies, for example, can give informal advice to newly pregnant younger woman, telling her what symptoms to expect and how to deal with them. Similarly, a person with long experience or particular medication may 'lend' some to a friend with similar symptoms.

Individuals' experience of ill-health are sometimes shared within a self-help group or healing cult, where it can be used for the benefit of other members. The group may also act as a repository of knowledge about a particular ailment, which can be of use to the rest of the society. In non-western societies, a self-help group often has a religious flavour. 'Spirit possession' cult, for example, is common in parts of Africa, especially among women. In these cults, women who have been 'possessed' and made ill by a particular spirit from what Turner (1974, 14) calls 'a community of suffering', the members of which ritually diagnose and treat the rest of the society suffering from possession by the same malign spirit. Lewis (1989) sees some of these spirits possession cults, like the Hausa *bori* cult in Northern Nigeria, as essentially women's protest movement against their social disadvantage. Membership in a cult brings prestige, healing power and special attention from their men-folk who lavish gifts on them to the benefits of members, such as sharing advice on life style or coping strategies, or acting as refuge for isolated individuals, especially those suffering from stigmatised conditions, such as obesity, alcoholism, or homosexuality.
All aspects of the popular sector from self-treatment to consultation with others can have negative effects on patient's health. The family, for example, may impede for facilitate health care. In Taiwan, according to Kleinman (1980, 200), the family response to a sick member 'attempts to contain the person, his sickness, and social problems it generates within the circle of the family', instead of sharing it with an outsider, such as a medical practitioner.

In general, ill people move freely between the popular and the other two sectors, especially when treatment in that sector fails to relieve physical discomfort or emotional distress. (See chapter 5, part 6)

2.4.2.2 The folk health care system

In this system, which is especially large in non-western societies, certain individuals specialise in forms of healing which are either sacred or secular, or a mixture of the two. These healers are not a part of the 'official' medical system, and occupy an intermediate position between the popular and the professional sectors. There is a wide variation in the type of folk healer found in any society, from purely secular and technical experts like bone-setters, midwives, tooth extractors or herbalists, to spiritual healers, clairvoyants, and shamans. Folk healers stem from a heterogeneous group with much individual variation in style and outlook; but sometimes they are organised in associations for healers, with rules of entry, codes of conduct, and sharing of information.

Most communities include a mixture of sacred and secular folk healers. For example, in her study of black folk healers in urban America, Loudell Snow (1978, 69-106) has described: 'herb doctors', 'root doctor', spiritualists, 'conjure' men or women, Voodoo *houngans* or mambos, healing ministers and faith healers, neighbourhood 'prophets', 'granny women' and vendors of magical herbs, roots and patent medicines. Spiritual healers, who operate out of the temples, churches 'or candle shop', are particularly common, and deal with illness that believe to be due to sorcery ('hexing') or to divine punishment. A neighbourhood 'granny women' or 'herb doctor' deals with more secular illnesses by self-medication. In practice, though, there is some overlap between their approaches and techniques. In another community, the Zulu of southern Africa, there is also an overlap between sacred and secular healers. While sacred divination is carried out by female *isangomas,* treatment by African herbal medicine is by male *inyagomas*; both though, will gather information about the social background of the client, as well as about details of his illness, before making a diagnosis (David 1999).

An example for a purely secular healer is the *sahi,* health worker, as described by Underwood (1981, 271-297) in Raymah, Yemen Arab Republic. These healers have appeared only in Yemen recent year, and their practice consist mainly of giving injections of various Western drugs. They have little training (usually a brief association with health professionals, in one case a month's work as a hospital cleaner), limited diagnostic skill, and they utilise little counselling or psychological skills. To the inhabitants of Raymah, however, the *sahi* practices what is considered to be the quintessence of Western medicine-'the treatment of illness by injection'. Kimani (1981, 333) in Kenya has described other example of this trend in the under-developed countries. Their untrained 'bush doctors' administer medicines and injections, and 'street and bus- depot doctor boys' hustle antibiotic capsules, acquired through the black market. Most folk healers share the basic cultural values, and worldview, of the communities in which they live, including beliefs about origin, significance and treatment of ill health. In societies where ill health, and other forms of misfortune are blamed on social causes (witchcraft, sorcery, or evil eye), or on supernatural causes (Gods, spirits or ancestral ghosts), sacred folk healers are particularly common. Their approach usually is a holistic one, dealing with all aspects of the patient's life, including his relationship with other people, with the natural environment, and with supernatural forces, as well as any physical or emotional symptoms. In many non–Western societies, all these aspects of life are part of the definition of 'health', which is seen as balance between man and his social, natural and supernatural environment. A disturbance of any of these (such as immoral behaviour, conflicts within the family, or failure to observe religious practice) may result in physical symptoms, or emotional distress, and require the services of a sacred folk healer. Healers of this type, when faced with ill health, often enquire about the patient's behaviour before the illness,

and about any conflicts with other people. In a small–scale society, the healer may also have first hand knowledge of a family's difficulties through local gossips, and this may be useful in reaching a diagnosis. Similar to gathering information about patient's recent history and social background, the healer may employ a ritual of divination. There are many forms of this world of healing including the use of cards, bones and special stones (the random arrangement of which is interpreted by the healer), the examination of the entrails of certain animals or birds, or directly consulting with spirits or supernatural beings by going into trance. In each cases, the divination aims to uncover the supernatural causes of the illness (such as witchcraft or divine retribution), by use of supernatural techniques.

Trance divination is common in non–Western societies. The relative of a sick person, who remains at home, for example, consults the Zulu *insangoma*. Going into trance and 'communicating with spirits' that tell her the cause and treatment of the illness makes her diagnosis (Ngubane 1981, 361). Another form of this is Shamanism, who is found in many cultures (Jakobsen 1999). In Lewis's definition (1971, 49) shaman is "a person of either sex who has mastered spirits and can at will introduce them into his own body"; divination takes place in a séance, in which the healer allows the spirits to enter him, and through him diagnose the illness and prescribe treatment. This and other forms of divination, sometimes take place in the presence of the patient's family, friends and other social contacts. In this public setting, the diviner aims to bring conflicts within a community, which may have led to witchcraft or sorcery between people to the surface, and to resolve these conflicts in a ritual way. Sacred healers also provide explanations and treatment for subjective feelings, guilt, shame or anger, by prescribing, for example, prayer, repentance, or the resolution of interpersonal problems. They may also prescribe physical treatment or remedies at the same time.

For those who utilise them, folk healers offer several advantages over modern scientific medicine. One of these is the frequent involvement of the family in diagnosing and treatment. For example, as Martin (1981, 141) has pointed out, for Native Americans healing the patient's sickness places the responsibility on both patient and family to participate in healing rites. The focus of attention is not only the patient (as in Western medicine), but also the reaction of the family and the others to the illness. Helpers who take part in the ceremony, give explanations to the patient and his family, and answer any of their queries usually surround the healer himself. From a modern perspective, this type of native healer with his helpers, together with the patient's family, provides an effective primary health care team, especially in dealing with psychological problems. Fabrega and Silver (1983, 218) have examined the advantages to the patient of another type of folk healers, the *h'ilol* in Zinacantan, Mexico, over western doctors. In particular, there is closeness, a shared world view, warmth, informality and the use of everyday language in consultations; the family, and other community members are involved in treatment; the *h'ilol* is an accepted person in the community, and believed to act for the benefit of the patient, the community, as well as the god; he can influence society at large, particularly the patient's social relationships; he can influence the patient's future behaviour by pointing out the influence of past action on his present illness; and his healing takes place in a familiar setting, such as the home or a religious shrine. Because folk healers, such as *h'ilol,* articulate, and reinforce the cultural values of the communities in which they live, they have advantages over western doctors, who are often separated from their patients by social class, economic position, specialised education, and sometimes-cultural background. In particular, these healers are better able to define and treat 'illness', that is, the social psychological and moral dimension associated with ill health, as with other forms of

misfortune. They also provide culturally familiar ways of explaining the causes and timing of ill health, and its relation to the social and supernatural worlds.

In general, folk healers have little formal training equivalent to the western medical school. Skills are usually acquired by apprenticeship to an older healer, experience of certain techniques or conditions, or by the possession of inborn or acquired 'healing power'. People can become folk healers in a number of ways, such as (1) succession being born into a 'healing family'; (2) by position within a family, like the 'seventh son of a seventh son' in Ireland; (3) by certain signs and portents at birth like a birthmark, or 'crying in the womb', or being born with amniotic membrane across the face (the 'caul' in Scotland); (4) by revelation discovering one 'has the gift', which may occur as an intense emotional experience during an illness, dream or trance. In extreme cases, as Lewis (1971, 53) points out, the vocation may be announced by 'an initially uncontrolled state of possession: a traumatic experience associated with hysteric, ecstatic behaviour';(5) by apprenticeship to another healer a common pattern, in all parts of world, though the apprenticeship may last for years; (6) by acquiring a particular skill on one's own like the Yemeni *sahi*, or the Kenyan ' bush doctor'. In practice, these pathways into folk healing tend to overlap: someone born of a' healing family', and with certain portents at birth, may still need to refine their ' gift' by a lengthy apprenticeship to an older healer.

While most folk healers work individually, informal network or associations of healers do exist, and these provide for the exchanges of techniques and information, and monitoring of each other's behaviour. Ngubane (1981, 361-365) describes such a network among Zulu diviners or *insangoma*: meetings take place regularly between diviners to share ideas, experience and techniques. Each diviner has the opportunity to meet the ex–student, teacher and neophyte of each of her neighbouring diviners, as well as more distant ones. It is estimated that over a period of 3-5 years, a diviner might make contact with over 400 fellows diviners, all over South Africa In other settings, such as some low–income black neighbourhood in the United State, several healers might be ministers of spiritualist church, which also act as an association of healers.

The relationships between folk and professional healers tend to be marked by mutual distrust and suspicion. In the western world, modern medicine views most folk healers as 'quack', charlatans' or ' medicine men', who pose a danger to their patients' health. While folk healing does have obvious shortcoming and danger, it does also have advantages to the patient, especially in dealing with psychological problems. Other advantages of traditional folk medicine for the under doctored have been recognised by the World Health Organisation. In (1984, 2000) they recommended that traditional healing should be integrated, where possible, with modern medicine and stressed the necessity 'to ensure respect, recognition and collaboration among the practitioners of the various systems concerned'. The manpower resources that WHO hope to enlist in the folk sector include: traditional birth attendants; *Ayurvedic*, or Yoga practitioners; Chinese traditional healers, such as acupuncturists; and various others.

2.4.2.3 The professional health care system

This includes the organised, legally and authorised healing profession, such as modern western scientific medicine, or allopathic. It includes not only physicians of various types and specialities, but also the recognised paramedical professions such as nurses, midwives or physiotherapists. In most countries, scientific medicine is the basis of the professional

system. Helman (1980) mentioned that the traditional medical systems may also become ' professionalized ' to some extent; examples of this are the 91 *Ayurvedic* and 10 *Unani* medical colleges in India, which receive governmental support. It is important to realise that Western scientific medicine provides only a small proportion of health care in most countries of the world. Medical manpower is often a scarce resource, with most health care taking place in the popular and folk sectors. The World Health Organisation statistic, in 1980, illustrates the huge variations in the availability of doctors and hospitals beds throughout the world.

In most countries the practitioners of scientific medicine form the only group of the healers whose position are upheld by law. They enjoy higher social status, greater income, and more clearly defined rights and obligations than other types of healers. They have the power to question or examine their patients, prescribe powerful and sometime dangerous treatments or medication, and deprive certain people of their freedom and confine them to hospitals if they are diagnosed as psychotic, or infectious. In hospital, they can tightly control their patients' diet, behaviour, sleeping patterns and medications, and can initiate a variety of tests such as biopsies or X–ray. They can also label their patients (sometimes permanently) as ill, incurable, malingering, hypochondriacally, or as 'fully recovered', a label that may conflict with the patient's view. These labels can have important effects, both social (confirming the patient in the sick role) and economic (influencing health insurance or pension payment).

Those who practice medicine form a group apart, with their own values, concepts, theories of diseases, and rules of behaviour, as well as organisation into hierarchy of healing role; this group therefore has both cultural and social aspects. It can be regarded like lawyers, architects and engineers as a profession. Foster and Anderson (1978, 180) define a profession as being 'based on, or organised around, a body of specialised knowledge (the content) not easily acquired and that, in the hands of qualified practitioners, meets the needs of, or serves, clients'. It has also a collegial organisation of conceptual equals, which exists to maintain control over their field of expertise, to promote their common interests, maintain their monopoly of knowledge, set a qualification for admission (such as the licensing of new physicians) protect themselves from incursions or competition by outsiders, and to monitor the competence and ethics of their members. Although conceptual equals the profession is arranged in hierarchies of knowledge and power such as professors, consultants, registrars and house officers. Below them are the paramedical professionals: nurses, midwives, physiotherapists, occupational therapists, and medical social workers. Each paramedical group has its own body of knowledge, clients, collegial organisation and control over an area of competence, but overall has less autonomy and power than the physicians. The doctors themselves are divided into specialised sub–professions, which duplicate on a smaller scale the structure of the medical profession as a whole. Examples of this are the surgeons, paediatricians, gynaecologists and psychiatrists. Each has their own unique perspective on ill health, their own area of knowledge, and their hierarchy from experts down to novices.

Pfifferling (1980, 197-222) has examined the assumptions and premises underlying the American medical profession. In his view, it is: (1) physician–centred – the doctor, not the patient, defines the nature and boundary of the patient's problems; diagnostic and intellectual skills are valued above communication skills; setting for health care, such as doctors' offices, are often located for the benefit of doctors, far from their patients' home; (2) specialist–oriented – specialists, rather than generalists get the highest prestige and rewards; (3) credential–oriented – those with higher credentials can rise in the medical

hierarchy, and are considered to possess greater clinical skills and knowledge; (4) memory–based – feats of memory (of medical facts, cases, drugs, discoveries etc.) are rewarded by promotion, and the respect of one's peers; (5) single case–centred, - decisions are made on a single case of a disease, based on cumulative description of previous clinical case; and (6) process–oriented, – evaluations of the doctor's clinical skills are made by measuring his impact on quantifiable biological processes in the patient, over time (such as a fall in blood pressure). One could add to this list the increasing emphasis on diagnostic technology rather than clinical evaluations. Most of these points apply equally to physicians in other western countries, such as Great Britain. In most countries, the main institutional structure of scientific person is the hospital unlike in popular and folk sectors; the ill person is removed from family, friends and community at a time of personal crisis. In hospital they undergo a standardised ritual of 'depersonalisation' becoming converted into 'numbered cases' in a ward full of strangers. They emphasis their physical disease with a little reference to their home environment, religion, social relationship, or moral status. Hospital specialisation ensures that they are classified and allocated to different wards, on the basis of age (adults, paediatrics, geriatrics), gender (male, female), condition (medical, surgical or other), organ or system involved (ENT, ophthalmology, dermatology), or severity (intensive care units, accident and emergency departments). Patient of the same sex, similar age range and similar illnesses often share a ward. All of these have been stripped of the props of social identity and individuality, and clothed in uniform pyjamas, nightdress or bathrobe. There is a loss of control over one's body, personal space, privacy, behaviour, diet and use of time. Patients are removed from the continuous emotional support of family and community, and cared for by healers whom they may never have seen before. In hospitals, the relationship of the health professionals "doctors, nurses, and technicians" with their patients is characterised by distance, formality, brief conversions and often the use of professional jargon. Anthropologist such as Goffman (1961) has seen hospitals as 'small societies' with their own implicit and explicit rules behaviour. Patients in a ward form a temporary 'community of suffering linked together by commiseration, ward gossips, and discussion of one another's condition. However, this 'community' does not resemble, or replace, the communities in which they live; and unlike the members of self–help groups, their afflictions do not entitle them to heal others, at least not setting within the hospital setting.

In most countries, the professional sector is also composed of local general practitioners who are often deeply rooted within a community. There is some resemblance between these doctors and the healers in the folk sector, particularly in their familiarity with social, familial and psychological aspects of ill health, even though their healing is based on entirely different premises (Helman 1986).

2.4.3 Patients: Therapeutic network

People who become ill and who do self-treatment, and not helped, make choices about whom to consult in the popular, folk or professional sectors for further help. These choices are influenced by the type of helper actually available, whether payment of their services has to be made, and the explanatory model used by the patient, this model, which is described in chapter 4, provides explanations of the aetiology, symptoms, physiological changes, natural history and treatment of the illness. On this basis, patient chooses what seems to be the appropriate source of advice and treatment for the condition. The relatives treat illnesses, such as 'colds', sacred folk healers treat supernatural illnesses such as 'spirit

possession', and natural illnesses usually treated by the physician, especially if they are very severe (Helman 1986, 2000). If, for example, the ill-health is ascribed to divine punishment for a moral transgression then, as Snow (1978, 69-106) points out, "Prayer and repentance, not penicillin, cure sin, though both may be used simultaneously: a doctor is used for physical symptoms, a priest or faith healer for the cause.

Helman (1986) noted "In this way, ill people frequently utilise several different types of healers at the same time, or in sequence. This may be done on the pragmatic basis that 'two (or more) heads are better than one". He mentioned one example that Scott (1974, 542) describes the case of a black woman from South Carolina, living in Miami, Florida. Believing that she had been 'fixed' (bewitched), she treated herself with olive oil and drops of turpentine on sugar cubes. When this failed to relieve her symptoms (abdominal pain), she consulted: two 'root doctors', who gave her magical powers, and candles to burn, and prayed over her; a 'sanctified woman', who massaged her, and prayed for her, and two local hospitals, for X- ray and gastrointestinal tests to 'find out what is down there'. At one stage she was following the advice of all three folk healers simultaneously. As Scott points out her contacts with doctors were not for curative purposes, but rather 'to check the effectiveness of the folk therapy' at each stage. Each of these healers may redefine the patient's problem in their own idiom, such as 'peptic ulcer' or 'witchcraft'.

Ill people are at the centre of therapeutic networks, which are connected to all three systems of the health care. Advice and treatment pass along the links in this network, beginning with advice from family, friends, neighbours, friends of friends, and then moving on to sacred or secular folk healer, or physician. Even after the advice is given, it may be discussed and evaluated by other parts of the patient's network, in the light of his or her own knowledge and experience. As Stimons (1974, 97) noted "A doctor's treatment is often evaluated 'in the light of his past performance, with what other people have experienced, and compared with what the person expected the doctor to do". In this way, ill people make a choice, not only between different types of healers (popular, professional or folk), but also between diagnoses and advice that make sense to them and to those that do not. In the latter case the result may be 'non-compliance', or a shift to another part of the therapeutic network. (See chapter 5, part 6)

2.5. Belief systems in Sudan

Systems of belief include historically developed and socially transmitted ideas, homogeneous and well-integrated beliefs reasonably consistent and mutually reinforcing. Belief essentially functions for each society's ideology to help its members answer the very personal questions. A person's choice of belief is more often dictated by his special position and his family than by independent evaluation of alternatives (See Knoph 1969; Elguhary 1988, 11).

2.5.1 Social belief

Social belief is the idea and feeling that generates people to interpret all the phenomena in the world whether physical or psychological. In addition social belief differs from social practice since the latter refers to what belongs to a certain society as part of its history and

culture, while social beliefs are perspectives that are common in most societies and similar in content but differ in names (Elguhary 1988). Elguhary identifies such beliefs as being social meaning that belongs to society as part of customs. He analysed belief within the origin of religious beliefs: Islamic, Christian or any other religion. Then it changes from being a religious belief into other new forms in mind gradually through generations; thereby it is not part of religion principles. Rather, it used to be called folk and had many forms such as magic and witchcraft; related concepts in the system of sickness include *zar* "spirit possession", sophism and *kujurs*, which are all embedded in the history of Sudan. The following are some systems of belief that are associated with Sheikh/*Faki* "healer" healing methods. So Sheikh/*Faki* is taken in this comprehensive package rather than in isolation. The use of Sheikh/*Faki* here is only an example rather than a structural differentiation from other systems of belief or institution.

- **Kujurs belief**

Gafour (1997, 38) noted that "In some societies such as in Southern Sudan, people believe in the possession of another type of 'soul or genus', which is described as follows: Man possesses two souls, one is located in the left shoulder, which 'accounts for all that is evil in his nature'. The other is in the right shoulder 'representing the unusually powerful' evil. If it comes in the form of the witchcraft, and if it is good, the person becomes a great man or tribal leader. At death, the soul returns to another human being. They believe in the survival of the dead; the soul inhabits various places, trees, graves etc".

Nuba people of Cordovan state (a Sudanese region), distinguish between witchcraft and operations of sorcery. Witchcraft is an inexplicable innate power possessed by certain individual men or women. It is passed on by inheritance, while sorcery is not necessarily inherited and can be learnt. If a person is usually fortunate in hunting or harvest, people think he must have some unexplained power. Witchcraft is an unconscious power that a person is not conscious of and it operates against his will, for example, an 'evil eye', or a 'wicked mouth'. If a person becomes ill he may be a victim of witchcraft. He then will consult *Kujurs*, the medical or spirit-priest. The word *Kujurs* is derived from the word *Kujri*, meaning to hang or ride on. The vocation of a *Kujurs* is heralded by dreams and becomes more regular, convincing and demonstrated by result. That they are accepted as giving evidence that the spirit has chosen its human medium and a *Kujurs* status is assured. Stevenson (1984) noted that these *Kujurs* speaks in different voices that are of spirits. He prophesies future cures, diseases, offers indications and suggestions to help his client to deal with practical and social daily problems.

- **Spirit possession belief**

Asad (1982) mentioned the spirit possession among the *Kababish* tribe of North Cordovan and claimed that there are two main sorts of possession; a human spirit (*dastoor*) or a non-human spirit or demons (Jinn).

A human spirit: It is known as *dastoor* and that may possess men or women; however, most of the cases are women. Regardless of whether the *dastoor* is male or female, a person possessed by the *dastoor/zar* is called host. *Zar* word refers to healing practice and rituals centred on the belief in existence of powers or spirits, which possess people through whom they make certain demands. A Faki or religious Sheikh cannot exorcise *zar* spirit. They do not like them (but *zar* healer (*Sheikha*) can exorcise it. Once haunted by it, completely comes by requesting of needs through the host and usually demands as spoken

performances, especial clothes and *zar* ceremony. This type of spirit usually possesses a person with a long illness (Asad 1982)

Non-human spirit (Jinn): Jinn spirit possession is less common. A person who is possessed by Jinn sometimes screams all night and runs about widely. The host of Jinn is dangerous to himself and for others. Jinn spirit could only respond to the holy world and sometimes may by exorcised by *Faki*, it could be treated through holy words and then it will leave the host. (Asad 1982).

This type of belief particularly, belief in witchcraft is found among many societies especially in central and West Africa. People there believe that some people are witches and some are sorcerers who may do them ill by performing magic rites with bad medicines. Witchcraft is described as 'being like a mouth with large sharp teeth' and that a witch may be a person suffering from appendicitis, perhaps, accompanied by internal abscess. It is also said that if maggots come out of the dead man's body before burial it is a sign that he was witch. Witchcraft is not only a physical trait, but can also be inherited. It is believed that all sons of male witches are witches but daughters are not, whereas the daughters of female witches are witches but not the sons (Elguhary 1988).
Witchcraft itself is part of human organisms and its action is psychic. The *Zande* tribe believes that the soul of witchcraft is the concept that bridges over the distance between the person of a witch and the witch's victim. An example of this is that a witch was in one's heart at the time when he was supposed to have injured someone else (Pritchard 1986). The concept of witchcraft provides a natural philosophy for the relationships between men; it is an "organised" system. Witchcraft or magic is thus part of every activity of life.
The man who practices magic with the help of evil spirits (using techniques and magic) is called sorcerer. His power comes from "medicine". Sorcerers cause illnesses while witches act without rites and spells, using psychotherapeutic power to attain their end (Isak 1997, 43).

2.5.2 Religious belief

It is a system of organised ideas and practices that are naturally arranged into two fundamental beliefs: the state of opinion and consistent representations, and the rites, which determined modes of action. Religious beliefs, simple or complex, present common characteristics that represent profane or sacred concerns. Furthermore, social belief is expressed through the system of myths, dogmas, and legends, while beliefs in sacred concerns are the power, the values attributed to them. The profane or sacrilegious concerns are expressed in the material world; the relation between sacred matters is superior to profane ones. Moreover, religious beliefs are always common to groups, united by common faith, leading a common way of life, and with some thought about sacred matters and their relation to the profane world.

"In short, religion is a unified system of beliefs and practices relative to social concerns. They set beliefs and practices, which unite into a single moral community known as a church, mosque or temple" (Yinger 1999).

Durkheim distinguished between the sacred and profane when he claimed that the sacred is to be treated with a certain specific attitude of respect, which he identified as the appropriate attitude towards moral obligations and authority. The sacred, the objects that are symbols, have essential qualities which symbolise an entity that command moral respect. Durkheim's view is that religious ritual is of primary significance as a mechanism

for expressing and reinforcing the sentiments most essential to the institutional integration of the society (Robert & Durkheim 1986). This distinction persisted throughout the history of religious studies. The belief in the supernatural powers extended to reach individuals as holders of such powers such as *Faki*, Sheikh, *Zar* leader, etc.

Religious practices: Include acts of worship and devotion; the things people do to carry out their commitment. Religious practices have two sets of performances: (1) Ritual, which refers to the sets of rites, formal religious acts and sacred practices in which they expect adherents to perform. (2) Devotion is a kind of, but different from, ritual. While the ritual aspect of commitment is highly formalised and typically public, all known religions also valued personal acts of worship, a contemplation which is relatively spontaneous, informal, and typically private (Browne 2002).

Experiences: Experiences take into account the fact that all religions have certain expectations. However, the ideal religious person will all the time or other achieve a direct, subjective knowledge of ultimate reality, that he will achieve some sense of contact, however, with supernatural agency. This dimension concerned with feelings, perception and sensations experienced by an actor or defined by religious groups or a society. It involves some kind of communication, however slight, with a defined essence, that is, with God, with ultimate reality and with transcendental authority.

Knowledge: Refers to the expectation that a talented religious person will possess some minimum of information about the basic talents of his or her faith and its rites, scriptures and traditions. However, belief need not follow from knowledge, nor does all religious knowledge bear on belief. In essence, a man may hold a belief existing on a basis of very little knowledge.

Consequences: Identification of the effects of religious beliefs, practices, experiences and knowledge in a person's day-to-day life.
Although religions prescribe much of how their adherents ought to think and act in everyday life the extent to which religious consequences are part of religious commitment is not entirely clear (See Clerk 1968; Weatherhead 1986).

The appearances of Gods are various, depending upon natural and social conditions, and they have strong influence on the individual in his everyday life. The empirical and functional specialization of the Gods, whether original or subsequent, are determined by new experiences concerning the special spheres of interprets by metaphysical speculation even as world creators. The reason for this is that these natural phenomena vary but little in their course.

Max Weber (1920) sees that these Gods depend upon both rational, economic practices and secure, regulated harmony of sacred norms in the social community in which the priests are the primary representatives of these sacred norms (Weatherhead 1968).
Weatherhead (1968) noted, “A power of living persons may be coerced into the service of man just as the naturalistic power of a spirit could be coerced. Then the religious behaviour is not a worship of the God but rather coerced by the God. And invocation is the exercise of a magical formula 'This is the original thought' and prayer formula is fixed with songs, dance and drama, on occasion of a marriage, for instance, as religious practices” (See Al-Nagar 1987; Issa 2000).

On the other hand, God's favour can be obtained by entreaty, gifts, services, and tributes. As Gods of this type evolve, worship comes to be regarded as a necessity and becomes composed of prayer and sacrifice. Weatherhead mentioned that sacrifice, at first, appeared as magical instrumental service of the coercion (craving) of the god. The relationship between man and supernatural force, which takes the forms of prayer, sacrifice and worship, may be termed as cult-religion, distinguished from sorcery that is magical force. Corresponding all this with the term god, in contrast to demons, which are magically forced and charmed, issues such as belief in a persons' ability to harm or bless. (See chapter six, part 4)

In a comparison of sorcery with religion those professionals who influenced the God by means of worship, magicians, are those who force demons by magical means. Weber (1920) stated, "Any other great religions have the concept of the priest with such a magical qualification. However, the priesthood is a sociological phenomenon and the priest is a member of an organised guild. Distinguished then from a sorcerer, the priest has the professional equipment of special knowledge, while the sorcerer is very learned" (citation from Weatherhead 1986, 47). Other institutions such as *Faki*, Sheikh, etc. could be interpreted similarly.

2.5.3 Cultural beliefs of reproductive health care

These beliefs represent people's life in all its stages from birth till death; many Sudanese tribes practice these beliefs. They differ in some things from one place to the other, but they share in others things. For example, if some one leaves these beliefs, the result that occurs will be in physical or psychological diseases. These foster concepts, such as *Seiber* (see below), a process implies that during and after the conception period, the mother, as well as the whole family, are to follow a systematic mode of 'appropriate' behaviour for the external environment, and for *Mmushahra* (see below), mainly related to the period after birth where the 'imbalance' of the internal/environment state is brought about to the mother as a result of her being exposed to an internal inappropriate phenomenon. These two concepts are related to the cultural beliefs systems of reproductive health care and rooted in the basic structure of the Sudanese society (Noor 1992).

Birth rituals

Women play three parts in a man's life: 'the role of mother, the role of a wife and the role of a sister'. Psychoanalysis declares, absolutely, that there is a deep effect of the mother towards her children that is reflected in the building of the human self. This not only will affect the childhood but it will continue till the end of one's life. It will clearly appear in behaviours and in interaction with health and illness, as well as in all other different ways of life. This influence is well known in producing beliefs and behaviours in their children.

Noor stated "In most African countries, such as Sudan, when the woman feels the first delivery pains, the family send someone to call all women in the area, and they put a branch of a tree in water and the pregnant woman keeps looking at it during the delivery; it will make delivery easy. But if there are any difficulties in delivery, the Sheikh of the town write certain verses of the holy *Quran* on a paper and puts it under the feet of the pregnant woman". After the delivery, the woman is covered by a special *tobe*, (sheet of clothes); it

may not to be in a red colour, they believe that a blue colour protects the mother from evil and bad eyes. And if the child is a male, they put the holy *Quran* beside him (Noor 1992).

Mushahra

From the Arab word *Shahar* means 'month' and *mushara* is a time during which the pregnant woman feels a pain that may cause abortion to her and she might face difficulties in delivery. They believe that the pregnant woman faces *mushahra* when she sees a funeral or someone who is wearing gold sees her, or another one who crosses the sea and sees her (Noor 1992).

Altayeb (1992, 8) has studied the belief system during the reproduction period stating that the *mushahra* is a name applied to all the apparently inexplicable claimants to which a pregnant woman had been exposed and which would cause a miscarriage or difficult birth, if not treated and dispelled at once. He noted that the period of *mushahra* begins in the 7th month of pregnancy, continues up to seven days after giving birth, in the case that the mother suffered circumcision. During this period the woman is considered to be in a period of crisis; she is ritually decorated. A long needle with a long red thread is fixed to her newly plaited hair, even precious metals, for example, gold are used. The ornaments are gifts from visitors who have recently been to a funeral, or from a patient or those wearing gold ornaments. Visitors should thus ”exorcise” these spirits out and make them visit some other place or they can exorcise the spirit by looking into a well before seeing the pregnant woman. The latter she is forbidden from seeing a sick person, particularly the mentally sick ones or she is forbidden doing the rite of consolation to the family of a bereaved neighbour. If, for any reason, any of these taboos is broken, the pregnant woman is said to have the *mushahra* or *kabssa,* and special procedures should be followed to attain a cure situation again. A long bone of a donkey, which is dead at least for one year, is brought into the house. It is shrouded and mourned over earnestly and then buried. The evil spirit has apparently been transferred to the bone and thus been expelled. In another procedure the pregnant woman is taken out of doors to the outskirts of the town to face the moon, because they believe that the moon protects her and the child from bad eye and spirit possession (Noor 1992). Among the same belief there are certain customs that have been practised in these days such as the preparations of *Kojra*. Elsafi (1981, 37) defined *Kojra* as a sheet of material that was fixed to the headrest and footrest of the bed to protect the woman from light and red colour, 'whatever it is'. People, what they are afraid from, is what happens or results from spirit possession, such as causing a bleeding, wound blowing, or laying in fever infection, or the inadequacy of milk in the mother’s breast and perhaps she may then not deliver after that at all. This happens to the mother if one visitor comes to her after having seen a funeral or crossed a sea or graveyard or looking at the appearance of *Alhilal* (the moon) before. So the laying-in women comes out to see the emergent *Hilal* immediately after it enters and after its appearance in order that *kabssa* (such problems like: be in a state of shock for a short or long time) might not happen to her. If the visitor was forced to enter he/she must enter by his/her backs. In addition she wears a ring, which is called ring of *jeenah* (pound) and on her neck there is something made of silver that protects and keeps the lying woman safe. She wears also a special kind of necklace called *Alrikhamy*-Shells, which is worn on the head.

A similar story in the Bible says that the wise men came from a land where it was believed that the stars affected men's health. Even today newspapers give space to horoscopes, and in our language, in words, such as lunatic, mercurial or saturnine, reveal earlier beliefs

concerning the part played by the moon and planets in the drama of healing (Weatherhead, 1968).

Seiber

Noor (1992) stated, "The *seiber* is a systematic mood in behaviour followed during the period of pregnancy and after birth. It is a common Sudanese kind of magic that causes problems to human life". It is said that this magic releases *'infaka seiber'* that is in "*seiber*" remission. Tribes that believe in *seiber*, their men are very careful not to slaughter any animal or bird around the period of pregnancy or the wife will abort her child and suffer from sickness. The husband can prevent himself from the *seiber*. He can go to the Nile and after washing his hands and face say, "I leave the *seiber* of my father and mother." In this belief, he then becomes free from all these rituals. If not, then sickness and certain delusions such as fears result of dreams with evil and hearing some noises, immediately come to the mother (See Gassim 1985; Noor 1992).

Period of pregnancy and delivery

The duration of pregnancy is the most important occurrence in family life and in that of the community. The woman with her first pregnancy will have a special provision given to her and to her husband. The entire family actually gains psychological satisfaction as well. On the other hand, the community gives her different kinds of respect and she will suffer if she fails to have this job. The importance of pregnancy is not restricted to the wife and her husband and family, but it is enlarged to cover all the extended family and tribe.
On the one hand, the pregnancy period is a transient time which, transferring the women from one stage to another stage, in which she will have a different biological as well as social position. Thus the dangerous period needs concentrated attention from old mothers in the family to the pregnant women. The period of pregnancy has different ritual practising for many different purposes, such as: protection from evil eye, the safety of the child and his mother from spirit possession and witchcraft (See Noor 1992; Altayeb 1992).

In the seventh month after conception, the first ritual dealing with known problems is, for example, an injection of a pin on her head or a pin with a silk thread. They believe that if she hears a sound of a bird during night, especially that of an owl (sound), she will abort her child. Also in this month, the family of the women will prepare a special kind of Sudanese food and provide it to seven neighbouring women. These women, who are invited to this feast, must be married. After eating, every woman rubs her hands on the stomach of the pregnant woman and asks God to let her give birth safely. Then the pregnant woman goes to the Sheikh to mend the knots for her that is a thread with many knots used to tie round the oddment. She also wears a silver bracelet and *someyta*. These things will not be taken off until the day which is specified for the name of the new birth and which she will then put for them on a tray near her bed.
When the woman feels that she is about to deliver her child, the family make her wear a special ring and necklace to protect her from evil and bad eyes. When delivery happens, the thrill begins, deliberating a new birth, whether it is a male or female. A faithful man will then come and sound the *azzan* in the child's ear saying you are Muslim, son/daughter of Muslim and your mother is Muslim.
After birth the abstract is buried. This process takes place by digging a small pitch outside the house and putting a little amount of Dora (some sort of seeds) in it. Small children gather and make everybody laugh by offering sweet food and a happy environment, until they finish the burning of the abstract on that pitch. Their belief is that when the child

grows up, he will become happy or glad and he will never suffer from sadness or depression (Khater 1990, 72).

Customs of delivery among some Sudanese tribes

One of the traditions that is practised by certain tribes, e.g. the Fur tribe, is that (most) women in the first seven days after delivery, do not move unless carrying a piece of iron as a defence for herself from any obstacle or possession. The placenta is put in front of the house and no stranger may see the newborn child, during these seven days. Then they prepare some primary drink, including some sort of boiled herbs. The woman giving birth uses this to clean the genital wound. She should also eat a special kind of food, such as milk and honey. They believe this sweet food will make the body unacceptable to the spirits (Khater 1990, 81).

Mushahra beliefs and their boundaries

The idea of incorporation is represented in practices and conditions involving another essential female fluid: blood, the source of a women's fertility.
Women are prone to illness involving excessive blood loss, called *nazif*. Such ailments derive from the Arabic *shahr* (meaning new moon or month). Wehr (1976, 490) similar to Kennedy (1978, 126), in reference to *mushahra* among Egyptian/Sudanese Nubians tribes: It is a custom associated with the term that certain actions are engaged in before the appearance of the new moon (indicating the beginning of the lunar month), people believe that if a women ignores to perform this custom, a magic spirit will possess her and cause some problems, such as loss of the mind or loss of excessive blood, "*nazif*" (citation from Noor 1992).

In some villages, as Boddy (1989) stated, the practices associated with *mushahra* are not emphasised, despite the new moon's acknowledged suspiciousness. However, the links are made simply, for one of the *jirtig* ornaments, worn by children recuperating from circumcision and bridge-rooms during their wedding, is a cloth band tied around the crown of the head to which a recent-shaped piece of gold metal is fastened at the mid forehead. This crescent is referred to as *hila*l or new moon. *Mushahra* is closely connected with the jirtig as shown below, and their joint association with the moon can hardly be fortuitous: Just as *mushahra* practices are concerned to control female genital bleeding, lunar rhythms are emblematic of regularised, disciplined genital blood flow. A women or girl is likeliest to suffer *mushahra* haemorrhage at child birth, circumcision or defoliation, hence as in upper Egypt the customs associated with at such times are essential elements of life crisis rites (See Kennedy 1978; Noor 1992).

Women experiencing blood loss from the gentile region or pain in their heads are particularly at risk from spirits. *Zar* spirit and other types of jinn, including river spirits, which might enter through the pregnable orifice and possessing her, inflect sterility. For treatment, the women must visit a river or deep water near her place, and she must wash her face and her body in this water. Because they believe that a devil must have some kind of incarnation, if not that of a man, then that of an animal, the patient and all his contemporaries believe that deep water is the only finally satisfactory way of getting rid of devils (Boddy 1989).

The women given birth, is newly circumcised, or has become a bride must wear a gold ring made of a coin known as a *khatim jineh-masri*: This is one of several *jirtig* charms that protect women especially at time of delivery. Moreover, when a woman discovers she is pregnant, any gold she is wearing at the time cannot be removed until after the birth, lest she miscarries. *Nazif* and strong pain in the head are often caused or exacerbated by a spirit which, as Kennedy (1978, 133), noted, "Is thought to be attracted to blood and gold; a menstruating women who visits the graveyard therefore courts sterility, for it is known to be riddled with jinn. The gold women wear may divert the spirits' attention from her genital region, which is rendered available because it has been opened, has bled and is liable to bleed again. This condition also, of course, attends the newly deflowered bride" (citation from Noor 1992).

Women who have recently shed blood through genital surgery and childbirth are apt to suffer uncontrollable haemorrhaging if visited by people returning from a funeral, or who have seen a corpse or a butchered animal and not yet erased the effects of death from their vision. To prevent such blood loss, about a container is filled with Nile water containing some millet and ex-head or some coins. It is placed outside the door of the room in which the woman confers. Her visitors must first look into the bowel, after which they may enter the room with impunity. If river water is not provided for the purpose, guests should gaze into a well and see a reflection of the stars or moon before proceeding to their destination. Should one suffer *nazif*, a result of a guest's omission, one might counteract the affliction by peering into a bowl of Nile water, throwing a gold coin into a well in which stars are reflected just after sundown (Elguhary 1988, 37).

Here is also another association of blood with female fertility that highlights the complementary relation between a married couple. During his wife's pregnancy a man is forbidden to slaughter animals because it is feared that the shedding of animals' blood induces miscarriage in the wife. The association is one between husband and wife alone, for a man can make a commission to a neighbour or kinsman to slaughter on his behalf. As in other *mushahre* contexts, discussed below, it is the mixing of instinct experiential domains having to do with blood that must be avoided. (Boddy 1989)
All these customs and traditions have a great psychological impact upon the Sudanese society according to their beliefs, and these actually lead to further continue in practising traditional medicine if something happens.

2.6 Country experience and official policies

Traditional medicine, with its different types, provides health care for most of the population in developing countries especially in rural areas. Generally traditional medicine suffers from being neglected and from policy isolation. In many countries traditional medicine is not officially recognised. It is however not legally prohibited (WHO 1994).

Sudan traditional medicine represents a unique blend of indigenous cultures with Egyptian, Babylonian, Persian, Indian, Arabian and West African cultures. In the past there was no systematic records of traditional medicine and traditional medical practices. In most cases information about the state of health, illness and medical practices are the recorded observations of early travellers explores, traders, hunters, historians and medical and non-medical officers. This data can be found in official reports, travel accounts, memoirs and publications of the one or other. Other resources are the native chronicles, archaeological

excavations, fossil studies and literary works and oral traditions (Elsafi & Bassher 1981). Systematic record research in Sudan regarding traditional medicine began in the year 1903, when the welcome Research Laboratory at Gordon Memorial College in Khartoum, had to study the obscure substance used by the natives in poisoning cases. At the beginning of this century some officers described in four invaluable volumes (1908-1913) indigenous medical practices in some parts of Sudan. From 1918 onwards publication, apart from a few medical articles published here and there, were mainly published in Sudan Notes and Records. More organised scientific institutional research on traditional medicine was initiated by the establishment of Medicinal and Aromatic Plants Research Institute, in 1972, under the National Council for Research. In 1982 a Traditional Medicine Research Institute was established as a part of the National Council for Scientific Research. Although recently, the Medicinal and Aromatic Plants Research Institute and Traditional Medicine Institute have been joined to one institute, but they are still engaged by exploring the herbal products medicine (Community Health Unit, report 1998).

Elsafi & Bassher (1981) noted, "It is worth mentioning that there are no available systematic studies concerning the general traditional practitioners of Sudan, particularly the religious and spiritual healers, and they are not officially acknowledged. They practice their traditional ways of healing without license, registration or training. Also the magical therapy practices, e.g. *zar* ceremony, are now forbidden. However, it is practised secretly".

2.6.1 Other countries policies

Due to WHO reports, in Yemen, traditional medicine is very common. However, there are no systematic and serious studies on this issue. The common types of traditional medicine in Yemen are magic-religious, involving the treatment of conditions caused by evil eye, magic or spirits. The main forms of treatment are by the dance ceremony (*zar*) and scarifies. Faith healers are common in Yemen also. They may use herbs, seeds, cauterisation and physical manipulation.

In Egypt, practice of traditional medicine has been made illegal. The common types of traditional medicine are zar, cauterisation and recently acupuncture. Herbalists have officially listed some of medicinal plants for use. In fact research into medicinal plants is given a high priority. It is worth saying that medicament for certain conditions and disease have been recently approved for clinical use.

In Jordan, there are different types of traditional medicine and traditional healers, such as the use of plants, amulet charms, surgical, orthopaedic procedures, psychotherapy, religious sessions, childbirth attendance and acupuncture. However, there is no serious or scientific interest in traditional medicine.

In the Kingdom of Saudi Arabia traditional medicine is a religious one. Solutions to social and psychological problems are obtained more readily with the help of the *Quran* and employment of Islamic principles. Therefore praying and philanthropic acts are of great value. Herbal medicine also plays a very important role among people in Saudi Arabia.

In Somalia, there are different types of traditional medicines such as cauterisation, bone setting, sacrifices, and blood letting. There are different types of healers such as religious healers, oriental healers, astrologers, star mongers, Arabic medicine men, herbalists and

bonesetters. In 1974, traditional medicine (with the exception of non-religious, spirit magical cult) was officially recognised. Traditional medicine is taught at the Faculty of Medicine and has a special place in the Department of community medicine. Researches into medicinal plants are carried out by the Ministry of Health through its agencies, for importation and manufacture of drugs. The Somalia National University has established an inter-faculty programme of research into medicinal plants, and it is supported by the National Academy of Science and Arts. The programme is designed for the activities of healers and professionals in primary health care services. It is worth mentioning that the research team includes traditional healers.

Contemporary Ethiopia is a culturally diverse and complex society. Indigenous medical beliefs and practices provide an example of this cultural diversity. However at very general level of comparison, it is possible to identify significant similarities in the medico-religious beliefs of many of the country's cultural groups, confirming the existence and continued evaluation of what some researchers has called "Pan-Ethiopia culture traits". Distinction between illness and other personal misfortune are blurred or nearly absent among most groups. Greater emphasis is placed on what we calls "supernatural", as opposed to the natural causation and treatment of illness and other misfortune. Traditional medicine plays a very important role in Ethiopia. Now over 80% of the population continues to rely on it. Official attitudes towards traditional medicine appear to have become more positive since 1974, especially after the adoption of the Primary Health Care Strategy in 1978. However in actual practice there continues to be considerable uncertainty about the interpretation and implementation of Government policy (WHO 1984, 1994, 2000).

2.7 Spiritual dimension and mental health

With the "Global Strategy for Health by the Year 2010" the World Health Assembly stressed the importance of the spiritual dimension and resolved that it implies "a phenomenon that is not material in nature but belongs to the realm of ideas, belief, values and ethics that have arisen in the minds and conscience of human beings" (WHO 1984, 1994). It was also affirmed that these ideas have not only stimulated world-wide action for health but have also given to health, as defined in WHO's Constitution; an added "spiritual dimension". This timely and meaningful worldwide resolution has revived vital interest and given a new impetus to a basic human element that had long been pushed to the fringe and remained neglected in modern medicine.

In this respect, it seems important to recall that psychology in today is considered to be the study of the mind, "behaviour and experience" (Prichard 1986). However, when it was first introduced, psychology was primarily concerned with the study of the soul and the higher spiritual qualities of man. As critically stated by Fromm (1950) "modern psychology, trying to imitate the natural sciences dealt with everything except the soul". Contrary to this, the leading psychiatrist and psychologist Jung, more than half a century ago, emphasised in his well known book, Modern Man in Search of a Soul (1961), the importance of the spiritual perspective for attaining psychological health and enjoying a normal state of mental well-being. This was clearly stated when he pointed out that "during the past thirty years, people from all the civilised countries of the earth have consulted me. Among all my patients in the second half of life, there has not been one whose problem, in the last resort, was not that of finding a religious outlook in life". He concluded by saying that "it is indeed high

time for the clergyman and psychotherapist to join forces to meet this great spiritual task" (citation from Bassher 1994)

2.7.1 The fact

Bassher (1994) noted "For indeed, the challenge that all of us have to face in the 'Mental Health field' is so great and generally overwhelming. To begin with, it seems important to point out that despite all the well-known differences in the methodology, the nature and conditions of studied populations and the researchers' zeal and attitude, the fact still remains that mental health problems in both industrialised and non-industrialised countries, are generally immense and widely distributed" (Abd El-Rahim & Cederblad 1986, 629-641; Baasher & Hag Ali 1997,67-78; Giel Van Luijk 1969, 149-163; Goldberg et al. 1970, 439-443; Orley & Wing 1979, 513-520; Carstairs 1973, 271-274; Shepherd et al. 1966).
Worth noting is that even in countries with advanced health services Mental Health problems in approximately one third of the patients with psychiatric illness in general practice may not be identified (Goldberg & Blackwell 1970, 443) and hence are inappropriately treated.

Equally important is that the growing movement for healing institutions has shifted the trust of care from psychiatric hospitals to alternative community-based services (See chapter 5, part 2). However, a basic element, which is often missing, is a dynamic policy for appropriate community mobilisation and sufficient utilisation of the wider humanistic and spiritual perspective. The fact has now been even more strongly felt in the face of emerging, intriguing, and multi-dimensional epidemics of modern times, notably drug-related problems, alcoholism (Smith 1986, 971-1002), crimes of all sorts and the gruesome psycho-social, medical problem, commonly known as the Acquired Immune Deficiency Disease. Bassher argued that despite the great advances in the field of genetic, neurochemistry, neuro-psychology and neuropathology, the underlying causes of major mental disorders, such as schizophrenia, are still not clearly known.

2.7.2 Ideological approaches

Consequently, as we mentioned in (chapter 4, part 1), there are a number of ideological approaches for dealing with mental illness, mainly, the organic, the psychotherapeutic, the behaviour and the socio-therapeutic. Similar to the medical model and because of the increasing demand, the sheer faith in and easiness of physical treatment, the greater numbers of psychiatrists follow an organic ideological approach. Remarkably though, in the last three decades, there have been great advances made in drug treatment, in the use of psychotherapy, and in behavioural modification and social remedies. On the other hand, it is not clear why more than fifty percent of certain neurotic and psychosomatic conditions, for example, benefit from inert "placebo" substance (Pfefferbaum 1977). Bassher (1994) argued that the studies of placebo responses, including the personality (Linton & Langs 1962 and 1982, 53-67), social class (Rickles 1970, 318-328) as well as the influence of other variables (Honigfeld 1964, 145) indicate the complexity of the underlying mechanism. Nonetheless, it seems essential to mention in this respect the influence of faith in the physician and the patient's expectation in the healing process. Obviously the insistent question for the better understanding of the human being and the search for more effective psychotherapeutic remedies continue. It is, therefore, not surprising to see the development

of alternative approaches with a striking move from limited psychoanalytic school to the behaviourist, the humanistic and more recently to transpersonal approaches. The latter denote a wider and broader therapeutic perspective (See Belschner & Gottwald 2000).

2.7.3 The integrated model

In the light of modern trends and the search for more holistic approaches, it seems relevant to refer to the recent development of the integrated model of, psycho-syntheses. For justifying its name, Hardy (1987) stated that "the model and its techniques do offer a coming together of inner experience and outer events, of the personal and the social, of past wisdom and present science of psychotherapy and theology, in a way not precisely achieved by any other form" (citation from Bassher 1994).

Bassher, 1994, noted that ”it is clear from this approach as well as from other current thinking that at the later part of the twentieth century a new search has been advocated to merge the valuable cultural into the modern sciences, and that the welfare of man and society should be conceived within a total context, both materially as well as spiritually”. Essentially this modern school is fully realising that though man in the twentieth century is enjoying the highest fulfilment of material life. And as Hardy (1987) stated, “There is the need that one has to look into 'The dark side of human nature'. For if spirituality and soul are denied then there is no vehicle for the modern person to see and come to terms with the (dark) shadow" (citation from Bassher 1994). This is why a great emphasis will be given to this model of the religious quest and the search for basic meaningful of spiritual life.
Consequently, it seems relevant to further elaborate the basic issues of the underlying concepts of religious searches and their role in the promotion of Mental Health (See Belschner & Gottwald 2000).

2.7.4 The religious search

Each culture has its individual ideation and concept regarding spiritualism; the religious search in general tells us about the basic human make-up, his inner weaknesses, potential qualities and the need to set up guiding principles for leading a meaningful life and attaining a healthy state of mind (See the Holy Quran book). As an illustration, reference will be made here to some of the Islamic guiding principles as revealed fourteen centuries ago of Prophet Mohammed and communicated to his followers. Remarkably, in the *Quran*, (Syrah No. 95), it is clearly stated that: "Surely we created man of the best stature. Then we reduced him to the lowest of the low, save those who believe and do good works, and theirs is reward unfailing". As explained by Wagdly, the Holy *Quran* verses describe the sharp contrast between the magnificent external physical appearance of man and his inner emotional turmoil, his inherent tendency to cruelty, passionate reactions, greediness and aggressive behaviour. Hence, as part of his destiny in life, man has to face these human weaknesses and strive hard to overcome them. Surely, the clear understanding of man's inner emotional, spiritual and biological mechanisms, the development of ways and means for ensuring an optimal state of psychological well-being and the enhancement of his potentialities to live a creative and happy life still remain the most challenging problems of mankind (Barton & Bellak, 1972).

Bassher (1994) asked "What is the role of religion in the promotion of mental health and how can spirituality and faith contribute to the alleviation of psychological sufferings and the prevention of mental and behavioural disorders?"
He supposed the answers to these questions could be briefly presented by three sub-headings, namely:

1. The basic context of religious principles.
2. The concept of mind and heart and their relationship to faith and spirituality.
3. The practical implications of these beliefs.

The religious principles

With regard to the religious principles, the Islamic doctrine, for example, is based on the holy commandments and rules regarding right and wrong. Primarily, these provide the true directives for leading a health and a meaningful life.

In the Holy *Quran* (Syrah No. 2), under the verse referring to piety, for instance, it is fundamentally ordained that: 'it is not righteousness that you turn your faces to the East and the West; but righteousness is to believe in Allah and the Last Day and the Angles and the Scriptures and the Prophets; and gives wealth, in spit of love it, to kinsfolk and to the orphans and the poor and the wayfarer and to those who ask and to set slaves free and observe the worship and pays the poor-due. And those who keep their promise when they make one, and are patient in tribulation and adversity and time of stress, those are the sincere and the pious".

Within the framework of these basic and clear directives for a firm belief, for securing equity and social welfare and for endurance of hardships and stress in life, man has been entrusted with the will to choose and the ability to decide (Verse 46, Syrah No. 41). This is indeed his supreme advantage on earth (Verse 72, Syrah No. 33).

Furthermore, the Islamic principles have ensured due respect for human integrity, the rights of others and the appeal to wisdom and reason (Verse, 125, Syrah I6). These guiding principles as well as others constitute fundamental rules and regulations for the development of a healthy way of life and for the promotion of a rational state of mind (citation from Bassher 1994)

Concept of heart and mind

However, along with the inherent qualities for rational thinking and sound judgement, man's higher faculties extend into the broader perspective of faith and spirituality. This makes us search for a better understanding of the complete elements of psychic phenomena and its relationship with the different concepts of mind and heart.

In orthodox medical teaching, for instance, the determinants of feeling, thinking and behaviour are considered to be centred within the brain and to be the functions of the mind. Specifically, in the Holy *Quran* scripture, there are forty-nine references calling upon man to use his mental faculties rationally and sensibly, to strictly observe his religious duties and to abide by a healthy style of life. Moreover, besides the clear indication in the *Quran* with regard to the inherent functions of the mind for appropriate thinking and understanding, special emphasis is given to the heart, as the seat for more insightful

perception, deeper feeling and true belief. These concepts are specifically revealed in one hundred and twenty-two *Quran* verses.

It can be concluded from the contents of these verses that the heart in the Islamic doctrine enjoys a wide range of primary human perceptions and functions with special vital capacities for spiritual feeling and faith healing. These superpowers have led the leading Muslim scholar El Gizoe (1980) to describe the heart as the human "radar" which can direct man into the way of true belief, meaningful life and great achievements.

A pertinent question that may be posed here is: How do we see these dynamic and complementary functions of the mind and the heart in the light of modern sciences and technological advances?

However, prior to answering this question, it is to be noted that the conclusion which can be drawn from modern research studies is that, despite the progressive technical advances in scientific knowledge regarding the anatomical, biochemical and pharmacy-dynamic functions of the brain, the nature of some of the vital inner mental mechanisms continues to be intricately complex and ill understood (citation from Bassher 1984).

On the other hand, during the last quarter of the century substantial progress has been made in the field of psycho-neuro-endocrinology. Sachar (1975, 135) reported important findings regarding the influence of peripheral hormones on receptors, enzymes and other variables of the central nervous system. The determination of these peripheral hormones in the blood and the demonstration that they are regulated by the same neurotransmitters which are involved in the regulation of mood and behaviour have led to the designation of the enlightening concept of "the window into the brain". It is also interesting to recall that this is the twelfth anniversary of the isolation of encephalon.

Hughes (1975, 265) indeed, the remarkable growing evidence concerning the role of opined peptides in response to stress, to neuroimmuno modulation as well as the other wide-range reactions. Evidently, the isolation of these internally secreted opium-like and sedation inducing substances are crucial developments. It has been significantly shown that the axis of the determinants of mood and behaviour extends from the brain to the suprarenal and the kidney zone. In the light of these recent scientific discoveries and advances, one has also to consider the religious concepts of mind and heart, as previously explained in their wider perspective (citation from Bassher 1994).

Due emphasis has to be given to the broader aspects of the psychic dimension and the inherent human capacities for the development of faith and the attainment of peace of soul and rest at heart. Within this context, one should readily see the importance of the newly introduced spiritual dimension in the field of health.

Practical implications

The importance of faith healing and the role of spirituality in health have been recognized since the early dawn of history. The "incubation" or "temple sleep" was one of the popular psychotherapeutic practices commonly used.

The therapeutic model was associated with the name of *l-em-hotep* (he who comes in peace), the earliest known physician in history and who was later regarded as the patron saint and god of medicine (Bassher 1994). These models of treatment were greatly

influenced by the psycho-religious climate of the temples; note the profound confidence people had in the supernatural powers of the deity, and in the suggestive techniques carried out by the divine healers. Today, across continents, there are the well-known shrines and temples, famous for spiritual restoration of Mental Health and faith healing (Pfleiderer 1981).

However, Belschner (2000, 73) argued that since the time of Ebbinghaus 1919 "who emphasised the psychology as the science about the contents and processes of mental life, or as is said, 'the science about states and processes of consciousness' in his book "Grundzuge der psychologie[*]", he never recognised the word of "transpersonal" or "spiritual" in the books that concerning the development of the German academic/educational psychology (conversion by the author). Significantly in the past few decades, in some Western countries, a wide range of religious healing movements has developed. They are well described in exploratory studies by Jones (1985). Though the conclusion reached that "alternative healing groups are responses to dissatisfaction with traditional medicine, especially the latter over-reliance on administration of drugs, its impersonal approach and its symptom related treatment (citation from Bassher 1994). However at this point the author can argue that the development of these movements signifies the need for emotional support, social gratification and for the fulfilment of mental well being through spiritual means and ways.

In this connection, we can mention what Belschner under the topic 'towards integrate the transpersonal psychology in the academic psychology[*]' noted: "my thesis is: For a psychology that apprehends man with all developmental problems and concerns, it is indispensable to broaden the conceptual construction towards the objective of Transpersonal psychology and thus break the traditional delimitation and marginalization for this field of the academic psychology' (Belschner & Gottwald 2000, 73-74) (conversion by the author). Also Basset (1976) in one of his study has shown the need for religious services in hospitals for 'spiritual strengthening'. Clerk (1968), in his comprehensive study on the Psychology of Religion, states, "the increasing popularity of books on religion and Mental Health, also the flowering of many priests in the mentally ill and the success of dealing with psychotherapy and religion". In the book "Faith is the Answer", Peal and Planton believed that religion and psychiatry can and will make an ever increasing joint contribution in the coming years to help normal people live more normal, happier and more worthwhile lives. As a practical way for systematic mobilisation of inner spiritual power, Robert Schuller, the senior minister of the Crystal Cathedral, California, has "selected 366 faith-generating human motivating Bible verses" for daily practice. In his view, "faith is a noun but it must become a verb! Action". Hence, the objective of the daily exercise is to develop in "a one-year spiritual fitness program that will make it possible to go through tough times with survival power". In current political life, an example of the power of faith can be clearly seen in Bishop Desmond Tutu's work, when he said "They may remove a Tutu but God's intention to establish His Kingdom of justice, of love, of compassion will not be thwarted for victory is ours through him who loved us" (Tutu 1984) (citation from Bassher 1994).

[*] "Die psychologie ist die Wissenschaft von den Inhalten und Vorgangen des geistigen Lebens oder, wie man sagt, 'Die Wissenschaft von den Bewusstseinszustanden und Bewusstseinsvorgangen'".

[*] "Meine These ist nun: Fur eine Psychologie, die den Menschen mit all seinen Entwicklungsaufgaben und all seinen Anliegen wahrnimmt, ist es unabdingbar, das Konzeptuelle Gebaude um den Gegenstandsbereich der Transpersonalen Psychologie zu erweitern und damit di traditionelle Abund Ausgrenzung dieses Bereiches aus der akademischen Psychologie aufzuheben". (Belschner & Gottwald 2000,73-74).

2.7.5 The Islamic approach

This section aims to see what the Islamic principles and approaches can offer for the development of preventive strategies and appropriate programs in the field of Mental Health. In general, the Islamic doctrine has dealt with a number of psychosocial issues, including marital relationship, child rearing, family care, adoption, orphanage, woman issues, virtue, love, mercy, truthfulness, justice, modesty as well as topics that include well defined guiding principles on everyday and civic duties.

The Islamic strategy for the promotion of mental well-being is based on the recognition of the inherent human deficiencies and calls for systematic and constructive enactment to overcome them. Essentially, in the five time daily prayers the true Muslim recites the Opening of the Holy *Quran* and appeals to the Lord of the World to "Show us the straight path, the path of those whom thou has favoured, not the (path) of those who earn thin anger, nor those who go astray". Indeed, the *Quran* as a "guide" and source of 'enlightenment' includes a variety of traditional events, human endurance and supremacy, exemplary characters of prophets and the dismal fate of deviant behaviour. The aim is to encourage people to learn from past events, develop a refined quality of life and enjoy a healthy state of mental well-being. (Bassher 1984) noted, "The eloquent and resourceful dialogue between the Prophet Lout and his people is an example of exacting endeavours to combat indulgence in homosexuality. This is a serious reminder for the Muslim communities to beware of the gloomy fate of such sexual disorders and a practical demonstration of a deterrent against deviant behaviour. Other intricately complex problems such as suicide and drug abuse have been adequately dealt with by the Islamic doctrine. The *Quran* is a religious code and not a medical text. Nonetheless, specific Mental Health problems, e.g. suicide, have been ordained with clearly precise and firm directives"

Bassher (1994) noted that "The Holy *Quran* verse, which positively states: 'Do not kill yourself, for God is merciful to you', plays a great role in the prevention of self-injury and self-destruction in Muslim communities". He added that a number of Muslim patients seen by him and who had entertained suicidal ideas, stopped short of taking their lives for fear of acting against the will of God.

Within the Islamic context, to atone for one's sins is an exercise of faith and a practical process of learning by doing. It is a systematic and step-by-step enactment. Firstly, the person has to recognise his sin and doing. Secondly, he has to face and apprehend his mistakes. Thirdly, he should solemnly promise to give up and not repeat his wrongful behaviour. Fourthly, he invokes the help of God for forgiveness and guidance. Fifth, this act of regret has to be complemented by useful work (Verse 54, *Surah El Annam*). Furthermore, the daily and seasonal religious practices seem to be most helpful for personality adjustment and promotion of mental health. The Fasting Month of Ramadan and the Pilgrimage to Mecca, in particular, provide optimal opportunities for breaking away from adverse social habits, for resolution of guilt-feelings and for attainment of mental peace. Bassher (1994) mentioned that a number of drug dependant persons, for instance, have given up alcohol and the misuse of chemical substances through faithful adherence to religious commitment during the Fasting Month or by abreactive clearing up of the inner self, spirit awakening and devotional enactment during the pilgrimage.

Finally, religious institutions such as mosques can play a most effective and useful role in the promotion of mental health and the prevention of psycho-socially negative behaviour,

for example, the impact on health, education, public information, community mobilisation, promotion of mental well-being and the prevention of social harms such as the mistreatment of drugs. This was particularly so at a time when, nationally and internationally, there was a great movement made by the WHO for a Global Health Strategy and the attainment of the charitable goal of "Health for all by the year 2000). More recent efforts that the new plan of developing the ”African Traditional Medicine” during the period of 2001-2010 (WHO 2000)

In a number of countries efforts have been made to extend mental health care to a high level and the initial activities, which have been undertaken, including the association and involvement of religious healers and institutions promisingly well for future plans and programs. To sum up, a spiritual dimension when improved with a broad faithful concept, basic guiding principles, appropriate approaches, good practical examples and models of excellence can prove greatly useful in the promotion of health and in the relation of a meaningful life.

2.8 Collaborations between traditional and modern medicine

The World Health Organisation (WHO 2000) stresses the important role that traditional medicine plays in providing health care for the majority of the population, especially in rural areas. WHO is trying to explore the merits of traditional medicine in the light of modern medical sciences and suggesting a plan of action to promote and develop traditional medicine. The WHO argues that traditional medicine should be recognised, evaluated and developed, so as to improve its efficiency, safety, availability and wider application at low cost. WHO policies encouraged the Governments to recognise and integrate traditional medicine within their primary health systems. Mburu (1977, 185) stated, “To get the benefit of both practitioners in the field of mental health, it is more useful to educate and incorporate traditional healers into modern medicine to use them as vehicles of change rather than antagonists. Ignoring and harassing them, as is the case today, is banishing traditional medicine to its natural self-propagating cocoon where it is further entrenched to detriment of the health improvement and modernization potential of indigenous populations”.

According to World Health Organisation reports that some countries have witnessed an effective integration of traditional and modern medicine. China has provided a new and best example of integration of traditional and modern medicine. This means an effective integration first and then training of primary health workers, known as bare foot doctors. The whole country enjoys a remarkable health care.

In India, a dual system of traditional and modern medicine exists. The traditional system of medicine is already recognised, legalised and well developed. Most of the traditional methods, like Yoga, are now widely adopted through Government policy and are included in the curricula of several institutions of learning, including universities, colleges of medicines and secondary and primary schools, as well as in centres for the training of diverse types of health personnel. There are 108 colleges of indigenous medicine, and the statutory National Council directs their activities, controls standards of training, education and practice, and awards an acknowledged status, which is necessary for employment in public health services.

In Sri Lanka the traditional system of medicine meets the basic health needs of about 70% of the population. The traditional system in Sri Lanka is recognised, legalised, well developed and its integration into the public health service system is advancing satisfactorily.

In Pakistan in 1965 the Government established an Autonomous Board for *Tib* "medicine" and homeopathy with the view to enable the traditional medical practitioner training and practising their systems independently by supplementing such modern advances as the Board may from time to time determine. Pakistan has extensive programmes for opening *Tib* Dispensaries in towns and in villages.

In conclusion, traditional medicine is an integral part of people's culture. There are different traditional systems or methods of medicine all over the world. They all share a common goal of providing health care for the population. Traditional healers are those who are active within the traditional system of medicine. They range from secular healers such as bonesetters, herbalists and midwives to sacred healers such as Shamans, Priests and Sheikhs/*Fakis* as in Sudan. A strong relationship has recently been established between traditional and modern medicine.

Traditional medicine as well as modern medicine has a negative and positive aspect. The negative aspects should be discouraged, whereas positive aspects should be recognised, reinforced, developed and given place in the national health services. Goods (1981, 192) noted, "Health policy which fails to recognise the positive contributions of the ethno-medical system is neglecting an important source for improving the health status".

3. METHODOLOGICAL FRAMEWORK

Introduction

In the previous chapter the tendency and the decision framework of patients with respect to health systems was structured and presented. Based on the conceptual framework: the problem statement, the objectives, the hypothesis, the research questions and focus of the research are presented in chapter one and the methodology of data collection and analysis is described in this chapter. Data collection was mainly done using surveys i.e. two structured questionnaires described in the subsequent sections below. The chapter also dwells on the research area by describing the justification for selecting the research area, sampling stages, interview procedures, data collection and analysis.

3.1 Operationalisation of the conceptual framework

Sudan is a country with different types of traditional healers beside medical doctors. Among those types of traditional healers are the three selected for this study including *Quran* healers, Sufi healers and *zar* healers. These types can be classified into two groups of healers, the religious healers group, which include the *Quran* and Sufi healers, and the non-religious healers group, which is represented by *zar* healers. In spite of the difference in the two groups' background from a religious point of view, there is an agreement upon certain points concerning the classification and the causes of mental disorders that could be explained by the influence of cultural and traditional beliefs on both groups.

This study was carried out in two selected types of treatment for mental illness in Sudan. It covered both a western medical system of medicine and traditional one, in order to study the patients' tendency towards both health systems and the decisions of switching from one system to another. Two groups of patients selected from three hospitals for psychiatric health and from seven centres for traditional healing were interviewed. Also practitioners of the two health systems namely psychiatric doctors and traditional healers were investigated to compare the two different views on mental health and illness.

The conceptual framework showed a highly simplified way in which the patient tendency towards health systems is influenced by some factors and linked up with patient switching between these systems. It is assumed that the decision of changing the type of treatment was made under conditions that were characterised by uncertainty of the health system's effectiveness or absence of health signs. Patients would therefore make a choice of other health systems based on their experience with the first system of health and other factors that influence their decision to look for another way to become healthy.

The biggest task is to conceptualise modelling to study the factors that influence the patients' tendency towards types of treatment and to declare the patients' problem and treatment dilemma between mental health systems. These together lead the study to look

for a useful method to understand and present the traditional healers model and the psychiatric doctors model in the field of mental health and illness.

3.2 Methodologies of studying patients' tendency towards health systems

In order to determine the type of the methodologies that should be used in the study, the following questions were asked: Which research design is best? Which strategy will provide the most useful answers to decision makers? There is no simple, immediate and universal answer to those questions. The answer in each case will depend on what decision makers want to know, the purpose of the research, the evaluation funds available, the political context and the interests/abilities/biases of the evaluators and decision makers (Patton 1992, 7).

What is certain is that different methods produce different information. The challenge is to find out which information is most needed and most useful in a given situation, and then to employ those methods best suited to produce the needed information. Trow (1970, 149; 1994) points out the difference between arguments about which methods are most appropriate for studying a particular problem as opposed to arguments about the intrinsic and universal superiority of one method over another.

In this study the author is drawn towards ‘doing a qualitative research’ in order to get close to the situation and resources of data, to increase understanding, and to get and to generate a holistic description of the situation. The idea was to enter a social situation, attempt change and monitor results. These results will be setting up and contributing to a programme designed to raise awareness on health care systems. In the other side, the qualitative research is more strongly interested in the perspective of each person to bring the reader into the reality of the situation studied. So here is an area where the research aim and area lend themselves to a qualitative approach.

3.2.1 Quantification and qualitative experience

Quantification means to measure if only by frequency, on some numerical basis. For example, whenever we count or categorise, we quantify. Separating people according to astrological sign was also quantification, so was giving a grade to an assay. A qualitative research, by contrast, emphasises meanings, experiences (often verbally described), descriptions and so on.
Raw data will be what people have said exactly (in an interview or a recorded conversation) or a description of what has been observed. Qualitative data can be later quantified to some extent but a qualitative approach tends to value the data as qualitative.

Coolican (1994, 27) argues, ”The debate about qualitative research represents itself to some degree as practised or applied. If you are interested in the accuracy of human perception in detecting colour changes, or in our ability to process incoming sensory information at certain rates, then it seems reasonable to conduct highly controlled experimental investigations using a strong degree of accurate quantification. If your area is psychology applied to social work practice, awareness changes in ageing, or the experience of mourning, you are more likely to find qualitative methods and data of greater use”.

According to the research objectives, the author decided to choose the qualitative approach as a method of this study. In addition to that we prefer this study to be in the more 'realistic field’ setting, while there is a growing body of researchers with a humanistic, ‘action research’ approach that favour qualitative methods.

3.2.2 Qualitative methods

Qualitative method usually indicates a commitment to publish the results of research in qualitative terms (See Strauss 1991; Franz 1996). Denzin (1988, 8) noted that a qualitative methods attempts to understand the setting under study through direct personal contact and experience with the program, in addition to that a qualitative research designs requires that the evaluator gets close to the people and situation being studied in order to understand the minutiae of life program. This makes possible description and understanding of both externally observable behaviours and internal states (world view, opinions, values, beliefs, attitudes, symbolic constructs and the like). Based on Flick (2002, 206-207): "Empathic observation is a field strategy that combines at the same time: analysis of documents, interviews with interview partners and informants, direct participation and observation as well as introspection". Empathic observation can be understood in a twofold aspect as a process. On the one hand, the researcher shall become more and more of a participant and find access to field and persons (See below). On the other hand, the observation shall also pass through a process of increasing concretion and concentration on the aspects, which are important for the problem[*] (Conversion by the author).

Some researchers find that a qualitative approach is possible in the investigation of psychological phenomena. But not everyone agrees that this is the appropriate method for the study of active human beings rather than inert matter. Bruyn (1963, 226) mentioned that attention to inner perspectives does not mean administering attitude surveys. The inner perspective assumes that actively participating in the life of the observed and gaining insight by means of introspection can only achieve understanding. Actively participating in the life of the observed means at a minimum, being willing to get close to the sources of data. Coolican (1994, 34) noted that qualitative data consists of any information gathered during research, which has not (yet, at least) been quantified any rigorous way, and added that; we use qualitative data very often in supporting or contradicting our predictions and

[*] Teilnehmende Beobachtung ist eine Feldstrategie, die gleichzeitig Dokumentenanalyse, Interviews mit Interviewpartner und Informanten, direkte Teilnahme und Beobachtung sowie Introspektion Kombiniert. Teilnehmende Beobachtung ist in doppelter Hinsicht als Prozess zu begreifen. Einerseits soll der Forscher mehr und mehr zum Teilnehmer werden und Zugang zu Feld und Personen finden (s.u.). Andererseits soll auch die Beobachtung eine Prozess zunehmender Konkretisierung und Konzentration auf für die Fragestellung wesentliche Aspekte durchlaufen (Flick 2002, 206-207).

explanations. Much of our reasoning about people's motivations and decision-making is based on qualitative evidence.

3.2.2.1 Approaches to qualitative data

Looking through the literature on qualitative data, two general views seem to emerge on what to do with it. These correspond to the positivist and non-positivist dimension (See Strauss 1991; Franz 1996).
Coolican argued that for the positivist, un-quantified data is accepted in a subsidiary role. It seem to have the following uses:

- It can illuminate and give a context to otherwise neutral and uninspiring statistics.

- It can lead us to hypotheses testable in quantitative terms.

3.2.2.2 Analysis of qualitative content

It is not easy to give guidelines on the analysis and presentation of our qualitative data that a large quantity of written notes and material: audio and video recording have been transcribed. The method that used for the analysis of the data has been developed from different sorts of qualitative methods, namely: Coolican method of content analysis (1994, 384) and Mayring method of qualitative analysis (1997; 2000). The decision of following these two methods of content analysis has been influenced by the above theoretical background of our work model as well as the type of the data that generated from the field survey; bearing in mind that content analysis can be used to deal with originally qualitative information. The data is rigorously analysed and reduced to quantified units (categories), susceptible to statistical significance testing. The whole data set of this study have been produced from any of the following sources:

- **Participants' notes and diaries.**
- **Observer's field notes about the participants.**
- **Informal or part-structured interviews.**
- **Open-ended questions (interview or questionnaire).**
- **In-depth case-study (mixture of interviews, observations, records).**

Coolican (1994, 384) noted that the qualitative researcher too has to categorise data. This data might consist of speech, interactions, behaviour patterns, and written or visual recorded material. It might also include the researcher's own ideas, impressions and feelings, recorded as the research project progresses. The set of data has to be organised so that comparisons, contrasts and insights can be made and demonstrated. The qualitative researcher however, will not be categorising in order to count occurrences. Instead data will be categorised in order to analyse and compare the various meanings produced in any one category.

3.2.3 Reliability and validity

Qualitative researchers argue that their methods produce more valid data for the reasons that the qualitative study is naturalistic and the data gathered are realistic, even though the result may obviously not be valid for another context.
This research has developed safeguards against lack of reliability and validity. First: this study used a triangle approach, comparing the psychiatric doctors and the traditional healers perspectives on the field of mental health and illness and studying patients' tendency towards the two health systems (psychiatric medicine and traditional healing). Second: a pre-test of the patients' questionnaire was done with a sample of 10 patients (repetition of the research instrument by going around the 'research cycle' and checks the early assumptions and inferences before they are applied in the main survey). Third: the researcher consulted and interviewed some practitioners who are specialists and have knowledge in this field together with the patients based on randomisation procedures. To ensure more reliability of the measurement, the researcher postulated a group of questions that have different structures but give the same meaning to pick the reliable questions (See Howard, Moras, Brill, Martinovich, Lutz 1996, 1059).

3.3 Variables and measurements using the structured questionnaires

The study consists of two types of measurements:

- **Patients' questionnaire.**
- **Practitioners' questionnaire.**

3.3.1 Variables and measurements included in the patients' questionnaire

The first structured questionnaire is directed to patients who were exposed a medical treatment and traditional healing. Respondents were presented 42 open-ended questions believed to be measuring a given concept and they were asked to answer the questions or to state their opinion. This structured questionnaire (see Appendix 1) is considered the basic questionnaire to study the tendency of patients towards the medical and the traditional treatment and to investigate the patients' treatment dilemma.

The author initiated and designed the questions of the structured questionnaire according to Rolf Schwarzer's Model in Self-efficacy and Health Behaviours (*Sozial-kognitives Prozessmodell gesundheitlichen Handelns*, Schwarzer, 1992) (figure 3.1). This Self-efficacy makes a difference in how people feel, think and act. In terms of feeling, a low sense of self-efficacy is associated with depression, anxiety and helplessness. Such individuals also have low self-esteem and harbour pessimistic thoughts about their accomplishments and personal development. In terms of thinking, a strong sense of competence facilitates cognitive processes and academic performance. Self-efficacy levels can enhance or impede the motivation to act. Individuals with high self-efficacy choose to

perform more challenging tasks. They set themselves higher goals and stick to them (Locke & Latham 1990). Actions are pre-shaped in thought, and people anticipate either optimistic or pessimistic scenarios in line with their level of self-efficacy. Once an action has been taken, high self-efficacious persons invest more effort and persist longer than those with low self-efficacy. When setbacks occur, the former recover more quickly and maintain the commitment to their goals. Self-efficacy also allows people to select challenging settings, explore their environments or create new situations. A sense of competence can be acquired by mastery experience, vicarious experience, verbal persuasion or physiological feedback (Bandura 1997). Self-efficacy, however, is not the same as positive illusions or un-unreasonable risk taking. Instead, it leads to venturesome behaviour that is within reach of one's capabilities (Conner & Norman 1996, 164).

- **Description of the model**

Schwarzer & Fuchs (1994) noted that according to social cognitive theory, human motivation and action are extensively regulated by forethought. This anticipatory control mechanism involves three types of expectancies: (a) situation-outcome expectancies, in which consequences are cured by environmental events without personal action; (b) action-outcome expectancies, in which outcomes flow from personal action; and (c) perceived self-efficacy, which is concerned with people's beliefs in their capabilities to perform a specific action required to attain a desired outcome.

Situation-outcome expectancies represent the belief that the world changes without one's own personal engagement. Risks are perceived, and persons may feel more or less vulnerable towards critical events that they anticipate. Individuals may sit and wait for things to happen but illusions about future may help one cope with threat. When for example, people anticipate a disease; they may distort its likelihood of occurrence. This can be seen as a defensive optimism. Defences can be made in terms of social comparison bias. On the other hand, action-outcome expectancies and self-efficacy expectancies include the option to change the world and to cope instrumentally with health threats by taking preventive action. This action beliefs and personal resource beliefs reflect a functional optimism. Perceived self-efficacy implicitly includes some degree of outcome expectancies because individuals believe they can produce the responses necessary for desired outcomes. In order to initiate and maintain health behaviours, it is not sufficient to perceive an action-outcome contingency. One must also believe that one has the capability to perform the required behaviour. Behavioural change goals exert their effect through optimistic self-beliefs. These beliefs slightly overestimate perceived coping capabilities rather than simply reflect the existing ones (for an overview see Bandura 1992, 1997; O'Leary 1992; Fuchs & Schwarzer 1994; Maddux 1993).

Both outcome expectancies and efficacy beliefs play influential roles in adopting health behaviours, eliminating detrimental habits and maintaining change. In adopting a desired behaviour, individuals first form an intention and then attempt to execute the action. Outcome expectancies are important determinants in the formation of intentions, but are less so in action control. Self-efficacy, on the other hand, seems to be crucial in both stages of the self-regulation of health behaviour. Positive outcome expectancies encourage the decision to change one's behaviour. Thereafter, outcome expectancies may be dispensable

because a new problem arises, namely the actual performance of the behaviour and its maintenance. At this stage, perceived self-efficacy continues to operate as a controlling influence.

Perceived self-efficacy represents the belief that one can change risky health behaviours by personal action. Behaviour change is seen as dependent on one's perceived capability to cope with stress and boredom and to mobilize one's resources and take the courses of action required to meet the situational demands. Efficacy beliefs affect the intention to change risk behaviour, the amount of effort expended to attain this goal and the persistence to continue striving despite barriers and setbacks that may undermine motivation. This view suggests that success in coping with high-risk situations depends partly on people's beliefs that they operate as active agents of their own actions and that they possess the necessary skills to reinstate control should a slip occur (This section is a citation from Conner & Norman 1996, 194-195).

Figure 3.1: Schwarzer's Model of Health Action Plan

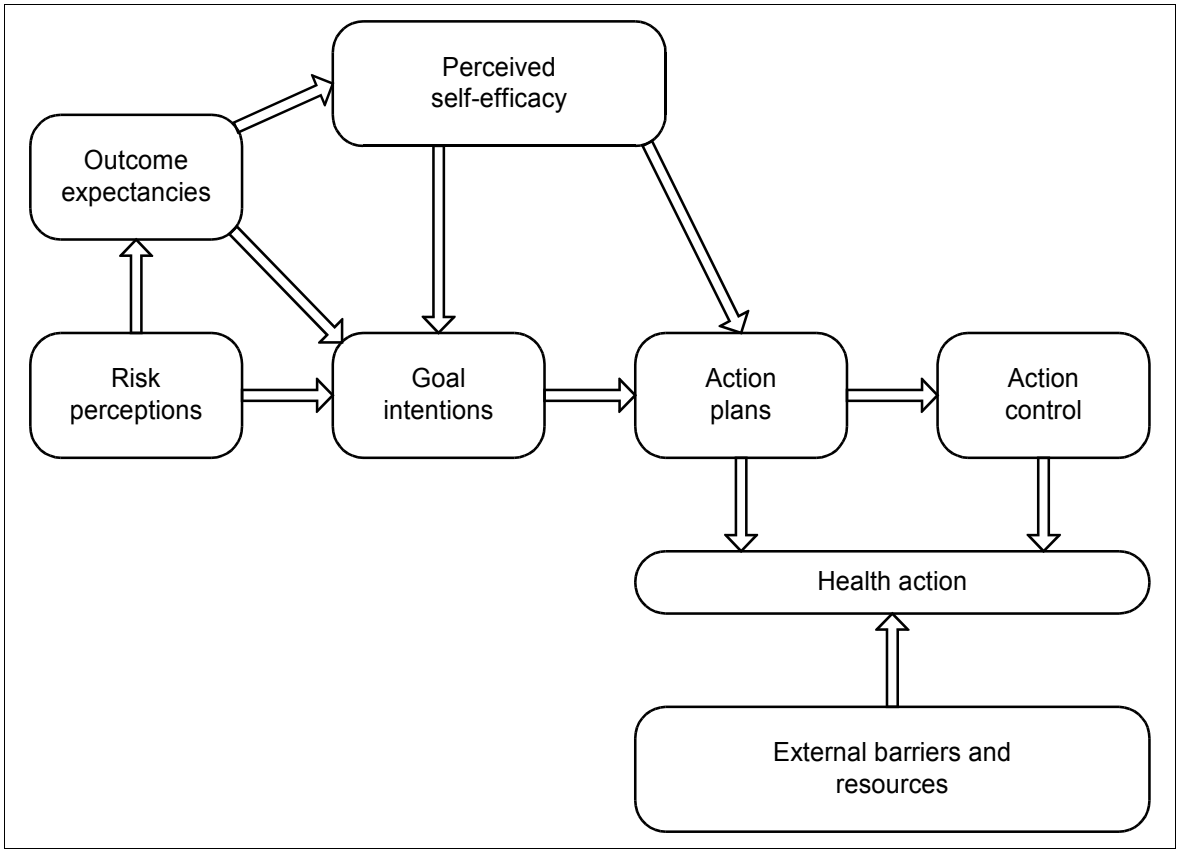


Figure reference: Conner & Norman 1996.

This model of Schwarzer (see Figure 3.1) pertains to eight variables that are considered as process of health action:

1) Risk perception.
2) Out come expectancies.
3) Perceived Self-efficacy.
4) Action plan.
5) Action control.
6) Goal intentions.
7) Health action.
8) External barriers and resources.

All the 42 questions were derived from other studies and adapted or newly constructed, based on the objectives of the research as well as on their validity and of course clustered into the above mentioned variables (see Appendix 2). The measurement also covered personal characteristics such as gender, age, religion, marital status, region, residence, education and occupation. A pre-test (a pilot study) of the measurement was done in10 patients who were not included in the research-sampled group. Then the measurement "questionnaire" was applied to a total sample size of 50 patients after necessary amendments have been introduced.

The use of open-ended questions was made to ensure that the patient could express his/her feelings and gives own correct answers. Moreover, the necessity of designing this questionnaire in a form of open-ended questions that the research aim and the concept lend themselves to this procedure, whereas research aims to study the patients' tendency towards medical and traditional treatment and to investigate the factors that influence the tendency and patient's decision of switching between the two health systems. And that means the research deals with different concepts such as tendency, perception, values, religious beliefs and culture heritage, such concepts can not be studied unless by using this procedure to avoid the looseness and inconsistency that accompany informally gathered interview data.

Later in the analysis, data were consisted and conformed to responses in order to be easily seen and conspicuous. Responses that are concurring and agree in opinion were coded and joined together into one category. This combination showing agreement and categorisation was mainly done to present the data in a frequencies form and moreover to simplify the process of data analysis. Brosius & Brosius (1995, 745) noted, "The set of variables lists merely all numerical variables of the data file. Text variables can't be examined by means of the X-test although it would be sufficient for a meaningful interpretation of the text in case of nominally scaled variables. For that reason you have to encode the text variables first into a numerical variable.[*] (Conversion by the author)

[*] "Die Variablenliste führt lediglich alle numerischen Variablen der Datendatei auf. Textvariablen können Sie mit dem X-Test daher nicht untersuchen, obwohl es für eine sinnvolle Interpretation des Tests genügt, wenn die Variablen nominalskaliert sind. Daher müssen Sie Textvariablen ggf. zunächst in eine numerische Variable umcodieren." Brosius & Brosius (1995, 745)

The author used the SPSS software package for analysing the data. In order to see how far the data we have obtained are from those estimates, simple test of difference/non-parametric test was chosen to be the appropriate statistical test. CHI-SQUARE' (a test of association between two variables) was therefore used to test the significant difference and to postulate the decision related to rejection or retention of the null hypothesis (See Reason 1981). The significant value for each cross tabulation/hypothesis is generated directly by SPSS/PC and agreed at the level set (0.05). Coolican (1994, 261) argues that CHI-SQUARE' test looks at the variation between observed frequencies and expected frequencies. For those frequencies expected if given row and column totals, there was absolutely no association between the vertical and horizontal variables. Also noted that the X calculation tells us just how often, in terms of probability, we could expect a result as extreme as the one actually observed.

3.3.2 Variables and measurements included in the practitioners' questionnaire

The second structured questionnaire is directed to practitioners of the two health systems namely psychiatric doctors and traditional healers in Sudan (Appendix 3).
After the author made the pilot study with patients in Sudan, she felt that there is something missing on this study and the patients' telling about some theories and models of health and illness particularly in traditional healing, which are not covered in the literature and that there is need to overview the health and illness theories that patients are exposed. The literature shows also that there is a need for looking at these two concepts separately.

The author suggested to consult the practitioners of the two health systems to provide feedback, to fill the gab in the literature review of this research and to develop safeguards against lack of information in this field, as Reason (1981) mentioned that involve the participants in evaluation of tentative conclusions and refine these in the light of feedback from this process.
The 22 questions in this questionnaire were newly constructed, based on the research objectives and the gap in the literature review. All the 22 questions aimed to cover and to present theories and models of mental health in both medical health system and traditional healing system in Sudan. These questions were clustered into 6 research categories:

- Qualifications of the practitioners.
- Aetiology and causes of mental disorders.
- Classification of mental disorders.
- Diagnosis of mental disorders.
- Treatment of mental disorders.
- Attitudes towards collaboration with other counterparts.

This questionnaire, applied to 16 practitioners in the field of mental health, consists of 8 psychiatric doctors and 8 traditional healers, and a tape recording was used during the interview phases. To present the data, which obtained through direct personal contact with

the practitioners of the two health systems, the researcher used an intensive analysis for the interviews. Chapter 4 presents the results emanating from the practitioners survey.

3.4 Data collection

This section describes the choice of the research area and the data collection procedures. The research was conducted in Khartoum capital city of Sudan (figure 3.2). The reasons for the choice of the research area and the description of the research hospitals and centres of healing are presented in this section. It also presents the sampling and the interview procedures for the two groups of the study: group one patients who are exposed to the two health systems, and group two practitioners of the two health systems namely psychiatrists and healers in Sudan.

3.4.1 Research area

Tendency towards mental health systems and patients' perception on health and illness are closely linked with the social-environment and the health system resources and other characteristics. In order to study the patients' tendency towards medical and traditional treatment, to investigate the factors that have influence on the tendency and to understand the patients' treatment dilemma, there is a need of understanding the geographical, social and economical environmental factors on the one hand and the hospitals and *masseds* system on the other hand. Specifically for this study, there is a need of understanding the relationship between patients' tendency and the components of the traditional healers system, namely the value system, the living system of people, the financial system and the service and healing system.
In an attempt to address the above-mentioned aspects, this chapter presents the general description of the study area and the sampled hospitals and healing centres in Sudan.

Figure 3.2 Republic of the Sudan: The research area

Map references: Africa/Sudan.net.

3.4.2 Choice of the research area

The study area is in the northern regions of Sudan. The researcher selected the capital city Khartoum and the regions around to be the area of this study, where cultural interaction and the availability of different kinds of treatment and healing methods for psychosocial problems and mental disorders. Moreover it is the area, which is more secure in Sudan in addition to some extent of available information about this area.

The researcher faced many difficulties during the time of the field survey. The first problem that arranging the appointments with the people who are working as a key informer of the health care in Sudan, particularly the traditional healers who are disseminated in rural areas and some of it are far away from Khartoum, the capital city where the researcher living. To reach these areas is also another big problem where, transportation for more than two days and safety for a female researcher were not easily granted. Moreover, in such societies that a "single/young" women to move around without a man combining her is not understandable and not acceptable, although she doing a scientific work. Another difficulty that discusses the issues of personal belief, religion, practices and traditional healing are not an easy message because for some people it's a taboo. Furthermore that asking people about problems such as mental sickness has not a welcome communication because such problems are considered as stigma for the person as well as his/her family.

List of hospitals and traditional centres for healing in this area were compiled from records of relevant governmental institutions (Ministry of health, Department of community health and Faculty of medicine in Khartoum University). Based on the estimates of the total population involved in each hospitals and centres for healing, the three biggest hospitals in Khartoum capital were selected to represent the area of medical treatment. These hospitals are:

1) Altagani Almahi Hospital situated at Omdurman.
2) Khartoum North Hospital situated north of Khartoum.
3) Khartoum Teaching Hospital situated at Khartoum.

The following seven centres in and around Khartoum capital were selected to represent the area of traditional healing:

1) Massed Sheikh Alyagout, for Sufi healing, lies south of Khartoum state.
2) Massed Shiekh Algeili Abd Almahmowd, for Sufi healing, situated east of Khartoum state.
3) Massed Umm Dwanban, for Sufi healing, situated near Khartoum North.
4) Massed Sheikh Abo Groun, for Sufi healing, situated at Khartoum North.
5) Massed Sheikh Abd Alrahim Albra'ai, for Sufi healing situated west of Khartoum.
6) Sheikh Shernobe centre, for *Quran* healing situated at Omdurman.
7) Sheikha Nafisa centre, for *zar* healing lies at Khartoum North.

3.4.3 General description of the three hospitals and the seven masseds, where the samples of this study were selected and the research was done.

Altagani Almahi Hospital

It is located at Omdurman city in Khartoum state. It is the only specialised hospital for mental health services in Sudan. It was expanded in 1971, has 128 beds now and admits 1500 patients per year. Three psychiatrists, two medical assistants, eight psychologists, three social workers and four nurses conduct the services at this hospital. From this hospital the author interviewed ten patients who had tried traditional healing before medical one, as well as two of the psychiatrist doctors and one of the medical assistants.

Khartoum North Hospital

It is located at Khartoum North, a city in the state of Khartoum. It is a general hospital. Three psychiatrists, two medical assistants, six psychologists, five social workers and two nurses conduct the services at the psychotic and neurotic patients unit. This unit admits an average of 12-20 outpatients every day. At this hospital seven patients were interviewed in addition to two of the psychiatrist doctors and one of the two medical assistants.

Khartoum Teaching Hospital

It is the third hospital that was visited by the author. It is located in the city of Khartoum in Khartoum state. It is a general hospital for academic students; the psychiatric department has 30 beds and admits 900 patients per year. Four psychiatrists, three psychologists, five social workers and three nurses conduct the services at this department. From this hospital eight patients were interviewed, in addition to two psychiatrist doctors.

Massed Sheikh Alyagout

This Massed is situated at Jabal Awlya city, which lays 40 kms south the state of Khartoum. This area has a population of about 4000 persons; most of them are farmers working in cultivation during the raining season. Electricity and water supply services are available, a small health unit, three elementary and two intermediate schools.
This Massed includes a big Mosque, many buildings and *a khlow*a (*Quran* school), crowded with visitors; the daily average of visitors to this Massed is around 50 persons from different areas for different purposes. The sheikh accounts for all their living expenditure and private facilities for visitors and reception rooms. Many small brick rooms were built for inpatients.

The head healer at this centre is Sheikh Alyagout, 82 years old, who learned *Quran* by heart and learned this job from his father a long time ago.
Quran and *Talasim* are used in diagnosing and healing ailments. From this Massed three patients, who are already received medical treatment were interviewed.

Massed Sheikh Algeili Abd Almahmoud

It is located of Algezira state at Tabat Village, situated about 300 kms east of Khartoum. The founder of this Massed was Sheikh Alsamani Abd Almahmoud, who is the founder of *Alsamania* Sufism in Sudan. People from all over Sudan come for the sake of cure and obtain blessings by touching his tomb.
The successor is now Sheikh Algeili, who is the youngest son of Sheikh Alsamani. Sheikh Algeili is 48 years old, graduate of Bachelor of Arts in Arabic and English languages in 1972 at Khartoum University, he learned this job from his father and became Sheikh immediately after his father's death in 1972.

Education was the first objective of this Massed. At Tabat village there are two basic schools, two secondary schools, a small health centre, a police station and a post office. The inhabitants are mainly farmers and tradesmen. The Massed consists of many rooms for all visitors; most of its visitors come from different parts of Sudan, different Arabic countries and few from other countries. The *Quran* and *Talasim* are used as a method of diagnosis and healing. In this Massed four patients were interviewed and also Sheikh Algeili.

Massed Umm Dwanban

It is located at Khartoum North, about 120 Kms from Khartoum state. Umm Dwanban, literally means the place of light. It is considered as one of the biggest Massed in Sudan. The currently responsible Sheikh is called *Alkhalifa* Osman Wad Badur, 75 years old, graduated in *Khalwa College* (*Quran* school) and learned this profession long time ago from his grandfather, who is the one of the famous Khalifa in Sudan.

This area has a population of about 3000 persons; most of them are educated and very hospitable to visitors. At the village there are two basic schools, two secondary schools, an academic *Quran* College and a small hospital, the Umm Dawanban hospital built in 1992 with funds provided by Sheikh Osman, this hospital has many units, one of these for mental disorders, with a medical officer in charge. People at this area call him Doctor Izz-Aldin but his actual status is that of a Medical Assistant with long experience in that field. The cases at this hospital are managed by the hospital personnel but in full consultation with the *khalifa* Osman. At normal days, the hospital receives 10 to 15 cases every day; they come from the village and the neighbourhood. This is the only Massed linked to a hospital and it has a co-operation with other doctors in Khartoum state. The *khalifa* uses *Quran* and *Talasim* in diagnosing and healing ailments. From this Massed four patients and the *khalifa* Osman were interviewed.

Massed Sheikh Abou Groun

It is located in Abou Groun village, which literally means horns. This village is situated at Khartoum North about 90 kms from Khartoum State and 40 kms from Umm Dawanban village, with a population of 2500 and most of them are farmers.
This Massed includes a big Mosque and a big tomb of Sheikh Aboshara. Some women believe that if they touch the tomb of this sheikh and ask with strong belief in him for a certain man to marry they will get him soon, even if this man is already married.

The current successor is Sheikh Alneil Abo Groun, 52 years old; he learned this job from his father and became a Sheikh after his father death in 2000. Sheikh Alneil graduated with Bachelor, i.e. at a low status, at Khartoum University, he stated the Islamic role of Sudan in September 1983 and he was one, who worked with the former President of the Sudan, Jahfar Nomeurie (1966-85), when he decided to create a political co-operation with the Islamic movement stream.

This Massed has a special system to heal mental disorders. The patients come to receive their treatment, by *Quran or Talasim,* and they attend *zikir* sessions, which are held every Sunday, Thursday and Friday nights, and also in big festivals or celebrations, such as Aid *Rummadan* (end of the fasting month). *Zikir* is considered one of the religious treatments, in concept; it is a spiritual practice that can be conducted individually or in a group to reach a spiritual elation. The author made a videocassette recording about this method of spiritual healing (*zikir*), and also Sheikh Alneil was interviewed as one of the traditional healers.

Massed Sheikh Abd Alrahim Albra'ai

It is located at Al-Zariba area, which lies between two big towns, Kosti and Alobeid. This area is about 800 kms away from Khartoum State. It is famous for its Massed, which dates back over 400 years. The area is considered a rural area composed of Mud huts with thatched roofs. The population of about 1500 person depends on sheep milk and meat as their staple food. They get water from wells that are far from the houses. There is no electricity in this area except for El Massed where the Sheikh meets his visitors and where *Quran* is learned and taught. This Massed also encompasses a dome with the tomb of Sheikh Wageilla, the father of Sheikh Abdalrahim. Whoever comes to this Massed pays a visit to this tomb. The visitor takes a handful of sand called *zuara* and gently rubs the soil on hands and face with the aim to obtain blessing and protection from skin diseases.

Sheikh Abdalrahim is a famous personality in Sudan, his age is 77 years and he was educated at this Massed on the hands of his late father from whom he learned how to treat people. From this Massed the researcher interviewed four patients in addition to Sheikh Abdalrahim Albra'ai.

Sheikh Shernobe Centre

Mohamed Shernoby Centre was opened in 1991, located near of Khartoum state at Omdurman city. It started with one room at Khartoum North, but at the present time it is a big house establishment in a religious foundation, renders its services every day except Fridays. Sundays is for male patients and the other days for female ones. The number of the patients is about 25-40 everyday.
Sheikh Shernobe is 25 years old; he studied two years in a *Quran* College after he had finished the intermediate school. He started to practice the *Quran* healing sessions, when he was 15 years old. Some physicians advise and refer their patients to him for *Quran* treatment. The patient should make appointments before he comes and register his/her name in the reception in order to meet him (in a group or individual session). Each patient pays a symbolic charge. This centre diagnoses and heals disease through *Quran* sessions only. From this centre five patients were interviewed, and also Sheikh Shernobe and his assistant Sheikh Alamin.

Sheikha Nafisa Centre

This *zar* centre is a part of the *Sheikha* Nafisa house. It is located near of Khartoum North at Halvayt Almlok. Sheikha Nafisa is 52 years old, had finished the primary school and started this type of healing when she was 15 years old. She learned her profession from her grandmother who used *zar* as a method of healing. This centre is opened for visitors twice a week (Sundays and Wednesdays) and plays the *zar* party during all the days of the week except Fridays.

In Sudan is not allowed for the people to deal with *zar* parties (according to the Islamic rules), unless with permission from the government and communities committee, but *sheikha* Nafisa has this permission. About 20 patients are seen here every week; the *sheikha* transfers some of them to other physicians and Sheikhs after the diagnosis. The

patient or a member of his/her family pays a symbolic charge before attending. In addition to healing different kinds of diseases, this centre also renders other services, such as solving family and social problems.

From this centre five patients are randomly selected and interviewed in addition to *sheikha* Nafisa and her assistant *sheikha* Amnah. The author tried to make some documentation for this type of healing but could not, as all of the patients are women, who themselves and their families are refused to be interviewed due to many reasons which were accepted by the author. S*heikha* Nafisa referred the author to another *zar sheikha* who accepted to make a video film of the day of *Fatah Alelba* (opening of the box), and that was considered as the last day of diagnosing the case and making agreement with the *zar* spirits to leave the client's body. Then the *sheikha* and her client will bless them by three to seven days of *zar* ceremony.

The whole study area lies north of Sudan; therefore people perform the same economic activity, which is farming. It is worth mentioning that different healers inhabiting the centres under study seem to be homogeneous, belong to closely interrelated tribes, share similar socio-economic characteristics and exhibit almost similar methods of healing. No wide variation was reported inside the centres as well as between centres in the same region. This observation is consistent with the conclusion drawn by El-Bashir (1993, 21). He noted that most of the people in north Sudan belong to the same tribe and hence they are governed by the same rules and in their lives.

3.5 Sampling and interview procedure

The data necessary to achieve the previously stated objectives of the study consist of both primary and secondary data. Primary data contained information generated through field survey and included two survey procedures: a preliminary survey which included 10 patients "five patients under psychiatric treatment and five patients under traditional healing"; a main research survey where 50 patients (25 patients were selected from three hospitals and the other 25 patients were selected from seven centres for different types of traditional healing) were interviewed and a detailed research approach about theories and models of mental health and illness in which 16 practitioners in the field of mental health (eight psychiatric doctors and eight traditional healers) were involved in the interview phase. Simon (2000, 14) defined the qualitative interview as a situation, which is consciously and purposefully established by the participants, so that the one person may ask questions that are answered by the other (Conversion by the author)[*]. Secondary data included published and unpublished material, the reports obtained from literature and the official documents of the relevant institutions

[*] Ein Interview ist eine Situation, die bewusst und gezielt von den Beteiligten hergestellt wird, damit der eine Fragen stellt, die andere beantwortet. (Simon 2000, 14).

The preliminary survey was done between April and May 1999. The objectives of the preliminary survey were:

- To establish the sampling units.
- Pre-testing of the questionnaire used in the main research survey (Appendix 1).
- Selecting the research areas and general description of the sample.
- Gathering preliminary information on the two health systems. The information was used as input in designing/modifying some questions of the questionnaire.

In the preliminary survey, a sample of 10 patients (i.e. 20% of the sample size) was used for pre-testing the questionnaire. These patients who were exposed to the two health systems were picked from the two hospitals' list of patients (Altejane Almahi and Khartoum North Hospitals) and two traditional centres' list of patients (Sheikh Shernobe Centre and Massed Al-sheikh Abo groun). A small sample sufficed because the aim was to get an insight in the patients' treatment dilemma and to use the information for further probing the questionnaire. The sample was also big enough to test the adequacy of the designed questionnaire.

The data-included information generated through the field survey was conducted by the author herself during the entire fieldwork period from January to May 2000 in Sudan, and supported by two assistants, who are well trained in the field of interviews under guidance of Dr. Slah Harown, head of the psychiatric unit in Khartoum North Hospital (Bsc. Psychology/ Elham Lutify and Bsc. Psychology/ Ablah, both are working as psychologists in Khartoum North Hospital). Simon (2000, 14) mentioned that the researcher is provided with an interview guideline. However, it is up to him or her to decide, basically and essentially, about sequence and formulation of the questions. Similarly, the guideline directs the interviewees' attention towards particular questions, but they can respond in an open manner and without pre-given answers[*]. The data were collected through purposely-structured questionnaires, informal discussions and structured interviews with patients and practitioners using a tape recorder as well as a live video camera for recording the daily life of those healers and their ways of communication with patients, moreover different methods of their healing were recorded, which reflect the traditional healing in Sudan namely: *Quran, Sufi, Zar* and *Zikir* healing methods (see the video tape of traditional healing in Sudan "4 hours"). A combination of several methods was used for collecting the data required to satisfy the objectives of the study and to reflect how people in this culture are dealing with health and illness. The nature of different types of data collected from the study area made the use of a unique universal data collection method in this study impossible.

[*] Dem Forscher ist zwar ein Interviewleitfaden, es bleibt aber ihm überlassen, Reihenfolge und Formulerung der fragen im wesentlichen selbst zu bestimmen. Ebenso werden die Interviewten durch den Leitfaden auf bestimmte Fragestellungen gelenkt, aber sie können offen und ohne Antwortvorgaben darauf reagieren (Simon 2000, 14).

3.5.1 Patients' sampling and interview procedure

Due to the large size of the study area a total census was not possible. For this reason, representative/stratified sampling of patients was decided upon as a method for the survey. Hinton (1995, 42) has advocated that the advantage of representative samples is the attempt to obtain as random a sample as possible and to make the sample fairly representative, by selecting individuals from important subcategories.

A method of selecting samples, so that each and every sample can exactly represent the other individuals in the target group, was applied for selecting the research sample. An alternative definition of the representative sampling can be also given under definition of the stratified samplings: "Sample selected so that specified groups will appear in numbers proportional to their size in the target population; within each subgroup cases are selected on a random basis" (Hinton, 1995, 44).

In this study there are several schemes for making sure that each case selected for an interview, represents the whole target group. With the help of hospitals directors and centres leaders (doctors and sheikhs), a stratified sample of patients, who tried the two types of treatment, was selected, standing at a random number in the list of patients and taking every 2nd patient in the list/table on that day. Those of the patient's sample who are mentally ill, with different disorders and their age above 18 years.

The sample size from each hospital for mental health or centre for traditional healing is based on its patient's size (our target group). A sample of 50 patients including about 50% women respondents was used in this survey. From a list of hospitals and centres, the patients included in the survey were picked at random from the lists. The sample of patients who are under psychiatric treatment is made up of 25 patients, while the other half represent patients under traditional healing (*Quran*, Sufi and *Zar* healing).

The sample size in each group of the study area must be considered large enough, as Hinton 1995 noted, "A minimum sample size of 25 is essential for social surveys". Coolicon (1994, 42-43) noted some arguments against large samples. He mentioned that one reason one can't always take such large samples is economic, concerning time and money. And another limitation is that large samples may obscure a relevant participant variable or a specific effect. Large samples may also disguise weaknesses in the design of an experiment, and so the small samples will demonstrate the real difference in field studies. He also argued that the optimum sample size, when investigating an experimental group is supposed to be in the average of 25-30 and this average is assumed to have a similar effect on most people.

Interview technique

The objective of the interviews with patients' (who were exposed to medical and traditional treatment) was to understand the tendency of patients towards both mental health systems in Sudan (the medical system and the traditional one) and to investigate the factors that influence their tendency towards traditional healing with particular reference to

reasons that have a major influence on patients' decision of changing/switching the treatment.

The setting and procedure for interviewing the patients was structured as an open-ended one, the author used this procedure to avoid the looseness and inconsistency that accompany informally gathered interview data. Moreover this type of interview has other advantages; Coolican (1994, 143) stated, "No topics missed or fleetingly covered, several interviewers could use reduction of interpersonal bias at the same time and the respondents not constrained by fixed answer".

For saving data the author used audiotape recordings during the interview time. The recorder has the advantage of leaving the interviewer free to conversation and encourages the greatest flow of information, which is potentially time consuming in addition to data saving. But throughout the first three interviews with patients, the author realised that the patients feel inhibited in the presence of a tape recorder and that could be also because we gave information about recording after the interviewee has taken place. However, soon after realising that problem, before starting an interview, the interviewers gave full information to the patient about the research purpose, who it is conducted for and how confidentiality will be maintained: We seated each patient down and made him/her feel comfortable (some patients ask for food, drinks or/and cigar to feel at easy). We told them that we have some questions and we will use a tape recorder to save the information as well as to run the interview as quick as possible, and there would be no serious deception and that they would not be tested in any way. We said that we just wanted their opinion about the two different types of treatment, which were tried during their sickness and that their answers would be combined with others' answers and anonymous ones.

It is worth mentioning that all interviewed patients responded positively, replying all the questions. The 100 percent response of interviewees can be attributed to the following factors:

- Questions were constructed in a simple form and presented in an easy understandable way as well as the interview procedures.

- The leaders of hospitals and centres (doctors and healers) were helping a lot. They introduced the interviewers to the patients and suggested the importance of the study.

- An average of a good seven days was spent in each of these hospitals and centres, in all of their visits the interviewers were wearing the local uniform of the inhabitants, sharing the same food and were participating in all of their regular religious rituals. That helped a lot in making both practitioners and patients feel at ease and more ready to disclose themselves and speak frankly about matters of traditional health habits which are hardly discussed with people of formal education.

The data obtained from patients by the structured questionnaire was analysed by using the software package SPSS Version 10 "Statistical Package for the Social Surveys". Cross tabulation of the hypothesised variables were made and the initial statistical test, Chi-square was conducted to test the significance of relationship between the two study groups of patients as regards the hypothesis variables.

3.5.2 Practitioners sampling and interview procedure

The sample of practitioners was selected and approached with considerable precaution. The investigator selected each head of the psychiatric unit at the three hospitals and his/her assistant and each head of the seven centres of healing (Sheikh or *Faki*) and his/ her assistant. The sample size of the practitioners is made up of 16 specialists including 5 women. Half of the sample represents the medical field, while the other half represents traditional healing.

Interview technique

The objective of the intensive and of the depth interviews with the practitioners of the two health systems was to obtain the data for constructing models and describing the theories of mental health and illness in the research area and specifically describing the six categories of variables: qualifications of practitioners, aetiology and causes of mental disorders, classification, diagnosis, treatment of mental disorders and collaboration with other practitioners.

Before the researcher started the procedure of interviewing the practitioners, she introduced herself to each one of those practitioners (doctors and healers) as a Ph.D. student in the field of psychology in Oldenburg University/Germany and a member of Khartoum University staff, whose ultimate goal is an urgent call for the foundation of a well established and systematic psychotherapy based on a religious model. She suggested the importance of the study and exploration of the religious beliefs and cultural heritage in this area and called for the inevitable co-operation of all healers and medical doctors. As such the interviews were run very easily in all the three hospitals and the seven centres.

It should be noted that the reliable information about the practitioners and their characteristics are reported in the next chapter (See table 4.1 and table 4.2). The accurate data that enabled the author to compare the medical system and the traditional one in the field of mental health and illness were categorised using the intensive analysis and the result is presented in two parts of chapter four.

3.6 Summary

After operationalisation of the study's conceptual framework (which is a continuous process) and defining and specifying approaches related to methods of methodology and analysis, attention was paid to the description of the research area, where the samples of this study were selected and the research was done, attention was paid to the criteria and reasons of choosing these areas.

The application of both questionnaires and variable approaches is presented. Two simple measurements were designed (the first measurement is directed to patients who were exposed a medical treatment and traditional healing, the second is directed to practitioners of the two health systems, namely psychiatric doctors and traditional healers) to ensure that

the study covered the three types of respondents of the research issue. Respondents were first oriented to the measurement procedures to ensure that they had adequate understanding of the study concepts.

A special focus was also placed on the description of the sampling stages and on the interviewing procedure for the two samples of the study. For the patients' preliminary survey, five respondents from each group of patients (patients under medical treatment and patients under traditional healing) were randomly selected. This was an input in designing the subsequent questionnaire and the measurements, which is designed according to the Rolf Schwarzer's Model (*Sozial-kognitives Prozessmodell gesundheitlichen Handelns,* 1992).

In the main survey, 50 patients (25 patients under medical treatment and the other 25 patients under traditional healing) were picked at random from a list of patients in each hospital and centre of healing. The 50 patients were selected based on a number of patients who were exposed to the other type of treatment, to ensure that there was equal representation in each hospital and centre of healing.

A questionnaire on measuring qualifications of the practitioners, aetiology and causes of mental disorders, classification of mental disorders, diagnosis of mental disorders and attitudes towards collaboration with the other counterparts was set up using a sample size of 16 practitioners, consisting of 8 psychiatrists and 8 healers. Using a relatively small number of patients and practitioners sample, was necessary because of the requirements of in-depth interviewing and close monitoring, also due to time and financial constraints, and last not least translation of local terms (in Arabic and other local languages used by healers) to English was not an easy work, as it is time-consuming.

In the following chapters extensive discussions of the research results are presented. Chapter 4 starts with the results emanating from the practitioners' survey. This chapter has two parts: part one concerns the results of the psychiatric doctors' interviews, while part two concerns the results of the traditional healers' interviews. Both parts give the general description of the sample characteristics as presenting the accurate data that enabled the author to compare the medical system and the traditional one with particular attention to theories and models of treatment in the field of mental health and illness.

4 Doctor-Healer.Interaction: Results

4.1 Mental Disorders: The Psychiatric Doctors' Perspective

Introduction

Chapter four presents results of the two groups of practitioners in the field of mental health and illness in Sudan, namely the psychiatric doctors and the traditional healers. An intensive analysis approach was used to explore the accuracy of the data set collected during the field survey, and to present a general overview concerning theories and models of mental health and illness in Sudan. One should bear in mind that this chapter aims to fill the gap in literature reviews concerning doctor-patient interaction in the Sudanese society. Sample size used for the interviews to generate this information data using a structured questionnaire (Appendix 3) comprises 16 practitioners. Out of those practitioners 8 are psychiatric doctors and 8 are traditional healers. The procedures and the basic assumptions concerning the practitioners' interviews are described in chapter 3.
In order to understand theories and models of the two practitioners in the field of mental health and illness separately, as well as to compare between these two health systems, this chapter has two parts:

The first part presents results of the psychiatric doctors' perspective about mental disorders. The second part presents results of the traditional healers' perspective about mental disorders. Those traditional healers can be divided into three groups: *Quran* healers, *Sufi* healers and *Zar* healers.

In the two parts of this chapter, attention was paid to present results of five categories used in the practitioners' questionnaire: aetiology and causes of mental disorders, classification, diagnosis, treatment methods and collaboration with the other counterparts. In addition, a brief description of the characteristics of the each sampled practitioners is presented.

4.1.1 Characteristics of the sampled psychiatric doctors

The main features of our sampled psychiatric doctors are presented in table 4.1. The sample of the psychiatrists was selected from the biggest three hospitals in Khartoum state: Altagani Almahi Hospital (T.H.), Khartoum North Hospital (N.H.) and Khartoum Teaching Hospital (K.H.). The average age of the sample was 47.9 years.

Table 4.1 Characteristics of the sampled psychiatric doctors

Sex	Age	Education	Marital status	Healing methods	Professional experience (years)	Religion
Male	62	Prof. Dr	Married	Medical	35	Muslim
Male	56	Dr.	Widowed	Medical	25	Muslim
Male	52	Dr	Married	Medical	24	Muslim
Male	52	Dr.	Married	Medical	22	Muslim
Male	47	Dr.	Single	Medical	15	Muslim
Female	40	Dr.	Married	Medical	12	Muslim
Female	39	Dr.	Married	Medical	9	Muslim
Female	35	Dr.	Married	Medical	6	Muslim

All the 8 sampled psychiatric doctors are Muslims and have a formal education level "university degree" with the average experience of 18.5 years in the field of medical health. Out of those psychiatric doctors, 3 are women and married, while the other 5 are men, three of them are married, one is widowed and one is single.

4.1.2 An aetiology and causes of mental disorders

Mental illness is certainly one of the major health problems today. For a long time psychiatrists and psychologists have found great difficulty in defining what constituted mental illness and what differentiated one type of illness from another. In 1980, the American Psychiatric Association published the diagnostic and statistical manual of mental disorders "third edition DSM–III". This manual has become the official guide for defining

mental disease categories. Although DSM-III presents the most exacting information presently available on mental illness, Dr. Jerrold Maxmen, a Columbian university, psychiatrist, has noted, “DSM-III shows how little psychiatrists actually know about mental disorders. Because solid data do not exist for many of these topics (disease), DSM-III spotlights the enormous gaps in factual information about mental disorders" (Jerrold 1985, 58).
There are different perspectives taken on disease. In some cases, these perspectives, that are models, might be very different from one another. Littlewood & Lipsedge (1982, 73) point out that in psychiatry, for example, different psychiatrists use in explaining psychoses multiple and manifestly contradictory models. These include the organic model, which emphasises physical and biochemical changes.
In different studies, most of the attention has been on abnormal social behaviour, rather than organic disorder or emotional states. For most researchers the social and cultural dimensions of mental illness are the main area of study. This cultural factors influence the clinical presentation and recognition of many of these disorders, even those with an organic basis.

4.1.2.1 Concept of mental disorders

During the past century, mental health professionals have debated the nature of mental illness. They have asked to what degree mental illness is biological or organic and to what degree it is psychological? Until recently some psychiatrists took one side or another on this issue.
According to DSM-IV, each of the mental disorders is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present stress (e.g., a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increase risk of suffering death, pain, disability or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a beloved person. Whatever its original cause, it must be considered a manifestation of behavioural psychological or biological dysfunction in the individual. Neither deviant behaviour (e.g., political, religious or sexual), nor conflicts that are primarily between the individual and the society are mental disorders unless the deviance or conflict is a symptom of dysfunction in an individual, as described above (Kaplan & Sadock 1996, 37).
In the medical science, there are different approaches in a definition of mental disorders. The combined approach is one of these approaches, which utilise elements of both the internal and external labelling perspectives and is the one that most of the interviewed doctors agree with. They simply stated that the influence of psychological and social stress together with the physical ones results in adjustment disorders. In this view, the aetiology and causes of mental disorders as noted by Brown & Harris (1989) are regarded as a complicated interaction of hereditary, environmental, psychological and physical factors.

There is some evidence that psychological and environmental factors play a part in the aetiology and onset of mental disorders, and that prolonged stress is particularly significant for such factors. Jerrold (1985, 112) noted that there is consensus among psychiatrists

today that, generally speaking, biological factors primarily determine the types of symptoms of disorders that a person experiences (e.g., delusion, insomnia), while psychological factors are primarily responsible for the content and meaning of these symptoms.

The personality is the individual's internal and external pattern, if any complex, interaction of these patterns happened *it would bring maladjustment.* (N.D.)

Emotional conflict results from the interaction of different factors; these factors could be social, psychological or physical factors. (T.D.)

Mental illness is a result from some psychosocial factors working together with physical factors and influence in presenting these illness, also each factors could play a role in the individual's tendency towards mental disorders. (K.D.)

4.1.2.2 Theories of mental disorders cause

Too often one assumes that something that happens close to the time when a patient develops symptoms is "the cause" of the problem. It is, however, always easier to look for the effects of the causes than for the causes of effects. In reality, what we assume to be "the cause" is probably but another effect or another stress. The "cause" of the phenomenon is not so simple and may not ever be known. The Greek philosopher Democritus understood the paradox when he said that he would rather understand one cause than be king of Persia. The contemporary psychologist, Lawrence Le Shan, also questioned the value of finding the "original cause" of mental disorder. He noted, "one does not put out a forest fire by extinguishing the match that started it".

Medicine, based on scientific rationality that is all assumption and hypotheses, must be capable of being tested, and verified, under objective, empirical and controlled conditions. Phenomena relating to health and sickness only become "real" when they can be objectively observed and measured under these conditions. Once they have been observed, and often qualified, they become clinical "facts", the cause and the effects of which must then be discovered. All "fact" has a cause, and the task of a clinician is to discover the logical chain of causal influences that led up to this particular "fact".
The doctors who were interviewed differentiate between two factors that cause or lead to mental disorders which are precipitating and predisposing factors.

I can say the causative factors of mental disorders could be precipitating factors or predisposing factors. (N.D.)

4.1.2.2.1 Precipitating causes

There are some actions or events that work on an individual who already has a tendency to mental illness, and they will be responsible for bringing the signs and symptoms of mental illness to the surface. The psychiatric doctors mentioned these factors as event that led up

to particular disorders such as emotional problems or special stress. These precipitating factors could be age factor, mortal status factors, occupational factors, or other immediate factors.

There are immediate causes or different bad situations occurring at once without others coming in between, such feelings are often aggressive and showing enmity, which later precipitates some disorders in the personality. (K.D.)

a Age and sex factors

The interviewed doctors mentioned the age and the sex as precipitating causes that play a major role in presenting different emotional disorders. Brown & Harris (1989, 154) noted, "One effect that emerged from different studies was that of parental loss or separation in childhood. Such individuals may become sensitised to insanity danger in late life, indeed, most of the difficulties reported by this group of patients represented threat to the security in relationships or at work".

The human being undergoes a process of psychological and physical development, from the moment of conception until he or she reaches maturity. During the development there are different sensitive periods, which in some individual show signs of maladjustment or cause some mental disturbance. For example, adolescence or the period of old age is periods of special stress, not only because of somatic changes, but also because of psychological stress. (N.D.)

We just finished the work of the statistical manual book of the psychiatric illness for this hospital. It is found that concerning age, more adolescents than children with emotional problems consult physicians, while more women than men with emotional problems consult physicians. These emotional disorders show affective reactions and they are more common among women, while alcoholism is much more frequent among men. (K.D.)

b Marital status factors

The doctors mentioned that instability in family life and in the relation between parents plays a major role in presenting emotional disorders.

There are some people who are very sensitive that any conflict in their family life could present emotional disorders rather than only conflicts as happened in their work life. (N.D.)

According to our statistic, mental illness is less common among married people than it is among the divorced and widowed persons. (K.D.)

c Occupational factors

Also, instability in occupational life that could be due to conflicts with authorities or competition in the work, and overwork could be a factor that leads to some disorders and emotional disturbances.

Overwork is usually a symptom of emotional problems, and it could be also a causal factor. (T.D.).

Conflict about accepting the authority or supervision may be a precipitating factor. Also competition for promotion itself may precipitate an emotional disorder. (N.D.)

d Other factors

There are some other factors or causes that happen suddenly and lead to some disturbance. Some of the interviewed doctors mentioned loss of friend or one of the relatives, financial collapse, taking some chemicals and drugs, and some diseases as example for these factors.

There are some difficult situations that take effect on an individual and become responsible for bringing symptoms of mental illness, such as loss of job, loss of parents, friend or relative. (T.D.)

There is certain infection disease that may lead to lack of sleep or sleep deprivation that causes inability to concentrate and restlessness which lead to personality changes, also alcohol and others drugs may lead to brain changes which produce a delirium or organic brain syndrome. (K.D.)

Some of the interviewed doctors commented that these precipitating factors are not necessarily causes of emotional problems or present mental disturbance for all people because there are differences in the personality as variation in their response to these factors.

Not all of our patients with life events of difficulties showed endocrine abnormalities because there is wide individual variation in response to stress. (T.D.)

4.1.2.2.2 Predisposing factors

There are some factors, which are already on an individual and liable before the event to diminish the individual resistance occurs, some of these factors, as some interviewed doctors mentioned, are hereditary, psychogenic and sociogenic, organic factors and physical illness.

a Hereditary factors

The concept of hereditary factors, as some interviewed doctors mentioned, are some factors transmitted and transferred to the person by the parents and they are responsible to reduce the person's abilities to observe life stress and present some mental disorders such as schizophrenia or manic- depressive states.

There is an important determinant of some factors passed on from parents to child, from one generation to the following generation and becomes a base to bring tendency of mental disorders. (N.D.)

Some hereditary factors play a big role in presenting some mental disorders; also it reduces the person's abilities to tolerate the stress of life. The incidence of schizophrenia is much higher in the offspring of schizophrenic parents than in the general population. The incidence of manic-depressive illness is higher among the offspring of manic-depressive parents than in the general population. (K.D.)

It should be clear that some factors are familiar rather than hereditary; the nature of emotional states may be transmitted to the person by the parents' neurotic behaviour rather than through germ plasma, organism or any other hereditary factors. (K.D.)

b Psychogenic and sociogenic factors

The concept of psychogenic and sociogenic factors as causes of mental disorders is mentioned by some of the interviewed doctors. They are as well interpsychic as extrapsychic factors, forces operating during the early developmental years attitudes of the parents towards the individual as well as environmental and cultural factors. The mental disorders that are caused by these factors could be adjustment disorders or emotional conflict.

There are causes that are regarded as a chief importance in mental illness, some of them are from and within the personality such as aggressiveness and it's known as intrapsychic, the others are from the environment and social surrounding such as influence of parents or constraints by society and they are known as extrapsychic. (N.D.)

Often, the interaction of psychological and social stress with the physical ones result in adjustment disorders. (T.D.)

c Organic factors

The concept of organic factors, as some of the interviewed doctors mentioned, is organic damage or disabilities resulting from the nervous system or disturbances of the endocrine system and causes deterioration of some disorders such as depression and paranoid psychosis or disturbance of the whole person.

Davison & Neale (1974, 417) argued that some psychoses, such as cerebral or brain traumas are thought to be explainable on an organic basis. However it seems unlikely that physiological cerebra changes by themselves can account for emotional disorders.

Certain disturbances may lead to associated personality disturbance, such as disorders of thyroid in many cases lead to anxiety and tension. (N.D.)

Here, there are many cases with brain damage that cause and lead to deterioration of depression or paranoid psychosis. (K.D.)

d Physical illness

The concept of certain illnesses as caused by maladjustment, emotional problems or aggression in relation to dependency or supportive persons are factors arising from the person's psychological needs or unconscious conflicts, which come as a result of physical illness.

Foster & Anderson (1978, 42) noted "Certain illnesses which require multilative surgery which means damage by cutting off a part of a body may cause disturbance of body image, and there is even universal agreement about the people who had many and various physical illness that they show aggression to and reaction of being repressed by other people in their surrounding".

Physical illnesses take up an important position as factor, which caused personal discomfort and emotional problems. (T.D.)

Physical illness may pose certain realistic problems for a person in terms of being able to have good living. Also it may pose emotional problems, which arise from the person's psychological needs, unconscious conflicts and even the reaction that the person kept it or put it down especially in relation to dependency on supportive persons. (K.D.)

Physical handicaps may serve as a focus of inferiority feelings that may be handled by the person through undesirable defensive attitude. However, many people with physical handicaps do not show any significant emotional problems attributable to the handicap. (T.D.)

4.1.2.3 Summary

Most of the interviewed doctors agreed to the aetiology and the nature of mental disorder as a complex result of working between internal and external structure of humans. They noted that the influence of psychological and social stress with physical or biological ones results in presenting most of disorders. About the causes of mental disorders, the interviewed doctors differentiated between two factors that cause or lead to these illnesses. There are some factors that work on a person who already has a tendency to mental illness, and they will be responsible for bringing the symptoms of mental illness to the surface. These factors are defined as precipitating factors or events that lead to a particular disorder

such as emotional problems or mental disturbance. Some examples of these factors are adolescence and the period of old age. They mentioned that sensitive periods are periods of special stress, for some people may cause mental disturbance, not only because of somatic change, but also because of psychological stress. The instability of family life and occupational life plays an active role in presenting emotional disorders. The last statistical manual for Khartoum hospital shows that mental illness is less common among married people than it is among the divorced and widowed people. Other factors that happen suddenly and lead to some disturbances such as loss of friend or one of the relatives, loss of job, alcohol and other drug use. They comment that these factors are not necessary to cause mental disturbance for all people because there is wide individual variation in response to such factors.

The other factors that may lead or cause mental disorders are defined by those interviewed doctors as factors that are already on an individual and liable before the event to diminish the individual resistance. There are four types of these factors that are hereditary factors, which are defined as some factors transmitted to the person by the parents and they are responsible to reduce the person's abilities to absorb stress and bring a tendency for mental disorders, and factors that operating during the early developmental years, such as cultural and environmental factors and attitudes of the parents towards their child, or certain disorders, damage, or disabilities resulting from the nervous or organic system, and other factors, for example, that many and various physical illnesses cause unconscious conflicts which lead to emotional problems and aggressive behaviour in relation to relatives or supporters.

4.1.3 Classification of mental disorders

Classification is our way of ordering our experience, of making sense of what would otherwise remain an endless chain of unrelated events. Classification recognises and gives importance to constants across experience, to similarities between events. Most of the interviewed doctors agreed to the concept of classification in psychiatry as systematic arranging or putting some characteristics into a class or group.

Davison & Neale (1974, 62) mentioned that classification is one branch of science by which knowledge is advanced; yet these statements imply neither that classification is useful in every instance nor that diagnostic classification in particular is inevitably a practical approach to the diagnosis, assessment and description of personality.

Wolman (1978, 15) defined classification as the name of such a process of grouping together objects or events or concepts on the basis of at least one common trait or characteristic. Also Davison & Neale (1974, 55) noted, "Classification scheme each grouping that categorises a person and his particular pattern of behaviour must convey specific and discriminating information about that person. If we know that a given patient is classified as "obsessive-compulsive neurotic", the system is useful only if membership in that category reveals something specific about the patient that differentiates him from non-members of that class".

Classification means grouping together symptoms or specific behaviour of one person and is related to a concept of one illness category. (K.H.)

Scientific classification means categorising signs and characters in one common meaning that has been clearly defined. (N.H.).

Classification is a systematic arranging of objects or signs in classes. (T.H.)

4.1.3.1 Purpose of classification

There are different purposes of classification, depending on the classification's criteria or system. But as the interviewed doctors stated, as general purpose of mental disorders classification is to facilitate a good diagnosis and to make a generalisation of specific events or concepts between different individuals. Kaplan & Sadock (1996, 33) argued that DSM-IV provides explicit rules to be used when the information is insufficient (diagnosis to be deferred or provisional) or the patient's clinical presentation and history do not meet the full criteria of a prototypical category (an atypical, residual, or not otherwise specified type within the general category). Also they noted that scientific classification enables the formation of general concepts, for example, when objects or events are put together into class or category on the basis of at least one common denominator to become possible to make a generalisation.

The main purpose of classification of mental disorders is to facilitate good diagnosis and treatment. (T.H.)

An adequate classificatory system should facilitate diagnostic problems. (N.H.)

Everybody is an idiophenomenon, but on the basis of single common traits in the sciences of classification one can group any number of idiophenomena and draw common or standard categories. (N.H.)

4.1.3.2 System of classification

The principle behind the diagnosis is straightforward. When certain symptoms regularly occur together and follow a particular course, clinicians agree that those symptoms constitute a particular mental disorder. When people display this particular cluster[1] and course of symptoms, diagnosticians assign them to that category. A comprehensive list of such categories, with a description of the symptoms characteristic of each and a guideline for assigning individuals to categories is known as classification system.

Emil Kraepelin developed the first modern classification system for abnormal behaviour in 1883. By collecting thousands of case studies of patients in mental hospitals, he was able to identify various syndromes and to describe each syndrome's apparent cause and expected course (Zilboorg & Henry 1941). The categories of disorders established by Kraepelin have

[1]* A cluster of symptoms is called a syndrome.

formed the foundation for the psychological part of the International Classification of Diseases (ICD), the classification system now used by the World Health Organization (Jablensky 1995). This system, which covers both medical and psychological disorders, is currently in its tenth revision, known as ICD-10.

Kraeplin's work has also been incorporated into the diagnostic and statistical Manual of Mental Disorders (DSM), a classification system developed by the American Psychiatric Association. The current edition DSM-1V is by far the most widely used classification system in the United States today, it lists close to 300 mental disorders, and each entry describes the criteria for diagnosing the disorder and its essential clinical feature. The feature that is invariably present. It also describes associated features, which are often but not invariably present, and age, or gender trends, or culture. Finally, it includes disorders' prevalence and risk, course, complication, predisposing factors and family patterns (Comer 1998, 138-139).

Also Kaplan & Sadock (1996, 29) argued that the l0th revision of the International Classification of Diseases and Related Health problems (IDC-10) is the official classification system used in Europe and the fourth edition of Diagnostic and statistical Manual of Mental Disorders (DSM-IV), published in 1994, is the latest and most up- to-date classification of mental disorders. DSM-IV is used by the mental health professionals of all disciplines and is cited for insurance reimbursement, disability deliberation, and forensic matters.

It is found that there is no specific criterion or system of classification that is used by those interviewed doctors, one can choose any criteria or any common element, but they agree that the system of classification at least, should be based on a single criterion, namely that it should be according to the symptoms, origin of illness or treatment aims.
So some of those doctors use the symptomatology system to classify mental disorders. At this system, you find that certain symptoms could appear at any classes of disorders.

Comer (1998, 139) comments that the criteria in DSM-IV are more detailed and objective than those of early versions of the DSM. DSM-IV focuses entirely on verifiable symptoms, for example, and stipulates that a person's dysfunction must include the specific symptoms if it is to quality for a diagnosis. Davison & Neale (1974, 56) noted that science, also, is too difficult a taskmaster, for recent research indicates that this important criterion of homogeneity is frequently not met. They mentioned an example of a well-known study by Zigler and Phillips (1961) who found that knowing what diagnostic category a patient falls into tells relatively little about the actual behaviour of the person. Similarly, they found that certain symptoms appeared in a number of categories, thus making it difficult to move reliably from a specific symptom to a specific diagnostic category (Citation from Davison & Neale 1974, 56).

In the diagnostic process, we look first in the patient's condition and history, and his/ her behaviour. Then after this observation we depend on that data and patient's symptoms to decide which type of disorder that patient suffers from. (N.H.)

At some cases we use to rely at the patient's symptoms to identify his/her disorder, but most of the symptoms accompany more than one type of mental disorders, so when we face

such problems, we go back and look for other diagnosis criteria that help us carry out our decision. (K.H.)

Some of these psychiatric doctors classified mental disorders according to the cause and origin of the illness. They support Freud's classificatory system and believe this system predicts the symptoms and the effective treatment. Comer (1998, 193) noted that DSM-I and DSM-II required diagnosticians to infer the underlying cause of disorder in order to make a diagnosis. To make a diagnosis of "anxiety neurosis" according to DSM-II, for example, diagnosticians first had to conclude that a person was experiencing internal conflicts and defending against anxiety. In DSM-IV such inferences are not required. Also Kaplan & Sadock (1996,29) argued that the approach to DSM-IV as it was in DSM-III-R, is a theoretical with regard to cause. Thus DSM-IV attempts to describe the manifestation of mental disorders; only rarely does it attempt to account for how the disturbances come about.

I think Freud's classificatory system was par excellence aetiological, it depends on the origin and causes of mental disorders which lead to predict the symptoms and this enables us to choose the right treatments. (T.H.)

The knowledge of the cause helps us a lot in a patient's diagnosis, for me it is a basis for the selection of appropriate treatment methods, and other things that are an increasingly important method of prevention. (K.H.)

I think the proper classification of mental disorders should be based on the origin and background of the patient and related to the particular nature of causes. (T.H.)

Some of the interviewed doctors did not agree to the origin-and-cause system of classification in psychiatry, they comment that there is not enough evidence that the same causes lead to specific disorders in all cases, and not each disorder has specific causes.

I think it is difficult to base the classification or identification of disorders on the causes, for there is no evidence that the same causes always produce the same effects or that a certain effect is always a result of a certain cause. (K.H.)

Other interviewed doctors see the only possible way out of this complex or confusing situation is to base the classification system on a combination of several factors.

I agree that an adequate classification system must be related to the treatment goal, to relevant origin and prognostic factors. From my experience, when I face a complicated case, I use to look through the patient's data, observe his/her behaviour, ask about the meaning of the behaviour and for the causes, use some clinical tests and look for appropriate methods of treatment. In all cases I will be happy about the result. (N.H.)

4.1.3.3 Classes of mental disorders

Wolman (1978, 37) noted that mental disorders could be divided into three large categories related to their nature and origin. Those categories are originate in the organism through hereditary or through interaction with the physical environment (injuries, poisons and so on), and are somatogenic (soma means body). The inherited disorders are genosomatogenic as genes cause them. The physically acquired mental disorders are ecosomatogenic because they are caused by interaction with the environment, the ecos. All other disorders stem from faulty interindividual relation, i.e. they are psychosocial, but since interaction with social environment is the cause of morbid conditioning and cathexis, we shall call this disorders sociogenic or sociopsychogenic. DSM-IV, the current diagnostic classification system, has 17 major classifications and more than 300 specific disorders, it is a multiaxial system that evaluates the patient along several variables and contains five axes. Axis II and I comprise the entire classification of mental disorders. (Citation from Kaplan & Sadock 1996, 33)
The interviewed psychiatric doctors mentioned different categories or classes of mental disorders, e.g., neuroses, psychophysiologic disorders, personality disorders, organic brain syndrome, mental retardation, and other mental disorders.

a Neuroses

Most of the interviewed doctors mentioned that neurosis disorders are one of the major classes of mental disorders. They defined them as emotional disturbance states resulting from unconscious conflict. Biological and genetic factors assume no role in the cause of this class of mental disorders.

Kaplan & Sadock (1996, 42) defined a neurotic disorder as "Mental disorder in which the predominant disturbance is a symptom or a group of symptoms that is distressing to the individual and is recognised by him or her as unacceptable and alien (ego-dystonic); reality testing is grossly intact. Behaviour does not actively violate gross social norms (though it may be quite disabling)". The disturbance is relatively enduring or recurrent without treatment, and is not limited to a transitory reaction to stressors. There is no demonstrable organic aetiology or factor. They added that DSM-IV contains no overall diagnostic class called "neuroses; however, many clinicians consider the following diagnostic categories neuroses: anxiety disorder, somatoform disorder, dissociative disorder, sexual disorders, and disthymic disorders. The term neuroses encompass a broad range of disorders of various signs and symptoms. The author believes that the term is useful in contemporary psychiatry and should be retained.

One of the major classes of disorders is neurosis disorder; it results from the conflict between the ego and id, in contrast to the other major classes of psychoses, which result from conflict between the ego and the super ego. (T.H.)

Neurosis is reactions represented in the individual's unsuccessful compromise efforts to deal with underlying primitive needs. It has different types of disorders such as anxiety disorder, phobias, panic disorder, obsessive disorder and many others. But the important

thing is that biological and genetic factors are not thought to be of any major significance in the cause of these neurosis disorders. (K.H.)

They added that the neurosis disorder has a major symptom, that is anxiety, and the patient shows unsuccessful experience in controlling these symptoms by some mechanisms.
According to DSM-II, the principal characteristic of a neurosis is conscious or unconscious anxiety. There are no gross distortions of reality, nor is the personality significantly disorganised (Davison & Neale 1974, 52). Comer (1998, 139) argued that some of the most common disorders listed on the Axis I are anxiety and mood disorders. Anxiety is the predominant disturbance in this group of disorders. People with anxiety disorders may experience broad feeling of anxiety and worry (generalised as anxiety disorder). Anxiety concerning a specific situation or object (phobia), discrete periods of panic (panic disorder), persistent and recurrent thoughts or repetitive behaviours or both (obsessive-compulsive disorder), or lingering anxiety reactions to extraordinarily traumatic events (acute stress disorder and posttraumatic stress disorder).

Usually a neurosis includes disturbances in which there is felt or expressed anxiety as a major characteristic or in which the individual automatically or unconsciously attempts to control the anxiety by use of various ego-defence mechanisms. Generally, these mechanisms produce subjectively distressing symptoms from which the patient seeks relief. (N.H.)

Most of neurosis disorders are characterised chiefly by the symptomatic expression of anxiety. (T.H.)
Anxiety is regarded as central force in the dynamic of neurosis. (N.H.)

b Psycho-physiological disorders

Psycho-physiological disorders are a group of reactions combined with somatic symptoms. Some of the interviewed doctors defined this group of disorders as a physiological expression or reactions result from emotional factors and involving the organ and the nervous system of the body.

Davison & Neale (1974, 52) argued that the psycho-physiological disorders are characterised by physical symptoms produced in part by emotional factors. Also Kaplan & Sadock (1996, 34) noted that Axis III lists any physical disorder or general medical conditions that are present in addition to the mental disorder. The physical condition may be causative (for example, kidney failure causing delirium), the result of a mental disorder (for example, alcohol gastritis secondary to alcohol dependence), or unrelated to the mental disorder. When a medical condition is causative or causally related to a mental disorder, a mental disorder due to a general condition is listed on Axis I, and the general medical condition is listed on both Axis I and III. In DSM-IV's example - a case in which hypothyroidism is a direct cause of major depressive disorder - the designation on Axis I is mood disorder due to hypothyroidism with depressive features, and hypothyroidism is listed again on Axis III.

There is another group of disorders that is known as psycho-physiological illness. It represents physical symptoms with physiological expressions that usually accompany certain emotional states. (K.H.)

The other disorders, as a result from emotional factors and characterised by somatic symptoms, usually involve organ systems and nervous system. (T.H.)

They mentioned that the symptoms of these disorders could be as clear as a physical or physiological symptom result from emotional symptoms such as tears result from deep sorrow or sadness, diarrhoea results from anxiety, and when the reactions of these disorders continue for long time then all the body system will be effected.
Davison & Neale (1974, 52) argued that the various organ systems might be implicated. For example, the respiratory system may be debilitated by asthma, the cardiovascular system by high blood pressure, the gastrointestinal system by ulcers, the genitourinary system by impotency, and the skin by hives.

In psycho-physiological reactions the symptoms could be more physical from emotional causes. Look at it in a normal life, in some violent or deep sadness people express their emotion in tears, others when they had anxiety or were in a difficult state, they get diarrhoea. Such physiological expression of affection, when it continues over a long period of time may result in all the body. For example in some cases the expression of anxiety is seen to some degree in all humans. (N.H.)

These types of disorders can be manifested in the various bodily systems, such as skin, because a single organ and/or the nervous system are affected. (T.H.)

The psychological responses or reactions could be present in most of the illnesses, if the situation continues for long time, then the changes will be more intense and sustained. (K.H.)

c Personality disorders

Personality is the sum total of a person, internally and externally. The person in his or her life usually reflects different techniques to adjust with the people in life. If he or she cannot develop these techniques and fails to adjust with life and shows some patterns of maladjustment then it could be an indictor for personality disorders. Some of the interviewed doctors mentioned that personality disorder is maladjustment or defect happened in the personality structure and it's a non-psychotic disorder.

Davison & Neale (1974, 52) noted that personality disorders are defined as "deeply ingrained" maladaptive patterns of behaviour that are different from those observed in psychoses and neuroses. Comer (1998, 140) explained this type of disorders; he noted, " People with these disorders display an enduring, pervasive, inflexible and maladaptive pattern of inner experience and outward behaviour. People with anti-social personality disorders, for example, have a history of continuous and chronic disregard for and violation of the rights of the others. People with dependent personality disorder manifest submissive,

clinging behaviour, along with fear of separation; they have an excessive need to be taken care of".

*There is another group of disorders, non-psychotic, but it could be disorders in which the personality structure is defective and resulting in maladjustment symptoms that can be difficult to get rid of. (*K.H.)

As you know, a person has a unitary harmony or agreement self as a human being with basic personality, when he/she losses that sense and feelings then he/she falls in a dissociate problem. (T.H)

This group of personality disorders has different types such as dissociate disorders, paranoid personality disorders, and sexual disorders, and most of these disorders could be remarkable at adolescence age.

Such of these disorders could be dissociate problems that we realised with alcoholism, also a variety of stresses and personal or psychosocial factors such as marital, financial or occupational problems may predispose a person to the development of dissociate signs. Some other types of these disorders are paranoid personalities and people whose sexual interests are directed towards objects other than humans of the opposite sex; as we call it, sadism or homosexuality. There are some doctors who classify these disorders as different major categories, depending on causes of each group, as it could be a result of brain damage and dysfunction, but the main thing is that such disorders are usually manifested by lifelong patterns of behaviour and affect the personality structure, as it is often recognised in adolescence. (K.H.)

At this hospital, there are more than 20 cases with personality disorders; most of them are dissociate with the aggressive reaction occurring in childhood and adolescence. They are more stable and resistant to treatment than other patients with other personality disorders. (T.H.)

d Mental conditions due to brain damage or dysfunction

There are disorders caused by or resulting from destruction or damage of brain or neurosis system. Most doctors agreed that these disorders are resulting from diffuse impairment of brain function that caused by a damage, infection, disease, alcohol or drug, and often are manifested by impairment of orientation and intellectual functions.
Davison & Neale (1974, 51) defined the organic brain syndrome as one of the six major categories of the Diagnostic and Statistical Manual (DSM-II, 168). Impaired brain functioning that is attributed to tissue or structural lesion causes organic brain disorders. Many human capacities such as intelligence, memory, and the emotions may of course be affected by brain dysfunction.

Other groups of mental disorders are mental condition or organic brain syndrome that often are manifested by dysfunction of intellectual functions such as absence of concentration and comprehension, weakness of memory and orientation or malfunctions in

many abilities. These conditions result from organic damage or brain damage and dysfunction. (N.H.)

These are some mental disorders associated with weakness in the brain function, e.g., the mental disorders that result from brain damage and dysfunction and sometimes physical illness such as organic manic disorders, organic hallucination and delusion, and the personality disorders that result from brain damage or disease and dysfunction such as organic personality and behavioural disorders, also the organic syndrome, which results from alcohol or drugs. (T.H.)

Some doctors argued that some psychological and socio-cultural factors also play a role in presenting this group of disorders.

There are other factors, which play an active role in causing the abnormal behaviour with brain damage. Most of our students and colleges did not care of it, e.g., the characteristic manner by which the person copes with social stress and internal conflict, also the characteristics of his/her cultural background. These psychological, social and cultural factors could be associated with impairment of brain tissue function and help to bring the typical clinical picture of organic brain syndrome. (K.H.)

e Mental retardation

Mental retardation is a heterogeneous disorder that consists of below average intellectual functioning and impairment in adaptive skills. In the diagnostic manual (DSM-II), mental retardation is defined as subnormal intellectual functioning associated with impairment in learning, social adjustment, and maturation. The manual specifies that the impairment may be attributed to one of several factors such as infection gross brain diseases, chromosomal abnormality and environmental deprivation. The American Association of Mental Deficiency and the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM IV) define mental retardation as significantly sub average general in intellectual functioning resulting in or associated with concurrent impairments in adaptive behaviour and manifested during the developmental period, that is before the age of 18 years.

The interviewed doctors mentioned mental retardation as a class of mental disorders that is associated with weakness of learning maladjustment and lack of maturation result of dysfunction of intellectual functioning. Comer (1998, 139) argued that people with this disorder display significant sub-average intellectual functioning by 18 years of age and concurrent deficits or impairment in adaptive function.

Long time ago, I wrote that it is important to distinguish between mental retardation and brain syndrome, I thought at least because of the differences in causes and treatment, because at that time there is no distinction between them. But now in the current classification, mental retardation or disabilities, is a major class of mental disorders, usually associated with the weakness or lack of learning, social and psychological maladjustment and less of maturation. (K.H.)

This class of mental retardation has a different level that depends on the degree of the intellectual functioning. Kaplan & Sadock (1996, 481) mentioned that the degree or levels of the mental retardation are expressed in various terms. DSM-IV presents four types of mental retardation, reflecting the degree of the intellectual impairment: mild, moderate, severe and profound mental retardation.

The degree of disability, which could be mild, moderate, severe or profound mental retardation, depends mainly on the degree of symptoms and intellectual functioning. (K.H.)

f Other mental disorders

Some of the interviewed doctors mentioned that there are some other categories or classes of mental disorders that most of the psychologists and social workers have no knowledge about. Such disorders are manifested in the people in transient situations disturbances or patients with special syndromes.

Some of our psychologists and social workers at some time have no knowledge about the many classes of mental disorders, such as behavioural and emotional disorders usually occurring in childhood, adolescence and adult age, e.g., there are some people in their psychological development represent sharp feelings or reactions to an overwhelming environmental stress in an individual, without any evidence of mental disorders. Everybody can show these reactions at different stages of his/her development and according to these stages it classifies, e.g. adjustment reaction of childhood, adolescence, adult life or late life. (T.H.)

The way of diagnosis for patients with mental disorders is not easy for all workers in the field of psychiatry. Here at this department, there is a patient, first diagnosed as patient with brain syndrome, then with mental retardation and now after many more diagnoses, some of our group suggest that he has personality disorders, maladjustment and speech disturbance resulting from brain damage. But other diagnoses this case as a psychopathology disorder that is manifested by a special single symptom. Now we are waiting to see the result of the last diagnosis. (K.H.)

4.1.3.4 Summary

Classification is a procedure of categorising symptoms and characters in a common concept of one class of illness that has been clearly defined. The purposes of this procedure are to facilitate good diagnosis and to make generalisation of specific events or concepts for individuals. The interviewed doctors agreed that a comprehensive list of disorder categories with a description of the symptom characteristics and signs of each helps them to diagnose cases. When a patient displays his/her problem and course of symptoms, diagnosticians assign them to one category in that list.

Apparently, there is more than one way to classify mental disorders, and several classificatory systems meet the logical purpose of the classification. The question of the

usefulness or of which is the best classificatory system is still unresolved, but most of the psychiatric doctors agreed that the system of classification at least should be based on single criteria, which could be according to the symptoms, origin of illness or treatment aims. Some of the psychiatric doctors mentioned that the pure symptomatology classification offers little if any guidance in planning therapeutic and preventive strategies. Some others argued, the classification, which depends on the origin of mental disorders, could exclude other categories. And some doctors see the only possible way to be out of such complex situations of one criteria classification system is to base the classification system on a combination of several criteria. For example, classification system can be related the treatment goal to the relevant origin and prognostic factors. According to these classification system, they mentioned different classes of mental disorders that are: psycho-physiological disorders, personality disorders, mental conditions due to brain damage of dysfunction, mental retardation, patients with special syndromes, people in transient situations and with disturbances, and the neuroses disorders which are considered the major classes of mental disorders.

4.1.4 Assessment and diagnosis of mental disorders

The first step the clinician takes towards helping patients is to learn as much as possible about his/her disturbance. Who is he/she, what is his/her life like, and what precisely are his/her symptoms? This information is expected to throw light on the causes and the probable course of the patient's present malfunction and help the clinician decide what kinds of treatment strategies would be likely to help him/her. The treatment program could then be tailored to the patient's unique needs and his/her particular patterns of abnormal functioning.

4.1.4.1 Concept of clinical assessment and diagnosis

Assessment is simply the collection of relevant information about subjects (Comer 1998, 120). Most of the interviewed doctors defined assessment and diagnosis disorders as providing information about a person's history, present and past disturbance and observe what is wrong with him or her. To draw a broad picture about all situations this process could be through different formal ways.

Stricker and Trieweiler (1995), argued that if practitioners are to help people overcome their problems; they must have the fullest possible understanding of these people and know the nature and origins of their problems. Although they also apply general information in their work, they can determine its relevance only after they have thoroughly examined the person who has come for treatment. To formulate such a diagnosis, the psychiatrist must learn as much as possible about who the patient is in terms of genetic, temperamental, biological, developmental, social and psychological influences (See Kaplan & Sadock 1996, 11).

Assessment and diagnosis procedures are more or less formal ways of collecting information and finding out what is wrong with a person, what may have caused his/her problem, what are the present symptoms and what steps may be taken to help the person. (K.H.)

I can say diagnosis is drawing out information about some area of the patient's conditions and experience, and integrate this information to relevant clinical picture of specific disorders. (N.H.)

The diagnostic process in the medical field has two stages, the first is concerned with collecting a case's history, signs and symptoms that are interpreted in the second stage which is done by grouping all information and relating them to the relevant disorder. (T.H.)

4.1.4.2 Purpose of assessment and diagnosis of mental disorders

Assessment and diagnosis procedures play an important role in establishing a work treatment. The interviewed doctors mentioned that the purpose of assessment and diagnosis is to collect information about the patient to draw a clinical picture about the patient's disorders, and help the practitioners to implement an effective treatment; also it examines and evaluates the effect of treatment. Comer (1998, 120) argued, "Clinical assessment is used to determine how and why is a person behaving abnormally and how that person may be helped. It also allows clinicians to evaluate clients after having been in treatment for a while; to what progress they have been working and whether the treatment ought to be modified".

The systematic diagnosis contributes to establish the probable concept of a patient's disorder, as it predicts the patient's response to the treatment, and moreover it evaluates results of treatment. (K.H.)

I think the ideal of assessment or diagnostic is to identify a person's problem and classify his/her disorder, and of course optimise the choice of treatment. (N.H.)

With observation and investigation data we can make a good diagnosis, and generally apply what is known about this clinical picture, then predict the treatment processes that are more helpful. (T.H.)

4.1.4.3 Assessment and diagnosis techniques

Clinician's selection of specific assessment techniques and tools depends on their theoretical orientation. Psychodynamic clinicians, for example, use assessment methods that provide information about a person's personality and any unconscious conflict he or she may be experiencing (Bulter & Sadock, 1989). This kind of assessment is called a personality assessment; enable them to put the pieces together to achieve a clinical picture in accordance with the principles of their model. Behavioural and many cognitive

clinicians, in contrast, use assessment methods that provide detailed information about specific dysfunction behaviours and cognition (Haynes 1990; Kendell, 1990). The goal of this kind of assessment, called behavioural assessment, is to carry out a functional analysis of the person's behaviours – an analysis where the behaviours are learned and reinforced. Hundreds of assessment techniques and tools have been developed from all theoretical perspectives. They fall into three general categories: clinical interviews, test and observation. If these tools are to be highly useful, they must be standardised, and they must have reliability and validity. (Citation from Comer 1998, 120).

Some of the interviewed doctors mentioned that each clinician uses his or her own implicit rules to form a clinical picture, but most of them use to interview and test the patient's mental status.

Each one of us has a theoretical way to assess and diagnose patients, but the ideal diagnostic could be through interviewing and testing the mental condition of the patient. (N.H.)

a. Clinical interviews and mental status examination

The clinical interview was seen to be varying widely in format. Almost all the psychiatrists who have been interviewed use this assessment procedure. They define it as face-to-face meeting with a patient in order to know the patient's personal data, history of the present and the past illness, nature of previous adjustment, and moreover to observe signs, symptoms and realise other specific points in the patient's speech and act to evaluate his/her mental status.

Comer (1998, 121) stated, "Most of us feel instinctively that the best way to get to know people is to meet with them. In face-to-face interaction we can see other person's reactions to our question. We can observe as well as listen as they answer, watch them observing, and generally get a sense of how they are". The clinical interview is the same sort of face-to-face encounter (See Nietzet et al. 1994; Wiens, 1990). Kaplan & Sadock (1996, 1) defined the mental status examination as the part of the clinical assessment that describes the sum total of the examiner's observations and impressions of the psychiatric patient at the time of the interview. The mental status examination is the description of the patient's appearance, speech, actions, and thought during the interview. They argued that the psychiatrist must develop interviewing skills and techniques that most effectively allow the patient to describe the signs and the symptoms that were brought together, constitute the various syndromes that are potentially definable and treatable.

Interview with the patient is a successful way to diagnose the patient and assess his/her situation. It is a formal conversation between a patient and a psychiatrist. The psychiatrist may ask directly some questions and listen carefully to what the patient is experiencing and observe how the patient is acting and talking during this meeting. (T.H.)

The only way to know a patient and diagnose his/her problem is to meet with him/her face-to-face. In the medical field we call it clinical interview with patient. During this interview we can ask different questions that we think it will help to identify the patient's disorders.

We ask as much questions as possible to collect information about the patient's history, current life situations and relationships, present and previous problems, symptoms, and feelings, as we try to be conscious to observe much behaviour such as aggressiveness, fearfulness, mood, speech, dress and other personal characteristics that help to evaluate the patient's mental condition and complete the diagnosing process. (K.H.)

Some of those interviewed doctors gave some examples of the interview questions during the verbal conversation with the patient. It is usually an open-ended question that tries to encourage a free communication with the patient and whenever necessary tries to bring out a point. They added that there is no specific or structure question that the psychiatrist can deal with, but from their experience, every doctor can initiate some questions that give a clinical picture about the patient.

Every one of us has developed ways of asking questions with which we are comfortable and which seem to extract the information that will be maximum benefit to the patient. Some of these questions are where we are now, the name of the place, address and location, what is your name, are you married, can you tell me about your complaints, since how long, how do you feel now. At some cases we try to see the patient's reactions towards specific things or relationship, e.g., how did you feel about these? What was the reaction in case of others? And so on. (K.H.)

The first interview with a patient is usually based on collecting information about the patient's history and personal data, so normally there are constant questions that each clinician asks a patient such as what is your name, how old are you, are you married, did or do you have children, with whom did you come here, what is your problem, did you consult other clinicians or other healers before you came here? And other questions that we believe to highlight the general situation of a patient as well as create a good relation with him/her. (N.H.)

The patient's history and personal data can be obtained from different sources as well as from a patient himself/herself. The interviewed doctors mentioned that records of the patient's life that they get from patient's family allow them to understand who is the patient, where the patient has come from, what is the patient's character, and when the symptoms of his/her disorder started to be realised and how we can get through verbal conversation interview with one of the patient's family, relatives or one of those closest to the patient. They believe this interview is very important because it gives a clear picture about patient's history as it helps to evaluate the patient's conditions.
Kaplan & Sadock (1996, 3) argued, "Many times the history also includes information about the patient obtained from other sources, such as the parent or the spouse. Obtaining a comprehensive history from a patient and, if necessary, from informed source is essential to making a correct diagnosis and formulating a specific and effective treatment plan".

We use to make interviews also with one of the patient's family or that has good relationship with the patient. We ask him/her about some questions concerning patient's personal data, history of patient and his/her family, whether there is anyone who has the same problem, and how and when the patient's problem started. Such information from

other sources makes judgement to insure and support information that we get from the patient's own words, as it gives a clear clinical picture about patient's general situation. (N.H.)

Usually after the first interview with the patient, we plan to meet one of the patient's family or relatives before we make the second interview with the patient. We suggest that person who has good relationship with the patient and knows much information about the patient and family to tell us about the patient history, about the patient's earlier development until he/she grew up, about the patient's relationships with other people in the family and outside in school, work and with the neighbours. In general that person can tell us as much as possible information that we need to diagnose the patient's disorders and find a choice of the probable treatment. (K.H.)

b Clinical tests

Clinical tests are structured tests that are used by psychiatrists or other specialists at the medical field to assess and examine specific characters of a person, and that depends on the test type. Most of the interviewed doctors use different types of tests and checklists to measure a person's characteristics. They believe these clinical tests to be helpful in the diagnostic processes when they are used in combination with interviews and mental status examination, as you can measure different persons and compare their results.
Comer (1998, 125) noted that more than 500 clinical tests are currently used throughout the United States. Tests are devices for gathering information about a few aspects of a person's psychological functioning, from which broader information about that person can be inferred (Goldstein & Hersen, 1990). A test may reveal subtle information that might not become apparent during an interview or observation.

There is another reliable way of diagnosing mental disorders that is used to support the interview information. There are different structured tests and checklists, which measure a person's characteristics. These tests are based on the assumption that differences in the characteristics can be measured and compared between two or more persons. (N.H.)

There are some clinical tests, which are very helpful at a patient's diagnosis. These tests are different in the purpose, but most of them are guided by standard interview schedules, and for others you can score the response behaviour at intervals during the session. (T.H.)

Examples of such clinical tests are psychological intelligence tests (IQ test) and personality test. Most of the psychiatric doctors believe these tests need special skills and training from interviewers because each test has a prescribed procedure for the administration.

As I said, clinical tests have different purposes. For example, a personality test includes a wide range of questions about a person's behaviour, beliefs, and feelings, indicates the person's character and other psychological functioning. Such tests need special skills and qualified psychologists to apply them, although they have a prescribed procedure for the administration. (N.H.)

In the test of personality, the responses of a person could be a sign of underlying traits that may be realised during the first consultation with a patient, but the psychological measures of intelligence sometimes enter into certain diagnoses, namely mental retardation. Such tests consist of different tasks that require a person to use various verbal and non-verbal skills. The score that the person derived from this test indicates his/her mental age, which is known as intelligence quotient (IQ). (K.H.)

Some of those doctors face some problems with these clinical tests, such as there are no available tests for different purposes, and some tests which are available, are not provided with structures and standardised methods for all cases, or are not up-to-date, or they are not adapted to their culture, also sometimes the results are not reliable.

At this hospital, for a long time, we had many problems in the diagnosis area, especially with standard clinical tests. The check list and rating scale to diagnose some disorders or to test some traits, were not available and even when they were available either they were not provided with structures and standardised methods for all cases, or not adapted to our culture, e.g., Binet's intelligence test for children includes different tasks that are not acceptable in our society, such as eating with fork and knife or sitting on a modern toilet. These problems are time-consuming and it needs work from some researchers to change such tasks and adapt them to this society. (T.H.)

Most of our hospitals are facing a difficult problem, which is unreliability of the clinical interviews because of less experience of some psychologists and social workers in the field of clinical tests. When it's necessary, I prefer such tests to be used under full supervision of expert psychiatric doctors. (T.H.)

c Physical and neurological examination

For some tests the psychiatrists depend on other physicians to do them. The result of physical and neurological examinations helps the psychiatric doctors to determine the organic and physical or biological causes of mental disorders. Some of the interviewed doctors believe in the laboratory tests. Other medical assessments are also very helpful for diagnostic procedures. They believe also that such examinations differentiate organic and non-organic causes, as it is defined for the concurrent disease or disorder. Examples of these tests are tests for blood or urine, haemoglobin, thyroid function, brain X-rays, and patient's medical status.
Kaplan & Sadock (1996, 16) noted that with the continuing advances in biological psychiatry and neuropsychiatry, laboratory tests have become increasingly valuable, both to the clinical psychiatrist and to the biological researcher. In clinical psychiatry, laboratory tests can help rule out potentially underlying organic causes of psychiatric symptoms. They added that the complex interplay between somatic and psychiatric illness may require the psychiatrist to differentiate physical diseases that mimic psychiatric illness and vice versa. Also, the presenting symptoms of some physical illness may be psychiatric signs or symptoms. For example, a chief complaint of anxiety may be associated with mistral valve prolapsed, which is revealed by cardiac auscultation. Some psychiatrists contend that a complete medical check-up is essential for every patient.
Comer (1998, 133) mentioned that some problems in personality or behaviour are caused primarily by neurological damage in the brain or alterations in brain activity. Head injuries,

brain tumours, brain malfunctions, alcoholism, infections, and other disorders can all cause such organic impairment. If a psychological dysfunction is to be treated effectively, it is important to know whether it stems primarily from some physiological abnormality in the brain.

Normal physical and neurological examination is necessary and the most important part of general psychiatric diagnoses, especially when the clinician has feelings or suspicion of organic involvement. It concerns general medical assessment and specific laboratory tests; such as of blood, urine, and thyroid function, and brain X-rays. Most of the mental disorders have an organic origin or cause. For example, hypothyroidism can present depression symptoms as it causes hallucinations and delusions. (K.H.)

Some information that generated through medical investigation with the patient or one of his/her family help the diagnosis process, particularly when patient reports somatic symptoms (T.H.)

Some patients who are suffering from fever, migraine, hallucinations and delusions, or other physiological or somatic symptoms, we prefer them to make some laboratory examinations and medical tests that help to explain the causes of disorder. (N.H.)

4.1.4.4 Summary

Diagnosis has two processes; the first concerns assessment and collecting of relevant information about patient that are interpreted in the second process, which is done by grouping all information and relate them to the relevant disorder. The clinical assessment is used to draw a clinical picture about patient's disorder and integrate picture of the various factors that are causing and sustaining the patient's disturbed functioning. Also it allows clinicians to implement an effective treatment and evaluate the patient's progress after he/she has been in treatment for a while.

Each of the interviewed doctors uses his/her own techniques and ways to form a patient's clinical picture, all these techniques fall into three general categories that are clinical interviews, tests, and observation. Almost all interviewed doctors use to interview patients as part of the assessment process. It is considered to be a successful way to assess and diagnose cases. In addition to that, they follow specific strategies for observing patient's behaviour; also they plan to meet one member of the patient's family or a relative. They argued that interviewing and collecting information about patient's past and present history from other sources make judgement easier about the information that they get from the patient's own words, as it gives a clear picture about patient's general condition. Clinical testes are considered a reliable way of diagnosing mental disorders because most of these tests are guided by standard interview schedules and based on the assumption that differences in characteristics can be measured and compared between two or more person. In the area of clinical tests, most hospitals face different problems, such as there is no available test for different assessment's purposes, and those which are available either are not provided with the structure method for all cases or are not adapted to our Sudanese culture. Sometimes they face another problem, namely that the result of these tests are not

reliable for some practitioners unless the test is done under full supervision of a psychiatric doctor, because of less experience of some psychologists and social workers in the field of clinical tests. The other technique to assess and diagnose patient's condition is asking other physicians to do some medical examinations and laboratory tests such as blood and urine tests, test of haemoglobin, thyroid function, brain X-rays, and physical examination. They noted that such examination explained organic causes of psychiatric symptoms.

4.1.5 Treatment of mental disorders

Each particular problem requires specific techniques of management. There is now good evidence that treatment after various exposure methods yield improvement in mental disorders.

4.1.5.1 Concept and purpose of mental health

Although treatment for the mentally ill was improved in the past few decades, it is still hard to think that perhaps some of the psychiatric care offered today will be considered outdated. In Sudan as in many developing countries, mental illness is certainly one of the major health problems today. Most of the interviewed doctors agree about psychiatric care as the main goal for all processes of assessment and diagnoses that psychiatric teams work to achieve. This goal could offer a good prospect for patients for developing internal controls or preventing relapse by using different approaches of psychiatric care. Comer (1998, 146) noted, "Therapist began of course with assessment information. Knowing the nature, causes, and context of patient's problem, the clinician could make informed decisions about therapy. The therapist also took into account the diagnostic information and selected treatment techniques that are known to be helpful in the case of the patient.

Treatment in a psychiatric field is a method of management, it depends on a case diagnosis, and attempts to help the patient to be balanced and adjusted with him/herself and with other people around him or her. (N.H.)

Psychiatric care helps patients to cope with and overcome their psychological problems, as it prevents them to become ill again. Generally I can say treatment has largely been responsible for favourable outlook and prospects for patients through different techniques. (K.H.)

4.1.5.2 Techniques of psychiatric care

There are various techniques of and approaches to therapy used in the psychiatric field. These techniques depend on the type and the severity of disorders. Some of the interviewed doctors mentioned many techniques that are used to treat psychiatric patients and the effectiveness of each technique according to its concept and the nature or origin of its disorder. They have asked to what degree mental illness is biological or organic and to what degree it is psychosocial. They believe psychotherapies treat the psychosocial and

behavioural condition, while medications treat the biological aspects of psychological problems. People with different disorders may respond differently to the various therapeutic systems, formats, and settings (See Barlow, 1996; Zettle, Haflich & Reynolds, 1992). Gordon Paul, an influential clinical theorist, noted that the most appropriate question regarding the effectiveness of therapy may be: "What specific treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances? (Paul 1967, 111). Therefore researchers have investigated how effective particular therapies are at treating particular disorders. Kazdin (1994) and Beutler (1991) have often found sizable differences among the various therapies. Behavioural therapies, for example, appear to be the most effective of all in the treatment of phobia, whereas drug therapy is the single most effective treatment for schizophrenia.

The major issues in the psychiatric treatment relate to what is to be changed and how change can be brought about. The first question entails definition, origin, and nature of the problem for which the patient is seeking help; is it biological, organic, or psychosocial? The second pertains to the process and techniques by means of which change is effected. For example, psychotherapy has different approaches and most of these approaches play an effective role in treating neurotic problems. (K.H.)

Psychotherapy helps people with psychological problems to understand and modify their behaviour, while most of the medications help people with psychosomatic disorders to relieve the organic symptoms. But in some cases of people with depression, we need to use different techniques of treatment. (T.H.)

4.1.5.2.1 Psychotherapy

Psychotherapy is the treatment by psychological means for problems of an emotional nature. Most of the interviewed doctors mentioned psychotherapy as a common technique in the psychiatric field. They defined it as formal relationship between patient and psychotherapist designed to assist the patient in achieving various kinds of psychological problems. Davison & Neale (1974, 459) noted any psychotherapy is a set of procedures by which one person uses language to change the life of another; it is so-called "talking cures". The underlying assumption is that particular kinds of verbal interchange can achieve certain specific goals, such as reduction of anxiety or elimination of self-defeating or dangerous behaviour. Carson & Butcher (1992, 76) noted, "Psychotherapy often includes a kind of comfort and advice that we get from our friends, but it differs in that it involve a formal relationship and furthermore, business relationship. In addition, many forms of psychotherapy that aspire to the level of science are claimed to be used upon and aim to contribute to the accumulation of empirically variable laws of a goal undimmed of by our friends and relatives".

Most patients with psychosocial problems need psychological interventions by a therapist to assist them to go over these problems. (K.H.)

Psychotherapy is a common and the broadest term in psychiatric health. In general we use this term for any type of treatment based upon verbal or non-verbal communication with patients and it has a favourable effect especially with personality and behaviour change. (T.H.)

Psychotherapy has a positive effect in different cases. Most of our patients receive different techniques of psychotherapy, as for the treatment of some disorders; it depends only on these procedures by which one of us uses verbal communication to change belief, thought, behaviour, and the life of another. (N.H.)

The main issue in psychotherapy is related to what is to be changed. The interviewed doctors agreed that psychotherapy is applied to patients with emotional and behavioural problems, as it helps to treat various kinds of illness such as depression disorder, psychosomatic disorders, and antisocial personality disorders.

Kaplan & Sadock (1996, 193) argued that the primary treatment for anxiety disorder due to general medical condition is the treatment of underlying medical condition. If the patient has an alcohol or other substance use disorder, that disorder must also be therapeutically addressed to gain control of anxiety disorder symptoms. If the removal of the primary medical condition does not reverse the anxiety disorder symptoms, treatment of those symptoms should follow the treatment guidelines for the specific mental disorder. In general, psychotherapeutic techniques, anxiolytic agents, and serotonergic antidepressants have been the most effective treatment modalities.

The patients, who suffer from emotional and behavioural problems, usually seek help for their psychological problems and desire a change for the better in their feelings as in their behaviour. (N.H.)

Traditionally, psychoanalysis and psychotherapy have been used to treat depressive and antisocial people, also people who have multiple physical complaints. Most of those people respond and develop personal insights because they have good reality testing. (K.H.)

The second issue in psychotherapy relates to how these changes can be brought about. It concerns the techniques of psychotherapy and the main goal of each technique. The interviewed doctors mentioned different techniques of psychotherapy, but most of them agree about supportive psychotherapy, insight psychotherapy, group therapy, and family therapy, as the most available techniques and they use them to help and treat their patients as well as the patients' families. Despite the accumulation of evidence indicating that psychotherapeutic interventions are efficacious and effective for mental health problems, the provision of such treatment is faced with different major challenges (Howard, Moras, Brill,Martinovich, Lutz 1996, 1063).

- **Supportive psychotherapy**

Supportive psychotherapy is one way of psychoanalytic psychotherapy in which patient and therapist are usually in full view of each other. Some of the interviewed doctors mentioned supportive psychotherapy as one way of helping patients to express their emotion and talk freely without consciousness feelings. They believe this way of support reduces the anxiety

of some disorders as it relieves stress and fear. Through this psychotherapy, some patients may find a good solution to their problem.

Kaplan & Sadock (1996, 379) argued that supportive psychotherapy, called relationship-oriented therapy, offers the patients support by an authority figure during the period of illness, turmoil, or temporary decomposition. It has the goal of restoring and strengthening the defences and integrating capacities and dependence of a person who needs help in dealing with guilt, shame, and anxious dealing with the frustration or external pressures that are too great to handle. Supportive therapy uses a number of methods, either singly combination including: 1) warm, friendly, strong leadership, 2) gratification of dependence needs, 3) support in the development of legitimate independence, 4) help in development of pleasurable sublimation (for example, hobbies), 5) adequate rest and diversion, 6) removal of excessive external strain if possible, 7) hospitalisation when indicated, 8) medication to alleviate symptoms, and 9) guidance and advice in dealing with current issues. It uses the techniques that help the patient feel secure, accepted, protected, encouraged, and safe and not anxious. They added, the expression of emotion is an important part of supportive psychotherapy. The verbalisation of unexpressed strong emotion may bring considerable relief.

There are different ways of psychotherapy, based on good and reliable relationship between patient and one of our team workers. Generally we attempt to help the patient to express his/her emotion and feelings and remove his/her conflicts, but the expert physicians lead the patient to face his/her conflicts and resolve it in the light of adult reality. (T.H.)

Supportive psychotherapy aims to relieve patient's stress and reduce the anxiety symptoms. (T.H.)

Such therapy, including emotional supports, reassurance, and suggestions, is the most common treatment for the psychosocial factors that caused hysterical neurosis disorder and it is considered enough treatment to relieve mild phobic patients. (N.H.)

- **Insight-oriented psychotherapy**

Insight-oriented therapy is a psychological treatment approach that focuses on individual personality dynamics from a psychoanalytic perspective. Also it is called psychoanalytical oriented therapy or psychoanalysis. Some of the interviewed psychiatric doctors mentioned that the psychoanalytical oriented therapy is the most helpful treatment for serious neurosis cases. They believe it helps the person to understand his/her personality as the reasons behind his/her behaviour. It is gaining insight into repressed reasons, frees the person from the need to keep squandering his/her energies on repression and other defence mechanisms. Kaplan & Sadock (1996, 278-379) defined insight; it is patient's understanding of their psychological functioning and personalities. They argued that the clinician should specify the level of understanding or experience into which and by which way to achieve insight. In insight-oriented therapy (also expressive therapy and intensive psychoanalytic psychotherapy) the psychiatrist emphasises the value of new insight in current dynamics of patients' feelings, responses, being careful, especially in current relationships with other persons. Insight-oriented therapy is the treatment of choice for a patient that has adequate

ego and all strength but who, for one reason or another should not or cannot undergo psychoanalysis.

Another form of psychotherapy is insight-oriented therapy, which was developed by Freud and his immediate followers, but this therapy needs expert psychotherapists to help patients in doing an intensive deep procedure for uncovering repressed memories, thoughts, fears, conflicts that we suppose to be part of the problems in early development. Through this therapy we hope that patient can feel free of the anxieties that prompted the repression in the time before dealing with therapy. Also I can say another thing, namely that this type of psychotherapy helps everybody to cope with his/her personality. (K.H.)

Conceptually, insight-oriented therapy tries to help people to discover the true reasons why they have been behaving as they do. (K.H.)

Insight psychotherapy is usually necessary for the more serious neurosis patients. It develops the patient's awareness to his/her personality as it helps for deep understanding to his/her behaviour. Through this therapy, patients every time feel free from the load of threatening material and from the effort of keeping it out of consciousness. They can turn their energies to better personality integration and more effective living. (T.H.)

- **Group psychotherapy**

Group psychotherapy is a technique of treatment for a group of patients with psychotherapist, discussing their problems and learning from each other. Some of the interviewed doctors use this form of psychotherapy with their patients. They believe that it is a useful way to treat patient's fears, especially the fear of rejection and the anxiety of failure. The patient joins in a group therapy in addition to individual and other medication therapy. The important thing with this group therapy is that the therapist should consider the types of patients and the goal of the group therapy. Kaplan & Sadock (1996, 383-384) noted, "Group psychotherapy is a treatment in which carefully selected emotionally ill persons are placed into a group and guided by a trained therapist to help one another personality change. By using a variety of technical manoeuvres and theoretical constructs, the leader uses the group members' interactions to make that change".

Patients could get help and benefit from group therapy. We use to encourage them to participate at such sessions and meetings in which a group of patients with different symptoms, behaviours and from different classes meet with the therapist, we promote the interaction to develop patients oriented towards themselves through their interaction with the other group members in the therapist attendance. (N.H.)

Group therapy has been helpful, especially when used in conjunction with the individual psychotherapy and other medication for patients with fears, especially the fear of rejection and failure. It provides an opportunity for developing personal insights and awareness. Also it helps patients understand the effect that their sensitivity to rejection has on themselves and others. (K.H.)

Many approaches are used by the interviewed doctors in the group method of treatment, such as behavioural group therapy and insights group therapy. Each approach limits the size of its group, but at all types of group therapy the doctors think the group number should not be more than 10 heterogeneous patients. Kaplan & Sadock (1996, 385) argued that group therapy has been successful with at least 3 members and not more than 15; most therapists consider 8-10 members a normal size. With fewer members there may not be enough interaction unless the members are especially talkative. But with 10 members the interaction may be too great for the therapist to follow.

In our department, each psychotherapist has a group of patients and is used to follow interaction sessions with individual interviews with them. The patients' number in each group and also the time and the numbers of these meetings are different from one group to another, because each therapist has a goal that they want to achieve with his/her group, for example, my group composes of 10 patients, with different kinds of problems and it's considered the maximum size for group therapy. We use to meet every Thursday to help this group to understand their interpersonal functioning and cognitive manifestations of their low self-esteem and pessimism. (T.H.)

Other types of group therapy that are useful include insight group therapy which helps patient to express his/her emotions in a group of people, and gaining help from the therapist and other group members to the underlying deep psychological materials that concern his/her character. Also behaviour group therapy offers good opportunity for members of group to learn how to solve their problems, how to adjust in his/her life with their disorders and learn other behaviour from each other. (K.H)

- **Family psychotherapy**

Family therapy is a treatment based on the concept that the family is a system and every member of this system is presumed to play a role that affects other members. The interviewed doctors defined the family therapy as interaction between patient's family members, and aimed to reduce family anxiety and solve problems, which result from family resistance to accept their patient member with his/her disorder and cope with that situation.

Family system theory states that a family behaves as if it were a unit with a particular homeostasis of relating that is maintained regardless of how maladaptive it is. The goals of family theory are to recognise and acknowledge the often-covert pattern of maintaining balance within a family and to help the family understand the pattern's meaning and purpose. Family therapists generally believe that one member of the family has been labelled the identified patient. Family identifies that person as "the one who is the problem, is to blame, needs help". The family therapist's goal is to help the family understand that the identified patient's symptoms are, in fact, serving a crucial function in maintaining the family's homeostasis. The process of family therapy helps reveal a family's repetitious and ultimately predictable communication patterns that are sustaining and reflecting the identified patient's behaviour (Kaplan & Sadock 1996, 388).

The patient's family often has a difficult time accepting the fact that the person with illness cannot stop distressing behaviour, some of the family members may show their anger and discomfort of the patient's behaviour, which results in an increase of the symptoms and misbehaviours. In such situations, we approach the patient family by different ways, individual or group awareness and therapy to reduce the family anxiety and resolve conflicts within the house and all the family. (N.H.)

Family psychotherapy has been used effectively in the treatment of families' conflicts, especially conflicts and problems between parents as well as between parents and children. Kaplan & Sadock (1996, 388) noted that family therapy is well enough known, so that families with a high level of conflict may request it specifically. When the initial complaint is a bout on individual family members, however, pre-treatment work may be necessary.

Generally I can recommend family therapy for specific situations. For example, big problems between parents or parents and their children, or misunderstanding within family, but here we use it specifically with patient's families who had problems to understand the disorder of their patient and what symptoms and maladjustment he or she has to cope with. (T.H.)

4.1.5.2.2 Behaviour therapy

The roots of behavioural treatment reach back over the centuries. John Locke, three hundred years ago initiated the same principle of exposure, which is the essence of behavioural treatment today for reducing fears and rituals (Tennent 1980, 1). That these behavioural principles have been known so widely for so long indicates they are rooted in common sense, which is as old as the human species. What is new is that these common sense principles have been welded together in the past 20 years into a potent therapeutic technology which can relieve several formerly untreatable conditions and holds promise for further advances.

a. Concept of behaviour therapy

Behaviour therapy is the use of conditioning techniques in therapy, based on the principles of respondent and operand conditioning. According to the interviewed doctors, behaviour therapy is a technique of learning, focuses on removing specific symptoms or behaviour and developing needed competencies and adapter behaviour as it helps to modify environmental conditions that may reinforce and maintain maladaptive behaviours. Kaplan & Sadock (1996, 393) argued that behaviour therapists focus on overt behaviour, emphasising behaviour of overt symptoms, without regard for the patient's experiences of inner conflicts. Also Tennent (1980, 1) noted, "Behavioural psychotherapy is a form of treatment of increasing importance for relief of a wide variety of problems in adults and in children. This psychotherapeutic approach tends to deal directly with clinical problems rather than to solve postulated underlying conflicts. It has been claimed that behavioural methods are based on learning theory. So this is debatable as many of the major clinical advances in the field have been on a pragmatic basis".

The behaviourists' therapeutic intention is straightforward and concrete: the extinction of maladaptive habits and attitudes and the substitution of new ones. It is based on the principles of learning the particular, operand and classical conditioning.

Behaviour therapy has a long history in psychiatry and has successful effectiveness through experience. It is a practical technique directed towards changing or removing of the inappropriate behaviours, which are viewed as symptoms of some disorders, and upon learning new more effective patterns of behaviour. (N.H.)

Other methods in psychiatric treatment are based on learning theory. It uses to relieve several formerly untreatable symptoms and behaviours under specific conditions. (T.H.)

Some of those doctors believe these behavioural methods may have a contribution in helping patients to solve their life difficulties and offer relief of wide behaviour and problems, but doesn't look in the causes to solve the underlying conflicts and the disorder itself.

Behaviour psychotherapy is a form of treatment of increasing importance for the relief of a wide variety of problems, but the comments that we use to tell it to our students is that: this approach tends to deal directly with clinical problems rather than to solve postulated underlying conflicts. (K.H.)

When we decide to use one of the behavioural methods, we tell our patients that we are not treating them; rather, we are giving them a series of coping strategies to deal with their problems, which will have a tendency to return from time to time. (N.H.)

b. Behaviour therapy techniques

Behaviour therapy has different techniques. The interviewed doctors mentioned some of these techniques; a version therapy, flooding therapy, assertive therapy and cognitive behavioural therapy. They believe that they are most effective techniques to solve difficult problems.

- **Aversion therapy**

The concept of aversion therapy is based on using a stimulant that brings harmful excitement or sting after the present of behaviours that wants to treat them. Some of the interviewed doctors mentioned that aversion therapy as an old techniques of punishment, depends on using an aversive stimulus, such as electronic shocks, to make changes in undesirable behaviour. Kaplan & Sadock (1996, 394) noted, "When a noxious stimulus is presented immediately after specific behavioural response, theoretically the response is eventually inhibited and extinguished. Many types of noxious stimuli are used: electric shocks, substance that induces vomiting, corporal punishment, and social disapproval. The negative stimulus is paired with behaviour, which is thereby suppressed. The unwanted behaviour usually disappears after a series of such sequences".

Aversion approach is a common technique of behaviour therapy, involves modifying undesirable behaviour by the old fashioned method of punishment, and from my experience, I can recommend electric shocks as aversive stimulus, although some colleges are not happy with its result, but I say this method needs trained psychotherapists to apply it under specific conditions. (T.H.)

Some of the interviewed doctors have considered the aversion therapy as the most effective treatment model for different cases such as patients with antisocial behaviour, obsessive and compulsive behaviour, and patients with alcohol use disorders. Kaplan & Sadock (1996, 394) noted that aversion therapy has been used for alcohol abuse, paraphilias, and other behaviours with impulsive or compulsive qualities. Aversion therapy is controversial for many reasons. For example, punishment does not always lead to expected decrease in response and can sometimes be positively reinforcing.

Often I use aversive therapy to reduce the attraction of such behaviours like antisocial behaviour, overeating, excessive smoking or drinking, and other compulsive and obsessive behaviours. (N.H.)
In many studies of behaviour therapy, behaviour modification techniques are found to be successful treatment for the majority of obsessive and compulsive patients who complete the treatment. (T.H.)

- **Flooding therapy**

Flooding is based on the premise that escaping from an anxiety-provoking experience reinforces the anxiety through conditioning. Some of the interviewed doctors mentioned one approach of behaviour therapy, namely that by forcing patients to face the real situation, which caused him/her fear. They believe this approach helps many people who don't imagine scenes realistically and people who are highly traumatic, as they use to apply it for patients with specific phobias. Kaplan & Sadock (1996, 394) defined this technique as a flooding approach that helps to encourage the patient to confront the feared situation directly, without a gradual build-up as in systematic desensitisation or graded exposure. No relaxation experiences are used, as in systematic desensitisation. The patient experiences fear, which gradually subsides after a time. They added that the success of the procedure depends on patients' remaining in the fear- generating situation until they are calm and feeling a sense of mastery. Prematurely withdrawing from the situation or prematurely terminating the fantasised scene is equivalent to an escape, which reinforces both the conditioned anxiety and the avoidance behaviour, the opposite of what was intended.

Some patients need to place themselves in real life situations as opposed to a therapeutic setting. This flooding technique is one of the suitable behaviour treatments for those patients. It helps them to practice uncomfortable psychological processes, and after time they feel free from the anxiety and the fear that was caused only by their imagination. (N.H.)

Usually patients who suffer from mild phobias and patients who live in a high traumatic world without realistic scenes, we treat them by some drugs and other procedures such as facing fear or experience the real situation to reduce unrealistic fears. (T.H.)

- **Cognitive therapy**

Cognitive therapy is a type of behaviour therapy that focuses on patient's public behaviour and extends of this behaviour. Some interviewed doctors mentioned this therapy technique as a way of manipulation of thinking and reasoning processes of the patient by using verbal speech and having knowledge about occasions of these processes. Comer (1998, 397) defined cognitive behavioural therapy, as the term suggests, stems from both cognitive psychologies, with its emphasis on the effects of thoughts or behaviour, and behaviourism, with its rigorous methodology and performance-oriented focus. Kaplan & Sadock (1996, 379) defined cognitive therapy as short-term structure therapy that is used in collaboration between patient and therapist to achieve the therapeutic goals. It is oriented toward current problems and their resolution.

In earlier times, to treat some cases, we used to focus on the relationship between observable behaviours, symptoms, and observable reinforcing conditions. But, at the present time after the development of cognitive technique, most of our therapists focus on observable behaviour and occasionally covert behaviour to help patients to pay attention to their cognitive assumptions and to learn new ways and behaviours to cope with situations. (K.H.)

The cognitive approach has a wide effectiveness in different disorders. First it helps patient to be aware of his/her structuring and overt behaviours, and modifying the causes and hidden reasons of these behaviour. Second it helps patient to change maladaptive behaviours and to learn adjustable behaviours. (N.H.)

A person's character is based on thought, believes, and cognitions. In cognitive therapy, we try to handle and manage these interpersonal, cognitions processes by forcing patient to understand his or her interpersonal processes and find explanations to his/her problems and illness. When the internal and private events that are operand of the mind are changed, automatically outer behaviour will change. (T.H.)

4.1.5.2.3 Electro-convulsive therapy (ECT)

This type of therapy is often the treatment of choice; it depends on using electroshock to relieve some disorders. This type could be an important treatment in psychiatry. The majority of the interviewed doctors defined it as a symptomatic method based on electroshock that produce sudden shock to shorten the course of illness, it doesn't help to relieve illness' causes. They believe this type of treatment is quickest, surest, and safer than treatment with drugs and sometimes it is the only successful treatment that will relieve some disorders, such as depression. Kaplan & Sadock (1996, 466) noted, "Electro-convulsive therapy (ECT) is a safe and effective treatment of patients with major depressive disorder, manic episodes, and other serious mental disorders. Many clinicians

and researchers believe that ECT is grossly underused as a treatment. The major reason for the under use is hypothesised to be misconceptions and biases about ECT, at least partly fuelled by the widespread misinformation and inflammatory articles in the lay press. Because ECT requires the use of electricity and the production of a seizure, ECT understandably frightens many laypersons, patients, and patient's families".

In our psychiatric treatment, we use somatic therapy, which is known as ECT. It is a symptomatic method, which shortens the course of illness, but doesn't treat the causes of illness. It is based on electroshock applied to specific areas of head to produce sudden grand attack. ECT is sometimes the only treatment that relieves some disorders such as depression. (K.H.)

I can say, the sufficient electrical current is safer than drug treatment. It is a successful treatment, especially for depressive patients, because it is a quick and sure way of relieving distress. (T.H.)

Some of those psychiatric doctors mentioned that this type of electroshock treatment might cause some physical risk, such as breaking or dysfunction of the short-term memory for some days, but at an extremely low rate. To avoid these risks, they give patient some relaxant medication before applying the electroshock. Kaplan & Sadock (1996, 466) noted that many inaccurate reports have appeared in both professional and lay literature about alleged permanent brain damage resulting from ECT. Although those reports have been largely disproved, the spectre of ECT induced brain damage remains. The decision to suggest ECT to a patient, like all treatment recommendations, should be based on both treatment options available to the patient and risk-benefit considerations. The major alternatives to ECT are usually pharmacy-therapy and psychotherapy; both have their own risks and benefits. ECT has been shown to be a safe and effective treatment; clinicians should not allow their biases to deprive patients of this effective treatment.

Most people fear ECT, but from my experience, this type of treatment is very safe, when it is carried out under anaesthesia and with a muscle relaxant, because it helps to overcome some physical side effects. (T.H.)

Electroshock or ECT needs especial administration of medications, it is very important to use specific inject-able treatment with ECT to avoid some risks such as nervous breakdown or dysfunction of short-term memory for some days or even disorientation. (N.H.)

Electro-convulsive therapy has different types. The interviewed doctors mentioned three types, which depend on symptoms and severity of the illness. The most common types that they use to deal with them are electroshock therapy (EST), regressive electroshock therapy (REST), and the insulin coma therapy. They believe these types have evidence in treating most of the depressive and manic episodes cases.

There are three types of ECT that are considered as the chief ones of the somatic therapy and they have effectiveness in depression: electroshock treatment that is often used in responding or mild cases to shorten the duration of illness, regressive or, as we call it,

intensive electroshock, that we use for chronic cases, and insulin coma therapy that is used in severe chronic cases, but now it is no more or rarely that we deal with it in our psychiatric treatment. (K.H.)

The most well known type of electro-convulsive therapy is electroshock therapy. Although most of the patients and their families prefer being treated by drugs rather than by electroshock. Although it has strong evidence and a great value for both depressive and manic episode patients and also it is a basis to prevent relapses. (N.H.)

4.1.5.2.4 Drug therapy

Drug therapy for mental disorders is one of the effective treatments in the area of clinical medicine. It depends on selecting and prescribing; it is believed to be the appropriate treatment for specific disorders. Most of the interviewed doctors couldn't deny the effectiveness of drug therapy in most disorders. They mentioned that it has different types and each type has a certain efficacy in specific disorders, and one of the important things is that most of these drugs are available.

Ullman (2002) noted that psychiatrists tend to utilise medication to deal with the biological aspects of psychological problems and psychological therapies to treat the psychosocial condition. Their determination of what drugs are to be used for is based on their understanding of brain function. Nerve cells transmit messages by sending electrical impulses and chemicals called neurotransmitters to one another. This action triggers other nerve cells to fire messages or to inhibit this firing, depending on the frequency and intensity of the message transmitted and the sensitivity of the nerve cell's receptors.

It is not possible to dispute the efficacy of drug therapy in psychiatry. However, it is necessary to try to eliminate the one misconception that certain drugs are more effective for one disorder while other drugs are more effective for another. This is why every time, we ask patients not to shift from drug to another, and also a qualified practitioner in the psychiatric field must prescribe it. (K.H.)

Medications decrease the symptoms of different disorders. Every day we use to prescribe different drugs for different patients with different disorders. With the help of recent advances in biochemical pharmacology, it becomes possible to provide a rational basis for differences between these drugs. (N.H.)

Psychopharmacology includes different types of medications. Some of the interviewed doctors mentioned tranquillisers and antidepressants medication. They believe it has high evidence in treating depression, paranoid, and it decreases the anxiety in the neurotic patients. Ullman added that psychiatrists believe that severe depression results from a decrease in receptivity to certain neurotransmitters; thus medications are prescribed to increase this receptivity. Tricycles antidepressant medications, most commonly amitriptyline (Elavil) and imipramine (Tofrani) are thought to have this stimulating effect.

Each type of drugs produces different effects, which depend on the type and the severity of the disorder. For example, tranquillisers and antidepressants are helpful in reducing any associated anxiety in the neurotic patients. Sometimes in paranoid patients, the major tranquilliser, particularly the phenothiazines may favourably influence delusional maintenance. (N.H.)

From my experience, antidepressant medications for the psychiatric depression patients are usually very helpful to produce relaxation, and for anxiety that is frequently present in depression. (T.H.)

Also some of the interviewed doctors mentioned lithium. They use it to relapse depressions and treat psychotic excitement. Their comment is that this medication is not available. Kaplan & Sadock (1996, 442) argued that lithium has proved to be effective in both short-term treatment and prophylaxis of bipolar disorder in about 70 to 80 percent of patients. Both manic and depressive episodes respond to lithium treatment alone. Lithium should also be considered as a potential treatment in patients with severe cyclothymiac's disorder.

Also lithium carbonate has been used widely in some countries to treat psychotic excitements. It is also effective with people who have relapsing depressions because it helps to decrease the severity and the duration of depression, but it is one of the medications that are not available here. (T.H.)

Some of the interviewed doctors mentioned the importance of medication awareness. They believe awareness must be maintained throughout medications treatment, to inform patients and their families about side effects of some drugs, dosage, and period of time because most of the patients get big problems, because they know little about the medication that they are used to take.

Kaplan & Sadock (1996, 401) noted that the failure of specific drug trials should prompt the clinician to reconsider a number of possibilities. First, was the original diagnosis correct? This reconsideration should include the possibility of an undiagnosed cognitive disorder, including illicit drug abuse. Second, are the observed remaining symptoms the drug's adverse effects and not related to the original disease? Anti-psychotic drugs, for example, can produce akinesia, which resembles psychotic withdrawal: akathisia and neuroleptic malignant syndrome resemble increased psychotic agitation. Third, the drug administered in sufficient dosage for an appropriate period of time? Patients can have varying drug absorption and metabolic rates for the same drug, and plasma drug levels should be obtained to assess that variable. Fourth, did a pharmacokinetic or pharmacodynamic interaction with another drug the patient was taking reduce the efficacy of the psychotherapeutic drug? Fifth, did the patient take the drug as directed? Drug non-compliance is a common clinical problem. The reasons for drug non- compliance include complicated drug regimens (more than one drug in more than one daily dose), adverse side effects (especially, if unnoticed by the clinician), and poor patient education about the drug treatment plan.

Usually I use to write and to tell the drug's treatment plan to my patients, and I think most clinicians consider this information as a part of medication treatment, because many people have big problem in maintaining drugs, either they withdraw from treatment or switch to other drugs or they change the type of treatment that could be maintained by non specialist doctors. So it is very important to tell patients about drug dosage and the period of time that such drugs are to be used and about the side effects of some drugs. Also it is very important to make a follow-up with the patients. (K.H.)

Every day we face problems with the patients who use medications. Most of them haven't got an idea about the high risk of discontinuing the drug therapy. They don't know that if they miss one day of drugs, relapse will follow. They need to continue with medication indefinitely, perhaps with a lowered dosage, even after symptoms have subsided. I believe most of the people need awareness sessions about medication administration. (N.H.)

4.1.5.3 Summary

Finally I can conclude by saying that all the psychiatric doctors agreed that the aim of mental disorder treatment is to help the patient to adjust with his/her life. Most of them defined the concept of psychiatric treatment depending on the treatment purpose.

There are different approaches and various types of therapy that are used in psychiatry, but most of the psychiatric doctors mentioned four of these types, which are psychotherapy, electro-convulsive therapy, drug therapy and behaviour therapy. Each one of these therapies has a concept and different techniques or approaches; also it has specific treatment measures, which are effective and helpful on them. The aim of these approaches is to help the patient to solve all the problems, to find a proper way to adjust with life, and to relief patients from illness. There is no doubt that this area has been disappointing. Another area is the training and qualification of the therapist, which is the one of the important areas that affects the interest, motivation and the positively determined attitude of the patient for a successful treatment.

4.1.6. Collaboration with traditional healers

The issue of collaboration does not concern just traditional healing. Rather it addresses purposeful utilization of traditional healing by government authorities, or conscious collaboration with traditional healers by physicians and other "modern" health care workers. To devote oneself to the concept of modern medicine in a community that has had a radically different system of medical concepts is not an easy achievement.
Mburu (1977, 161) agreed that illness ideas are very much a function of the social condition of the people, their values, philosophy, attitude, and the conviction that such diseases can or cannot be treated or cured. Such collaboration in the realm of health care is important. It legitimises the past in the present of a person who has 'Here and Now wishes and needs'. Westermeyer (1977, 96) defined collaboration as a dynamic relationship that

involves not just traditional healers themselves, but also government officials with a responsibility for public health, professional health care workers and, - most importantly -, patients and the population at large.

4.1.6.1 Decision of collaboration

Most of the interviewed doctors agreed that this issue of collaboration involves not only the professional workers and the traditional healers in the field of mental health, but at first concerns the patients and their families who make the decision about whom to consult in health problems.

The issue of collaboration involves the professional workers and the traditional healers, and at first involves the patients and their families who make the decision when to consult whom in case of health problem. (K.H.)

I think neither the traditional healers nor the doctors have much actual influence over their mutual relationship as it comes into focus in the individual patient. (T.H.)

The patient and the family determine how they will be related to a healer and a doctor. (K.H.)

4.1.6.2 Importance of collaboration

There are different reasons leading this issue of collaboration to be a fact and people get many advantages of that. The medical approach of treatment is certainly welcome in the developed West. However, this medical approach has hardly yet been made available to all who need it in the underdeveloped countries. Therefore doctors in such countries should be welcome to any help. Singer (1977, 10) noted, "The acknowledgement, as a good clinician, that he should be prepared to accept any help he can get from any source, whether it be the shaman, psychoanalyst, or the pharmaceutical substance: so different doctors in the interview mentioned the importance of the collaboration with the traditional healers. The aim is to improve the health of individuals and the well-being of the society".

I think no one can deny the importance of the collaboration with some of the traditional healers, like Sufi or Quran healers, because the complex of the beliefs, customs and religions associated with health is one of the main traditions persisted with in Sudanese sub-culture. So the issue is not so much about traditional healers to be or not to be! But in sum the issue we must ask into is how can the health of the individual and the well-being of this society be improved by our efforts and, most important of all that, what do the inhabitants of this place want. (K.H.)

A result of other countries' experience proved the importance of collaboration between traditional healers and professional doctors in mental health field. It helps the patients and the practitioners at the same time. (T.H.)

Some of the interviewed doctors mentioned different reasons for the collaboration with the traditional healers such as keeping the patient to avoid the dilemma between two health systems and saving his/her money and time. Moreover, collaboration will give a chance to reduce the harmful practices by some healers.

I think it is very important to make official relation with traditional healers, whatever it could be, because the benefit of collaboration will come true for the patient and his/her family. Even poor families often spend a huge sum of money going from one traditional healer or doctor to another one looking for help, and often they waste their time until the patient becomes worse in health. (N.H.)

I am convinced that by collaboration with traditional healers, it would be possible to reduce the harmful practices such as chaining, deprivation or keeping patients away from medical care. (K.H.)

Some of the interviewed psychiatrists make the point that illness in some cultures and societies can only be understood within the context of the own social system and milieu, and that it is useless to try to apply only psychiatric diagnostic and medicine.

I agree that the forms of functional mental illness may be defined only with respect to the cultural forms of behaviour in the society, then we should also be prepared logically to accept the forms of traditional and folk healing as part of some social context, and be just as tolerant to them. (N.H.)

Some of those doctors believe that they should share the good techniques of healing with traditional healers, some of those techniques arouse the patient's hope, bolster patient's self esteem, stir the patient emotionally and strengthen his /her ties with a supportive group.

I think the apparent success of traditional healing techniques seems to lie in their ability to arouse the patient's hope, bolster his self-esteem, stir him emotionally and strengthen his ties with a supportive group, and I think we as doctors in psychiatric field need to share these methods with some of the traditional healers. (K.H.)

4.1.6.3 Collaboration prospects

The interviewed doctors mentioned two ways that collaboration with traditional healers could be initiated. Either in a referral system or in joined clinics. Some of those doctors had already past experience in these ways of relationship with some healers and evaluate this experience as useful. They believe the success of the treatment depends on how the patient thinks about his/her sickness.

I think the issue of collaboration could be tested first by agreement between both practitioners to refer the patient to each other, particularly a patient who has a problem and this problem needs the other partner to interfere with it. One should take in

consideration that the place to which the patient comes should be an easily available and near source of health care. Myself I used to refer some of my patients to sheikhs and at the same time I used to receive patients from some healers. I believe that some of those healers do fairly well with self. In limited cases, but not so much with major, chronic disorders, the success of the treatment depends to some extent on the patient; mainly how he/she thinks about his/her sickness. (T.H.)

I had two years' experience at Um Dawanban Hospital. This hospital is the only joined clinic between psychiatric medicine and Sufi healing. Due to my experience, I can say there is no problem in doing my job as a doctor while the sheikh is doing his part job as a religious healer. Every day I use to go to the sheikh, we sit and eat together and at the same time we discuss problems of different cases that he referred to me in that way. Together we did good work, which helps many patients to recover in a short time. Until this time I have had a good relationship with the sheikh and all the people at that village. (K.H.)

I can say all my experience with the healers has not been subjected to scientific evaluation, mainly due to the mobility of the patients between sheikh centres and our hospital, which makes it difficult to identify the impact of the different treatments. But the general observation indicates that most of the cases have quickly recovered. (N.H.)

Some of the interviewed doctors have some reasons against the issue of collaboration; they mentioned that the function of traditional healing could be only within the healers group and the secret of the traditional healing always is kept secret by healers.

I believe those healers can function only within our ethnic group, because the conceptual basis for healers' practice is taken over by their cultural peers, and their knowledge and origin of possessing powers and powers to heal are usually kept secret. (N.H.)

Other interviewed doctors think that collaboration with traditional healers may add value to the effectiveness of healers and attracts patients and their families to this health system. Moreover, it supports magical thinking in the field of health and illness.

I can't agree to refer one of my patients to seek help of any one of traditional healers, because this will simply add value to the effectiveness of healers and drive patients and their families to these types of healing. But if the patient believes in one healer and he uses to consult him/her I will not be against that. (N.H.)

I haven't any experience, and I do not know anything about the effect of collaboration on patient's behaviour, but I can imagine this collaboration may enhance the confidence of the patient and his/her family in the healers and support magical thinking. (T.H.)

4.1.6.4 Summary

It is primarily the patients and their families who make the choice as regards whom to consult in the event of health problems. Most of the professional doctors who had past experience in relationship with healers agree to the collaboration for the patient's benefit. They suggest some forms that this issue of collaboration could be in a reality practised. These are referral systems or joined clinics. Other doctors could not identify the value of collaboration with the traditional healers because they haven't got any chance of contact with those healers. They believe that any ways of collaboration with the traditional healers may add value to those healers and drive patients and their families to this type of healing and this supports magical thinking in the field of mental health.

Doctor-Healer Interaction
Results

4.2 Mental Disorders: The Traditional Healers' Perspective

Introduction

This second part presents the results of the other practitioners in the field of mental health care, namely the traditional healers in Sudan. General description of the sampled healers characteristics are identified, such as sex, age, religion, education, duration of experience, and marital status. Note that this study includes only three types of healers who deal with three different methods of healing. Attention in this part was also paid to generate information about five categories concerning traditional healing in Sudan: aetiology and causes of mental disorders, ways of classification, process of diagnosis, methods of healing, and opinion about collaboration with the other practitioners.

4.2.1 Characteristic of the sampled traditional healers

The main features of the traditional healers sampled are presented in the following table (see Table 4.2). The average age of the sample was 53.7 years.

Table 4.2: Characteristics of the sampled traditional healers

Sex	Age (years)	Level of education	Marital status	Healing methods	Duration of experience	Religion
Male	77	Khalwa	Married	Sufi	50 years	Muslim
Male	75	Khalwa	Married	Sufi	42 years	Muslim
Male	55	University Graduate	Married	Sufi	29 years	Muslim
Male	47	University Graduate	Married	Sufi	2 months	Muslim
Male	25	Secondary school	Single	Quran	10 years	Muslim
Male	32	Secondary school	Married	Quran	7 years	Muslim
Female	62	Illiterate	Married	Zar	39 years	Muslim
Female	57	Illiterate	Married	Zar	18 years	Muslim

Four of the traditional healers are Sufi healers (S.H.), two are *Quran* healers (Q.H.) and the other two are *Zar* healers (Z.H.). All the eight traditional healers are Muslims, six of them are male and almost all of them are married, except for one who is single. Two of the healers had a high educational level (university), two had a secondary school education level, and four were illiterate. Out of the latter group two were shown to be *Khalwa*[*] (*Quran* school). The average experience of the sampled traditional healers is 24.4 years in the field of traditional healing.

4.2.2 Aetiology and causes of mental disorders

Theories about mental illness are part of wider concepts about the origin of misfortune in general. They are based on beliefs about the structure and function of the body, and the way in which they can malfunction. (Helman 1986, 11). Each culture provides its members with ways of shaping their suffering into recognisable ”illness entity” and of explaining its causes in some concepts which could be acceptable to this society.

4.2.2.1 Theories of mental disorders

There are four theories mentioned by the interviewed healers (*Quran*, *Sufi*, and *Zar* healers), identifying the aetiology and causes of mental and/or physical illness. These theories include the body humours, misfortune, illness of the soul and loss of the soul.

a. Concept of body humours

A first theory about mental disturbances is based on the concept that there is a lack of harmony among the various body components. To all members of all societies, the human body is more than just a physical organism, fluctuating between health and illness; it is also the focus of a set of beliefs about its social and psychological significance, its structure and function (Helman 1986, 7).
The most widespread concept of the human body in mental health is the humour theory, which was elaborated into a system of medicine by Hippocrate. In the Hippocratic theory, the body contained four humours: blood, phlegm, yellow bile and black bile. Health resulted from these four humours being in optimal proportion to one another, and not showing an excess or deficiency of one of them.

I can explain the illness as imbalance of the body, because everyone's body contains four liquids that are blood, phlegm, yellow bile and black bile, any deficiency of one of them will lead to this imbalance. (S.H.)

An insane is a person who has bad temper because he has something wrong in one of his body humours. (Q.H.)

[*] Khalwa is a religious school where people can recite the holy Quran and not necessary learn how to read or to write.

Client comes here asking for help because he is feeling weakness or something wrong with his body, that means there were a lack of harmony among his various body components (Q.H.)

Those healers mentioned the nature of body humours, which depend on four elements. Langleys (1977, 31) stated, "These humours correspond to four elements: (1) air, being hot and moist in nature, (2) water, being cold and moist in nature, (3) fire, being hot and dry in nature, (4) earth, being cold and dry in nature. Hot and cold here do not pertain to actual temperature, but to a symbolic power contained in most substances including food, herbs, and medicine".

Every body in his nature has four humours which correspond to four elements: (1) air (2) water, fire and earth. These elements are grouped in a binary fashion into hot or cold categories. The health of the body can only be maintained or lost by the effect of heat or cold on the body. (S.H.)

As noted above, healthy working of the body is thought to depend on the harmonious balance between two or more elements within the body. But to a lesser or greater extent, this balance is dependent on external forces such as diet, environment or other climatic factors.

Lay theory of health and illness relates the inner working of the body to outside influences such as over-exposure to sun or fire, or ingesting food or beverages (Greenwood 1981, 13) Traditional healers agreed about the natural world aspects that cause ill health. This perspective includes aspects of the natural environment, both living and inanimate environment. Common in this group are climatic factors such as excess cold or heat. Traditional healers would also include here the supposed influences on the health of food, and birth signs. The last influences can also be seen as a form of hereditary proneness to health or illness.

Diet and environment could effect this balance, as could the season of the year and birth signs. (S.H.)

Factors that affected the body's humours are mainly related to diet and climatic factors. (Q.H.)

Restoring the balance of the body's humours and eliminating the effect of the influence of some factors, achieves healing and finishes illness. (S.H.)

b. Concept of misfortune

A second theory is based on the concept that mental disorders are not a form of disease but a possession, which result from misfortune, or supernatural possession. In many non-Western societies health is conceived of as a balanced relationship between man and man,

man and nature, and man and the supernatural world. A disturbance of any of these may manifest itself by physical or emotional symptoms (Helman, 1986, 69).

This form of mental disturbance is called madness and it is often caused by the possession of supernatural power or misfortune of the person. (S.H.)

Powerful possessing of spirits or magic controls all types of madness. (Q.H.)

Healers believe on the social world causes, which are blaming other people for one's ill health, it is considered as a common or mainly causes of mental illness in traditional healing. To some extent healers differ to identify which power possessed the person and caused these disturbances. Some healers believe that these disturbances are a result from supernatural possession. These supernatural possessions or powers could be witchcraft, sorcery, evil spirits, or evil eye that is also called ayn spirit*.

The invading of supernatural forces such as witchcraft, evil eye, or evil spirits causes most illnesses. (S.H.)

The commonest forms that caused mental states disturbances are sorcery, witchcraft, and the ayn. In all three and other forms, spirit is ascribed to interpersonal malevolence, whether conscious or unconscious. (S.H.)

I used to heal different illnesses, especially those caused by the influence and attacked by zar spirit or ayn spirit. (Z.H.).

As noted above, healers believe that the supernatural forces invariably possess insane people. Each one of these supernatural powers has its way to cause the mental disturbance. Concerning witchcraft, there are certain people who are believed to possess a mystical power to harm others. This power exists within the individual and is exerted unconsciously. Behaviour of the witch is usually different from his common way and turns a way from a rule or society's customs.

Most of the supernatural illnesses are caused by witchcraft, the witch is usually different from other people, either in appearance or in behaviour, often they are ugly, disabled or socially isolated, also they are usually the deviants or outcasts of a society, on whom all the negative, frightening aspects of the society are projected. (S.H.)

In witchcraft, the power is usually an intrinsic one, and is inherited, either genetically or by membership of a particular kinship group. (S.H)

Sorcery, as defined by some healers, is the power to control and make some change in the client's behaviour with the help of magic or evil spirits. A friend, family, or neighbours for the reason of jealousy or disappointment usually practise the sorcery possession. Helman (1986, 67) defined sorcery as the power that manipulates and alters natural and supernatural events with the proper magical knowledge and performance of some rituals.

The sorcery exerts his or her power consciously, usually for the reasons of jealous or disappointment. (Q.H.)

Sorcery possessing is often practised among one's social group of people such as friends, family, or neighbours and often based on envy for reasons of jealousy. (S.H.)

Most of the illnesses were ascribed to sorcery included a range of gastro-intestinal conditions as well as a general change and usually happened in groups, whose living conditions are characterised by insecurity or a feeling of powerlessness.

Sorcery was used to control the behaviour of others, sometimes a wife, when feeling insecure, coming and asking for using spells to prevent her husband leaving her. (S.H.)

In some cases, people feel powerlessness to help themselves, and then they turn to the sorcery power to achieve what they want, such as weight loss or sex power. (S.H.)

Many healers have reported the evil eye in the Arabic words ayn[*] as aetiology and causes of some illness. According to Wetherhead (1968, 105), this bad look is found in the Middle East among all communities there, whether Islamic, Jewish, Christian or Zoroastrian. He defines the main features of the evil eye as related to the fear of envy in the eye of the beholder, and that its influence is avoided if counteracted by means of devices calculated to distract its attention, and by practices of sympathetic magic. Some healers believes that the possessor of the evil eye, most of the time he didn't a ware about his or her ability to cause some disturbance or illness to other people.

The possessor of ayn usually harms unintentionally, and is often unaware of his power and is unable to control it. (S.H.)

Ayn of some people has hard attack to cause several illness and life disturbance to others. (Z.H.)

c. Concept of soul illness

A third theory of mental disorders sees illness and any disturbances as a personal fate, and is ascribed to the direct action of supernatural entities, such as God punishment or bad luck. Both cases cause the soul illness. Some healers see the origin of these soul illnesses as lying outside their control, they think that people take responsibility for their health because these illnesses might be caused by two types of supernatural power, either good spirit (religious spirit) or bad luck or fate (irreligious spirit). In the first case the symptoms of the soul illness are all the time associated with religious behaviour, while concerning fate or bad luck, the symptoms are associated with non-religious behaviour.

[*] Ayn means bad look or evil eye.

Different types of spirits, good spirits associated with mystical and religious function, and fate or bad spirits associated with excitement and irreligious behaviour usually cause the soul illness. (Q.H.)

The power of the religious spirits comes as a punishment from God for past sins, but the power of bad spirits comes as a fate or sometimes as a possessing by zar or evil spirits. (Z.H.)

All healers agreed that these religious spirits possess a person if he/she breaks the religious rules or does something against the Islamic religion, such as not care about prayers or God's blessing. This type of illness is considered as a punishment from God for what person did wrong.

Possess by religious spirits usually occurs when the person breaks the religious taboos or does any things that are forbidden by the Muslims' rules. (Q.H.)

I can describe the soul illness as a reminder from God for some behavioural laps, such as neglecting to go to Mosque regularly, not saying one's prayers, not thanking God for daily blessing, or doing other behaviours which are not acceptable to custom or religion. (Q.H.)

Soul illness is a whipping and God's punishment for sinful behaviour. (S.H.)

d. Concept of loss of one's soul

A fourth theory of mental disorders defines illness as a soul loss. Weatherhead (1968, 74) noted that an individual is composed of physical body and one or more immaterial souls or spirits that under some circumstances may become detached from the body and wander freely. Quran and zar healers ascribe illness to capricious, magic, jinn, or zar spirit. These spirits are causing a variety of symptoms for their victims, which are called soul loss or zar illness. Their invasion is unrelated to the individual behaviour, and therefore considered blameless and worthy of sympathetic help from others.

Soul loss could be caused by the power of the magic or zar spirits. These spirits reveal their identity by particular symptoms and can only be treated by spiritual or zar ceremony. (Z.H.)

Insane people are invariably possessed by magic or jinn which enforce themselves into the body and make the afflicted go mad against their will (Q.H.)

There are different forms of spirits, which cause the soul loss, but a common form is the magic, which can cause ill health. (Q.H.)

4.2.2.2 Summary

Most of the traditional healers agreed that mental disorders are not a form of disease but a possession by supernatural powers, but they differ about how to identify which spirits or supernatural forces possess the person and cause the disturbances.
Sufi healers believe that the abnormal behaviours come as a result of an imbalance of the body humours (blood, phlegm, yellow bile, and the black bile), which are affected by outside factors such as diet, environmental or climatic factors, also they have the same belief or concept of *zar* healers about the abnormal behaviours, both of them agree that these disturbances result from supernatural possession. These supernatural forces or powers could be witchcraft, sorcery, evil spirits, or evil eye (*ayn*). While the *Quran* healers believe these disturbances are soul illness or loss of soul, which is caused by spirits when the person breaks the religious taboos or does whatever is forbidden by the religion, custom or rules. Those healers believe in different types of spirits and they can differentiate between them according to the form of the patient's behaviour. They believe that good spirits are associated with mystical and religious behaviour, which comes as a result of punishment by God for past sins or as power of religious spirits. While the evil spirits that associated with witchcraft, sorcerers, or evil eye usually causes excitement and irreligious behaviour.

4.2.3 Classification of mental disorders "Folk illnesses"

Mental disorders can be assigned to different classes and each of them has specific signs and/or behavioural damages recognised by the members of a cultural group and they conform to standardised ways. In Sudanese culture these disorders are known as folk illness. It is divided into three classes; most of the people who believe in this, seek help from traditional healers.

For the majority of illnesses there is some interplay of voluntary and involuntary responses in the expression of illness. The interviewed healers argued that both the presentation of illness and the others' response to it are largely determined by socio-cultural factors. Littlewood & Lipsedge (1982, 210) point out that where the mentally ill person comes from a cultural or ethnic minority they often have to utilise the symbols of the dominant majority culture in order to articulate their psychological distress and obtain help. Helman (1986, 73) argued that each culture has its own "language distress" which bridges the gap between the subjective experiences of impaired well-being and the social knowledge of them. That means cultural factors determine which symptoms or signs are perceived of as "abnormal", they also help shape these diffuse emotional and physical symptoms into a pattern which is recognisable to both sides, the sufferer and those around him.

The client has some control of the way in which he shows his illness and what he believes and says about it. (S.H.)

These resultant patterns of symptoms and sign may be termed an "illness entity". It represents the first stage of becoming ill. The interviewed healers term this illness as "folk illness" and it's well known to their group members. Rubel (1977, 119) defined folk illness

as syndromes from which members of a particular group claim to suffer and for which their culture provides aetiology, diagnosis, preventive measure and requiems of healing.

There are different types of folk illness; each of them is a unique disorder, recognized mainly by the members of our society and religion. (S.H.)

These healers have special classifications defined for this folk illness, because their healing is related to the type of illness. Broadly speaking, there are three classifications of the folk illness, each class with its own unique configuration of symptoms, signs and behavioural changes acknowledged by the cultural group members and conforming in a standardised way.

As Sufi healers, we have different classes of illness but generally there are two types of possession. The possession by Elrrih Elaswad[*] is known as jinn, and the possession by Elrrih Elahmar[*] is known as zar. (S.H.)

There are many classes and types of supernatural illness, but here I use to heal the patients who are suffering from zar sickness. (Z.H.)

Some of the interviewed healers mentioned that folk illnesses are more than a specific clustering of symptoms and physical signs. They also have a range of symbolic meanings, moral, social or psychological ones, for the patient as well as for people around him. In some cases they link the suffering of the individual to changes in the work of supernatural forces. Rubel (1977, 125) mentioned that symptoms regularly cohere in any specified population, and members of that population respond to such manifestations in a similarly patterned way.

When a patient comes and presents his pain and illness, we can differentiate between different illnesses according to his complaint. For example most of such illness as segregation, illusion and hallucination, called magical fright, which is caused by supernatural power, but each of these illnesses have a range of symbolic meaning for the patient as well as for people around him. (S.H.)

These classes are primarily a self-labelled folk illness which expresses a wide range of physical, psychological and social problems at the same time, the label "jinn" or "*zar*" or "magical fright" is an image which builds up a network of symbols, situations, motives, feeling and stress which are rooted in the structural setting in which the people of Sudan live.

The basic presentation of this illness however is in the form of common physical symptoms associated with psychological ones. (S.H.)

[*] Elrrih Elaswad means the black wind and usually concerns the people who are possessed by jinn spirit.
[*] Elrrih Elahmar means the red wind and usually concerns the people who are possessed by zar spirit.

4.2.3.1 Class of Jinn illness

All interviewed healers have the same concept of Jinn and its aetiology. Specific symptoms and signs such as the patient's awareness identify this class of Jinn. Those healers, in their own general practice, think it is easy to recognise how a patient's mind or his mental conditions and social circumstances are related, because the social circumstances are visible. So those healers believe that if a person looses his mind and becomes unaware of his/her self and his /her surrounding that means he/she has Jinn or is under the spell of jinn, and they call the person who is in these situations and has these signs *magnoun*[*] or *mighoub*[*].

We say a client had Jinn when he becomes mighoub and is unaware of himself or his surrounds. (S.H.)

Jinn illnesses identify a mad person or one who looses his mind and becomes mighoub. (S.H.)

4.2.3.2 Class of Elrrih Elahmar illness (Zar)

Most of the traditional healers who share the same belief about this class of illness and the same belief about the origin and causes share the basic cultural values and worldview of the communities in which they live. Most of this class are women, they believe in this class of *elrrih elahmar* illness, which is called "*zar*". It is an old folk practice, which presents the problems of the poor people, explains women's conflicts. It's known as Zar illness that is caused by Zar spirit power or evil eye. *Many healers mentioned elrrih elahmar*; particularly for the Zar healers in most cases it is associated with women or individuals in the lower socio-economic class. As Helman (1986, 78) put it, blaming other people for one's ill-health is a common feature of smaller-scale societies where inter-personal conflicts are frequent. In Sudan there is a common belief that there are two types of spirits; jinn and *zar* spirit. The former causes in a person to become mad with symptoms of mental and moral deterioration. Only the *faki* or *sheikh* can create this type of illness and it is believed to cause anxiety, emotional instability accompanied by somatic symptoms. The latter illness was considered to be treatable only by *zar* healers.
Daoud (1982) noted, "*Zar* is an old folk practice particularly in the northern Sudan, the eastern and central parts of Sudan, but rare in the remaining parts. Although some men practice Zar, it is strikingly a feminine practice that explains women's problems".

In most cases this zar illness is related to the women who have social problems and most of those patients complain of an uncomfortable life. (Z.H)

[*] Magnoun means mad.
[*] Mighoub is referred to mad persons, and it means the person who lost his mind and run against his well-being.

- **Concept of Zar**

The concept of *zar* healing is based on the assumption that supernatural agents or spirits possess a person and cause him or her some physical and psychological disorders such as dizziness, headaches, weight loss, bleeding problems, and sexual problems. Basically to this concept of possession is the idea that these spirits dictate certain demands that should be fulfilled by the patient and his/her relatives; otherwise these spirits may cause trouble for all. *Zar* healers defined *Elrrih Elahmar* which is a class of spirits, the power of this spirits possess some people by causing discomfort to life and use them to claim certain demands as *zar* ceremony so as to get rid of daily life stress. Al Nagar (1987, 9) defined *Elrrih Elahmar* as a cultural grouping of psychological disorders for all kinds of distress, which is accompanied with physical symptoms and signs. While Elguhary (1981, 31) referred to *zar* as a celebration that is based on special beliefs, which aim to satisfy and appease spirits through ceremonial sacrifices.

The person who had zar expresses his sickness in a way that the community understand his complaint. He often complains of a variety of generalized weaknesses, which are adjustable to physical complaint symptoms. (S.H.)

Mostly this illness is related to women. They complain of discomfort, pains, headaches and weight loss; in the case of married women, they complain also of bleeding, fever and sexual problems. (Z.H.)

Most of the *zar* healers consider *zar* as involving persons with depression disorders. They believe that the psychological and physical symptoms, which are attributed to the possession, may be more specific. This is a feature of the clinical presentation of depression, where depressed patients complain of specific and often changeable physical symptoms. Constandis (1972, 13) noted that *zar* is essentially cults of *bori* healing. *Zar* and *bori* involve ritual systems designed to cure or alleviate the symptoms of these sufferings from illness or misfortune and it believed to have been caused by invasive spirits. These spirits are frequently given names based on the spirits or devils, thus spirits of *husa bori* cult are called Jinn. In Egypt, Sudan, Ethiopia, Saudi Arabia, the Arabic golf states, Iran and Turkey both the category of spirits and the cult of healing are called *zar.*

It is interesting here to note that psychiatrists in Sudan regard *zar* as a cult which helps patients with hysteria or depression and other disorders.
Baashar (1984) connected the name of *zar* with the concept of supernatural power and healing cult, he noted that Walter Btawden also historically mentioned the healing cult in 1943 referring to *zar* as a healing cult, which really helps certain group of patients, particularly those with hysteria reaction, depression and anxiety states. For these, *zar* provides an appreciable alleviation of symptoms.
Bassher (1984) concluded that *zar* patients use the zar ceremony to compensate for their personality conflicts and frustrations. Also there is some scientific research into *zar*, giving mainly a descriptive orientation about *zar;* however in sociology, the study of Elmasri (1984, 17) has shown a different orientation, she defined *zar* as hysterical reaction which is used unconsciously by patients to obtain non-obtainable demands.

Most of our patients possessed by zar, often appear to be depressed but they deny this feeling. When we open the box it becomes clear that they have personal problems. (Z.H.)

Zar spirit usually causes weakness and depression, possessed people express their sickness in a way that the family understand their complaints and they become slaves to the spirit's complaints, till they perform the healing by zar and its ceremony. (Z.H.)

Quran healers know this class of *Elrrih Elahmar* or *zar* spirits as evil eye and it is called *ayn* spirits, which means eye spirits, they believe that people affected by evil eye are triggered with *ayn* and it is tripped up among the unbelievers.
Helman (1986, 113) noted that the evil eye as an aetiology of illness has been reported throughout Europe, the Middle East and North Africa. In Italy it is the *malocchia,* in the Spanish culture it is *maldeojo,* in the Arabic culture the *ayn*, in Iran the *casm-esur*. It is also known as the narrow eye, the bad eye, and the wounding eye or simply as the bad look.

The evil eye is called ayn spirit when it has been observed as signs of illness (Q.H.)

The person who had evil eye triggered up with ayn, this evil eye was clearly mentioned in the Quran book, sourat Elgalam verses 5 and prophet Mohamed Hadith[*]*, when he said; it is tripped up among the unbelievers. (Q.H.)*

Also those healers believe that, in all forms of evil eye, a person who is possessed by *ayn* has a spiritual material, which is ascribed to the same range of causes, body ache, itching and social problems.

A person who is possessed by ayn is believed to have occult or secret spiritual material that causes general body problems such as itching and body ache, and these may be the cause of occupational and social problems. (Q.H.)

4.2.3.3 Class of soul or fright illness

This class of illness is based on the believe that an individual is composed of the physical body and one or more immaterial souls or spirits, which under some circumstances such as breaking a taboo, or being sinful, may become detached from the body and wander freely.
The interviewed healers believe in most cases that the soul illness causes pain and emotions of shame or guilt, because the person unconsciously produced himself his feeling of physical illness to escape facing the psychological moral. The social treatment associated with religious healing is helpful to seek relief.

Helman (1989, 97) argued that although physical pain is particularly vivid, and also emotional symptoms, it can only be understood in a cultural context by seeing it as a part of a wider spectrum of misfortune; pain like illness is generally just a special type of suffering .As such, it can provoke the same type of questions into the victims as do other forms of

[*] Hadith means statement.

misfortune: "Why has it happened to me and what have I done to deserve this?" Where pain is seen as divine punishment for a behavioural lapse, the victim may be unwilling to seek relief for it; experiencing the pain without complaint becomes, in itself, a form of expiation. Alternatively they may demand a more painful treatment from a physician, such as a surgical operation or an injection. If pain is seen as the result of moral transgression, the response might also be self–imposed penitence, fasting or prayer rather than consultation with a health professional. If interpersonal malevolence such as sorcery, witchcraft or putting a hex on someone, are thought to have caused pain, the strategy for pain relief may be an indirect one by a ritual of exorcism.

Soul ill is the art of controlling the centre of feeling and thought by the pretended use of supernatural forces, the person utilizes different ways of distress in communicating his suffering to others. (S.H.)

The frightened person is a person who looses his soul usually by a sudden fright because he breaks a religious taboo or commits sin, and then he produces his shame and guilt in a way of illness to escape facing life and God, exposing this way guarded him against a more painful or worse illness. In these cases the Quran healing such as praying, reciting Quran and God's forgiveness of sin is only one way of relief. (Q.H.)

Those healers have a strong belief that the health of the body or the soul depends on its harmonious relationship with the other part of man's personality and its relevant environment. If that correspondence is entirely cut off or if man's God-World relationship is in conflict with other functions of the self such as guilt or jealous, hate, worry, resentment or other unhappiness feelings then the soul is in a state of illness.
Weatherhead (1968, 318) noted that the newly opening field of psychosomatic disease shows most significantly that illness, long-regarded as entirely physiogenic, is more truly described as the effect in the body of a disharmony in the mind or soul; the organic concomitants not merely of psychological disharmonies, but of spiritual ones; of broken spiritual relationships with other people, such as in case of jealousy or hate, where there is a refusal to love, and in a broken spiritual relationship with God.

Many mental illnesses are thought to be physically caused and to show great success in attending the attempt to cure them by physical means such as electro-therapy treatment, but we believe most of these mental illnesses are soul illness, like jealousy, hate, worry resentment and so on. They may be wilful sins in our religious belief. (Q.H.)

In many cases the moral illnesses such as jealousy, bad temper or guilt are conditioned by situations and circumstances that the patient could not control. (S.H.)

4.2.3.4 Summary

It is assumed that in the theories of mental disorders the classifications are related to the type of illness. Broadly speaking there are three classifications of mental illness: Jinn, *Arrih Elahmar*, and the soul and fright class.

All the traditional healers agree about the jinn class, and they have the same concept of jinn and what it causes, they call a person who has these types of possession *majnoun* which means insane or *mighoub* when he is loosing his mind, and according to them, this is reflected in a number of abnormal behaviours. Traditional healers differ about an identification of the second class (*Arrih Elahmar*), which means the red wind. *Zar* healers identify *Arrih Elahmar* as a class of spirits known as *zar* or *dastour*, and a person who is possessed by these types of spirits expresses his sickness in a way that the community understand his complaints and he often complains of a variety of generalised weakness, which are adjustable to physical complaint symptoms. Also he often appears to be depressed but he denies this feeling. While the *Quran* and *Sufi* healers call it *ayn,* and the person who is possessed by this evil eye or *ayn* spirit is believed to have hidden spiritual materials which lead to observable signs of illness such as itching, body ache and/or occupational or social failure. The third is the magic class; it is based on the belief that one of the person's immaterial souls or spirits is detached from his body and wanders freely. All the spiritual healers believe that magic is a supernatural force controlling the centre feeling and thought, which causes soul loss from the body and manifests other signs of possession such as loss of appetite, lack of interest in dressing, or sudden fright; and that leads to sleeping disorders and depression. This magical fright has different types, each type has its own meaning and specific functions or causes, for example when a wicked person asks an irreligious healer to possess another person with the spirit, because he is jealous of that person or for any others reason.

So I can say these classification theories by healers are a cultural grouping of psychological disorders for all kinds of distress, which are accompanied with physical symptoms and signs. More specifically, it is a feature of clinical presentation, e.g. jinn class is a feature of clinical presentation of psychosis and *Arrih Elahmar* is a feature of clinical presentation of depression or other neurosis illness.

4.2.4. Diagnosis of mental disorders

Most of the traditional healers share the basic cultural values, and world views of the communities in which they live, including beliefs about the origin, significance and treatment of ill-health .In their societies where ill-health, and other forms of misfortune are blamed on the social causes (witchcraft, sorcery or evil eye) or on supernatural causes (God, spirits). Their diagnosis approach is usually a holistic one, dealing with all aspects of the patient's life, including his relationship with other people, with the natural environment, and with supernatural forces as well as with any physical or emotional symptoms.

4.2.4.1 Concept of diagnosis mental disorders

Most of those healers mentioned that the first stage in traditional healing is to establish a diagnosis in order to identify the nature of the spirit or the operative agent that causes the illness, which usually involves different means and procedures.

Foster & Anderson (1978, 89) noted that diagnosing means organizing the symptoms and signs into a recognizable pattern and to give it a name or identify the causes. Also Coppo (1983, 79) argued that the symptoms and signs, which are recognized by both, the sufferer and those around him, usually help diagnosing the illness.

Most common and simple illness is treated at home based on the family diagnosis; however, a case of complicated illnesses where spirit possesses the person, needs our consultation to identify illness and the type of the spirit that causes this illness. (S.H.)

Some clients ask to identify the nature of their fate, and why they face trouble in their lives. They seek help by way of ancient forms of healing practised long before the appearance of modern scientific medicine. (Q.H.)

4.2.4.2 Ways of diagnosis

In the first instance, there are differences in the diagnostic criteria that usually involve different means and procedures, used by those healers to define a particular illness. These differences are labelling policy and may give an inaccurate picture of the incident of a certain illness by different healers. The interviewed healers mentioned the meeting or the interview with the client or with his/her family as one criterion of diagnosing the client's problem.

- **Therapeutic interviews**

This interview is based on establishing a relationship between the healers, the patient and his/her family .The aim is to get information about a patient's illness and to realise how the patient is behaving and thinking about his/her problem and the privacy of this information. Zborowski (1952, 22) has pointed out that a culture expectations and acceptance of pain as a normal part of life will determine whether the patient's problem is seen as clinical problem which require a clinical solution or not, part of this diagnosing decision depends on the person's interpretation of the significance of the illness, whether verbally or non-verbally, another part depends on the healers' definitions of these significances and what are realized in the person's behaviour.

Usually at the first consultation, I try to find out whether the patient is sick or just has stress problems, and how he prefers to talk, with me alone or in presence of his relatives, usually it is a short meeting, but we can plan of another subsequent meetings. (Q.H.)

When I meet a client, I ask about what s/he complains, religious life, and relation with family; whether he/she has any conflicts. All that might lead to the real causes of his/her sickness. (S.H.)

When I sit with my client, I can get a picture about his/her presence as well as the relationship with his/her self and other worlds. (S.H.)

- **Client and his/her relatives meeting**

Most of the healers meet and get information that helps diagnosing directly from the client's relatives which takes an average half an hour. Also healers think that their social status and recognition by the community is of much benefit for identifying the cause of different illness from the first interview.
Turner (1974, 230) remarks that relief might be given to many sufferers from neurotic illness if all those involved in their social networks could meet together and publicly confess their ill will towards the patient and endure in turn the recital of his grudges against them.
Helman (1986, 53) noted that the healer's perspective includes social and psychological dimensions of ill health, which determine the meaning of the disease for the individual patient, and for those around him. Factors such as personality, religion, beliefs and social status of the patient are often considered relevant in making the diagnosis, or prescribing a treatment, and he added that these healers are often a familiar figure in the community, take part in local community activities, and use everyday language in their consultations to deal with all problems, and counsel bereaved families, and most healers do home visits, and also deal with more than one generation of a family. Bassher (1994) noted; the diviner is already familiar with the social position of the patient, his relative and the conflicts that surround him and other information gained from the gossip and opinion of the patient's neighbours and relatives. And by questioning these people and by shrewd observations, he builds up a picture of the patient's social field and it's various tensions.

To be aware of the whole work, especially in diagnosing, I often enquire about the client's behaviour before the illness and about any conflicts if he/she have with other people .In this small village I can say that I have first hand knowledge of all family's difficulties, which makes the meeting with the client and his family *not difficult particularly during the consultation time, and it may take less than half an hour. (S.H)*

Usually I use to meet my patient after blessing the zar spirit by some rituals, then I try to get some information from the patient that help to identify problem and which spirit caused her sickness. At that environment, the spirit influences the patient and gives her strong power to talk about different things concerning her sickness, without need to ask many questions or to take long time. (Z.H)

Often it helps when I ask the client in the presence of his relatives about different things such as the character and behaviour of my client, does he follow the religious rules, also about his illness, when and how it started. (S.H.)

- **Observation of signs and symptoms**

Observation is one of the diagnostic ways in traditional healing, and aims at identifying the causes. The majority of the interviewed healers based their statements on their knowledge, personal experience and secret power to examine the signs and symptoms of the illness in an attempt of tracing back the real causes of abnormality. Castillo (1997, 69) argued that a doctor working in any culture should be aware of how folk illness is acquired, and displayed, and how this may affect the patient's behaviours and the diagnosis of disease.

In my first meeting with a client, looking at his/her face, I can discover his/her problem and other hidden events. (S.H.)

Based on long experience and secret power gifted by God enables me to identify the spirit that possesses a person and causes his problems. (Q.H.)

Some interviewed healers, when diagnosing a case, rely on the patient's behaviour because they believe that each illness shapes the sufferer with recognisable signs or symptoms such as guilt, fear, shame, anger, or uncertainty. Helman (1986, 47) argued that illness is the subjective response of the patient, and of those around him, to his being unwell, particularly how he and they interpret the origin and the fact of what he feels, how it effects his behaviour, and his relationship with other people; and the various ways he takes to remedy the situation. It not only includes his experience of ill-health but also the meaning he gives to the experience. He added that the patient perspective on ill-health is usually an important part of a much wider conceptual approach used to explain what the patient feels. Within this approach illness is only a specialised form of adversity. All forms of misfortune are ascribed to the same range of causes: high fever, a crop failure; all collapsing might be blamed on witchcraft or on divine punishment for some moral transgression. The latter case may cause similar emotions of shame or guilt. George (1988) made it clear in his paper about social science perspectives on medical ethics. He noted that in more traditional societies, the link between physical pain and social moral and religious aspects of culture is likely to be much more direct.

Each spirit influences the person's behaviour in a specific way, so the way of the patient's behaviour can identify which spirit caused his/her illness. (Q.H.)

Some reactions of the patient to the illness, such as fear, shame, anger, uncertainty, or other emotional reactions are important in identifying the real causes of the patient's sickness. (S.H.)

Other healers diagnose the illness, based on the degree of the patient's awareness of his/her surrounding. They argue that an insane person is always unaware of his environment.

You can immediately realise the person who is possessed by Zar spirit or Elhadra, he/she appears unaware of him/herself, place, date, and many things that help us to put our hand directly on his/her problems. (Z.H.)

When a client shows signs of awareness this implies that he/she is almost cured. (S.H.)

There are also other signs or emotional reactions shown by the possessed person, which are important for those healers in diagnosing the client problems or sickness. Most of them mentioned the importance of the emotional reactions or the behaviour of the client when he/she is speaking, such as: the higher voices' quicker utterance disconnects sentences, uncoordinated movement of limbs and eyes.

Lewis (1971, 178) notes that in sane societies, possession is a normative experience whether or not people are actually in a trance, they are only ”possessed“ when they consider they are and when other members of their societies endorse this claim which means it is a culturally-specific way of presenting, and explaining a range of physical and psychological disorders in certain circumstances, such as speaking in unknown tongues or showing uncoordinated movement of limbs and unstable formal eye movement. The form of “speaking in unknown tongues” according to Littlewood and Lipsedge (1982, 171) is believed to result from a supernatural power entering into the individual, with the control of the organs of speech by the Holy Spirit, who prays through the speaker in a heavenly language.

Healers with long experience can differentiate between a mad and a scared client, by the way of the client's talking. Despite both of them show similarity of some signs, like most of them talking with loud voices and unconnected sentences. (S.H.)

A common sign to identify the client, who is possessed by jinn spirit, is the movement of his/her eyes that nazro zaigh[*] *and we call him “mighoub” because the power of the spirit controls his/her behaviour.* (S.H.)

Women especially are the victims of zar spirits that reveals their identity by the specific symptoms and behavioural changes, when they are in trance, expressing their problems in a quicker utterance and talking in another language. (Z.H.)

Some healers believe when the sickness of a client is determined by God for a behavioural laps, the client shows abnormality. This abnormality shapes the person's behaviour by such signs as: (a) wandering around bushes naked or having no appetite for food, (b) the victims experiencing the pain without complaint because it is a self-inflicted form of expiation or searching for more painful treatment.

Castillo (1997, 67) noted that in many cultures, individuals are involved in interpersonal conflicts and are experiencing these feelings in a standardised “language” of distress. This may be purely verbal, or involve extreme changes in dressing, behaviour or posture.
In a study by Edgerton (1977, 360) lay beliefs about which behaviour constitutes madness or psychosis were examined in four African tribes. It was found that all four societies shared a broad area of agreement as to which behaviours suggested a diagnosis of madness. These include such behavioural activities as violent conduct, wandering around naked, senseless talking or sleeping and hiding in the bush.

Where ill is seen as divine punishment for breaking a religious taboo or for behavioural

[*] Nazro zaigh means his or her way of looking is meaningless

lapses, the person may be unwilling to seek relief for it, then he keeps wandering in the desert naked without appetite for food, or alternatively he may demand more tuff and hard treatment. (Q.H.)

Sufi believe that the person who is possessed by supernatural power has a big appetite for food, while the *Quran* healers think otherwise of their patients, as is mentioned above.

An insane normally has a big desire and appetite for all types of food because the possessing spirit eats from his body. (S.H.)

- **Ritual and spiritual powers of diagnosis**

Rituals are features of all human societies, large and small. This is important in the way that any social group celebrate and manage life. Rituals occur in many settings, take on many forms, and serve many functions.
Healers have defined the various attributes of ritual in a number of ways in all aspects of traditional values, which have social, psychological and cultural values.
As Turner (1974, 49) put it, "Ritual is a periodic restatement of the terms in which men of a particular culture must interact if there is to be any kind of coherent social life.

There are some ritualistic aspects in certain customs, but all rituals have important social, cultural and psychological meanings. (S.H.)

Every time we have foreigner visitors coming here to attend the zikir[*] *or other festivals, in these to know a lot about our society (S.H.)*

These rituals have also symbolic and more meaning for people, some healers mentioned that to the outsiders who are observing a ritual there is more than meets the eye; it tells them something about the value of their society, how it is organised, and how it views the nature and the supernatural worlds. Turner (1974, 48) has examined the form and the meaning of ritual symbols, particularly those used in healing rituals. He points out that, especially in pre-literate societies, information about the society, each ritual is an aggregation of symbols and acts as a storehouse of traditional knowledge.

The zar ceremony which includes music, songs, dancing with certain clothing and some ritualistic words has a whole range of associations for those taking part in the fest, during this ceremony I got a lot of information not just from the patient women but also from the visitors, and that helps to identify my patient's problems. (Z.H.)

The way in which rituals appear, such as zikir, has a big meaning to those groups of people, just looking at the way the people are moving and singing the religious songs, or when they are lessening to the sound of Quran words when sheikh recites it. These entire employ religious artefact in a healing power for the benefit of the client and all Muslim people attend it. (S.H.)

[*] Zikir is a religious (preliminary) ceremony, which holds the people in religious unity.

Those healers have described some models of the culturally patterned ways of diagnosing the illness by using ritual forms, but they differ in the way of using these rituals. For the religious or the *Quran* healers "this type of ritual" which is based on reciting *Quran* verses by the sheikh involves many people, the patients and those who are coming to hear the *Quran* and attend the session. The healer and the attending persons believe that during the reciting of specific verses of *Quran*, patients show some behaviour that the healer can use to identify the patient's problems or to identify which spirit caused his/her sickness and why. They believe that reciting *Quran* casts the spirit out of the patient's body and soul and also out of the place where the *Quran* is being recited, because the spirit feels uncomfortable.

I recite different verses from Quran, and if the patient has problems with the evil eye, witches spirit or has broken a religious taboo, then he responds to these specific verses, in which is the cause of this problem. The responses from the patients happen usually by a particular behaviour, such as movement like snakes, abnormal speech or hysterical crying or change of the body size, but by the end of these sessions everything will be normal, also the spirit that caused all these problems will be out of the patient's body. (Q.H.)

This holy Quran book contains all the things that concern the human beings' life, but most of the people did not know how it is expensive and what is the meaning of this book. Look; when sheikh Mohamed recites the Quran, how the people are doing, you realise that some of them are crying and quarrelling with tears, others are moving and talking in abnormal ways (those are possessed by spirits) and those who had Jinn or witch in their body can move in strange ways as the latter woman that was witched by Jinn to cause her bleeding and can not get a baby, so her stomach will reach abnormal size when she hears Quran. These signs identify the sickness of those people and by this Quran we cast out the spirit and all the problems from the person's body, soul, and from the place where the Quran was being recited. (Q.H.)

The spiritual diagnosis models of Sufi healers are based on making good communication and relation with the spirit or supernatural powers in order to provide information about the reason of possessing the person and identify the supernatural power that caused the sickness. The communication with the spirit takes place through different means. Some of the interviewed healers see the patient's *Khayrah. Khayrah* are clues obtained from the patient and depend on what the sheikh sees in his dream. This way of diagnosing which type of supernatural power has possessed the client, why, and what type of healing is needed, involves some symbolic rituals. Those healers have to perform certain ceremonies, act or dress in special ways and generally withdraw from ordinary life, so part of the functions of diagnosing by ritual as well as dealing with conditions is to provide explanations for the illness in terms of the cultural appearance of the patient. Foster & Anderson (1978, 115) point out that, in non-Western societies, illness is seen as a social event. The illness of the one member, especially if blamed on witchcraft sorcery, resulting from interpersonal conflicts, threatens the cohesion and continuity of the group. The group has an interest in finding and resolving the cause of the illness, and restoring both the victims and themselves to health. As a result, such healing is usually aimed to restore the harmonious relationships between man and man, and man and the supernatural world.

Sometimes I postpone the final diagnosis to see the client's Khayrah to provide a standardised way of explaining and controlling the supernatural power that possesses the client. As you know these sudden crisis cause feelings of anxiety in the client and his family, and bring many questions. They ask, "What has happened? Why has it happened? Is it dangerous? To reduce these anxieties and offer good healing to my client I usually make a good relationship with the supernatural power after doing special night ceremony and blessing, then I can consult and ask them for help by connecting the unknown into the known at that night. (S.H.)

I used Estikhara, especially with those who prefer things to be more clearly defined. It has many processes, first before I go to my bed, I did special rituals of social transition to protect the client, his relatives, and my self from danger, then I read some symbolic and Quran verses after writing the client's clues and the progress of the client during the course of his problem life on a blank paper and put that under my head. What I see in my dreams, good or bad, is the client's Estikhara. I tell the client his sickness and what caused these troubles. This explanation is the first step in healing. (S.H.)

Sufi healers mention other models of ritual diagnosis. They are using *Al-sebaha* to postpone the client's *Khayarh*. This method depends on the patient's name and birth chart, and the name of his mother, this works as a key to the riddle of the patient's life. Those healers learn the secret of how to calculate and read this riddle. This enables them to know many things about the supernatural powers and commands them to offer much information about the client's fate.

Sometimes, I would like to provide some kind of assurance that everything possible is being done to explain the misfortune or failure of my client and thus reach less feelings of guilt or responsibility of doing the wrong behaviour. This could not be unless by using sebaha secret to know the person's fate. Sebaha Khayrah depends on calculating the name and the birth chart of the client and the name of his/her mother, the result of this calculation could be a number between 0-9 that is used as a key to the riddle of the person's life. (S.H.)

The healers claim that they could not make any contact with the supernatural world to provide facts about their patients and offer good information about diagnosing and healing, unless they knew these spirit names, the secret of these names, and their weakness.

Nobody can make contact with spirits, command them or cast them out of the patient's body, only if he knows the spirits' names and their weakness. (S.H.)

To know the secrets of the supernatural forces and the names of the spirits is a key to gain power over these spirits. (S.H.)

The ritualistic diagnosis model of *zar* healers is named *Elhadrah*[*] day or *fath Elalba*[*]. This method takes place particularly in a big group of a patient's family, neighbours and friends. Those healers believe that most of their clients suffering from inter-personal malevolence, such as witchcraft or sorcery. By z*ar* ritual all the hidden social tensions of the patient and his family publicly are aired and resolved.
According to Turner (1974, 9) the way of seeing society life as an attempted imitation of models portrayed and animated by rituals, such as the use of "multi-vocal" symbols, can modify behaviour towards a more sociable form, and resolve the tensions between self interest and the interests of the group.

Sometimes zar spirits cause sickness in an individual if his family kin are not living well together or are involved in fighting or quarrelling. So to identify which is the spirit that caused these tensions in a person's social relation and possessed him, I call all the patient's family for Elmojmour and overwork them to bless the spirits, so as to resolve these family problems, when they are meeting together and gradually ride the patient. (Z.H.)

Some of those *zar* healers have described *Elhadrah* day or E*lmojmour*, which is governed by implicit and explicit rules of behaviour, clothing, and subject matters to be discussed after doing some rituals. These events take place at a fixed day, e.g., every Sunday and Wednesday.

Consultations of zar spirits take place at defined days and times, which are usually on Sunday and/or Wednesday, usually involve only one patient and his/her family. Their form is a ritualistic exchange of information such as asking about the causes, for what reasons the spirit possessed him/her, and giving advice or treatment. (Z.H.)

When a *zar* healer performs *zar* rituals at E*lhadrah* day, she opens her tin and calls all the names of spirits. Then the spirit that possesses the patient and causes his/her illness, reveals its identity by specific symptoms or behavioural changes, e.g., speaking and acting through the patient. *Zar* healers believe that most people freely admit being possessed by supernatural forces.

Lewis (1971, 189) notes that possession is a normative experience whether or not people are actually in trance; they are only "possessed" when they consider they are, and when other members of their society endorse this claim. He adds that trance divination is common in non-Western societies. The relatives of a sick person who remains at home, for example consult the Zulu isangoma. Going into a trance and communicating with spirits who tell the cause and treatment of illness make her diagnosis. Another form of this is the Shaman, who is found in many cultures. In Lewis' definitions a Shaman is a person of either sex who has mastered spirits and can as well introduce them into his own body, the definition takes place in a séance in which the healer allows the spirits to enter him and through him diagnose the illness and describe the treatment.

[*] Elhadrah means visiting and elhadrah day is the day when the spirit visits the healer.
[*] Fath Elalba means the tin opening [cf. Flaschengeist] and it is referred to the day when the sheikh asks the spirit to visit him or her. It is also called Fath Elmojmour.

Alhadrah or fath Elmojmar usually takes place in a specific time and context, at that day I dress in bright red the style preferred by zar spirits, and put on a special perfume "named Bit El-Sudan" and after uttering the exorcise and pronounce the names of spirits I will be into trance, directly consulting with spirits. I used to ask my patient to act a brief ceremony that called Fath Elalbah to explain the causes of his problems. This Elalbaha contains incense upon burning of the spirit that the patient possesses. When the patient starts this ceremony, the spirits will speak through him/her identifying themselves and why he/she is possessed. At the end of this ceremony the spirit claims specific demands to cast out of the patient's body. (Z.H.)

4.2.4.3 Summary

In the first instance, there are differences in diagnosis criteria used to define a particular illness. These differences are just labelling policy and may give an inaccurate picture of the incident of a certain illness by different healers. These interviews with the traditional healers prove that most of the healers directly address the client whenever it is possible or when the client prefers that, and other healers investigate cases through the client's relatives. *Zar* healers are keen to conduct their interviews with the client alone, whereas the Sufi healers prefer to take the history from the client in the presence of his relative; *Quran* healers are not particular about the privacy of their interviews with the client. The initial interview with the client or his relative, usually takes an average of 20 minutes. As for the planning of subsequent interviews, it differs from one case to another but when it is required it takes an average of 15 minutes.

In the first interview with the client each one of those healers tries first to find out whether the client is sick or simply undergoing an ordinary life stress. In the case of that, healers exclude ordinary life stress and proceed to examine the type of spirit that possesses the client and which sickness caused on the basis of signs, client's behaviour and case history, may be trailed back to a real cause of abnormality. Indeed, sometimes they use rituals and supernatural power to postpone the final diagnosis and that differs from one Sheikh to another. Sufi healers use the client's *Khayrah*, which are clues obtained from the patient and depends on what the Sheikh sees in his dream that night. Other healers use to know the patient's *Khayrah* by *Elsabaha* that depends on the patient's birth chart, and works as a key to the riddle of the patient's life. Most of the healers mentioned that no one could do this job unless he/she knows the secret and names of all spirits and their weakness. They believe if you learn how to read these riddles that means you are protected by your own power and you are able to know many things about supernatural power. *Quran* healers reciting *Quran* verses to discomfort the spirit that possesses the person also realise particular behaviour such as the movement and the speech of the patient which help them to identify the spirit that possesses the patient and forces it to let the patient's body free. This is justified by the belief that upon reciting specific verses of *Quran*, spirits will feel uncomfortable and cast out of the patient's body and also out of the place where *Quran* is being recited. *Zar* healers make such contact with supernatural power by using a variety of techniques such as *Elhadra* day or *Fatih Elilba* to finalise the diagnosis. At that day the *Sheikha*[*] performs ceremony rituals, she calls the spirits by their secret names and mentions

[*] Sheikha is the name of a woman zar healer.

some words of power that allow the spirit to speak through the client identifying itself and claiming its demand. All these different techniques are used to provide clear information about the causes of the sickness and the problems that the client seeks help for.

4.2.5 Healing of mental disorders

In most societies, a person suffering from physical discomfort and/or emotional distress has a number of ways to help his/her self, or to seek help from other people. The larger and more complex the society in which the person is living, the more of these therapeutic options are likely to be available within the Sudanese societies. Many groups or individuals offer them, each in their own particular way of explaining, diagnosing and treating ill-health.

For example, sharing advice with a friend, relative or neighbour, consulting a local sheikh, a folk or religious healer or wise person, or deciding to consult a doctor, provided that one is available. Patients may follow all of these steps, or perhaps only one or two of them, and may follow them in any order. The interviewed healers believe that their healing is an ancient form of health care practised long before the appearance of the modern scientific medicine and is still practised today in many parts of the world. The concept of this healing procedures is based on Quran and prophetic medicine, which include both preventive and curative measures, and their jobs as Muslim healers is to provide and restore care for all people by their healing power which they believe is a power from God. At the Asian's day, health was believed to result from harmony with God, bringing with it divine favour, and the cure of disease could be brought about only if the patients were restored. Helman (1986, 12) defines the traditional medicine as integral part of native culture. Elsafi & Bassher (1987) stated that traditional treatment is a primary health care for the majority of the population in the developing countries particularly in rural areas due to the lack of modern health facilities.

God controls every part of our life and ordinates both sickness and health. Sickness is a result of his disfavour and is a punishment for sin, while health is a sign of his favour and reward for righteousness. (Q.H.)

Cure is from God. Prophet Mohamed (peace upon him) gave special instructions on various aspects of caring and curing, which includes both preventive and curative measures. He had considered human well being as a whole entirety, the spiritual, the psychological and physical within the context of social influence, my job is to provide the basic elements that Islam seeks to achieve. (Q.H.)

This healing is an old form of care towards a natural and religious approach. As we know Islam calls for health and peace for all, but some Moslems are fatalistic, such people do not care about their health and religion, so God sent suffering and a kind of uncomfortable feelings upon these people to teach them moral lessons and to punish them for their sins (S.H.)

Healing is a power that comes from God and is granted to individuals and places such as mosques and healers' masseds[*]. (S.H.)

4.2.5.1 Concept of health

Each society decides what symptoms or behaviour patterns are to be defined as deviant or as the special type of deviance "mental illness". Therefore, health is only defined relative to the society in which it is found, and cannot be said to have universal existence because it is usually influenced by the belief of the local culture.

In the Sudanese's society where ill-health, and other forms of misfortune are blamed on social causes (witchcraft, sorcery, or evil eye) or on supernatural causes (Gods or spirits), traditional healers are particularly common. Their approach is usually a holistic one, dealing with all aspects of the patient's life, including his relationship with other people, with the natural environment, and with supernatural forces as well as any physical or emotional symptoms. These interviewed healers believe that all these aspects of life are part of health definition, which is seen as a balance between man and his social, natural, and supernatural environment. A disturbance of any of these aspects may manifest itself by physical or emotional symptoms.

A disturbance or any conflict in immoral behaviour, or a conflict within the family may play a big role in losing the body harmony, and result in physical or emotional signs. Here when the client asks for help, I propose a ritual healing because this ritual heals the energies of the client which helps him to restore balance and harmony of his body, mind and spirit. (S.H.)

Health is balance between a person and environment. The main purpose of the healing methods and curative measures is to rebalance or recapture the individuals' harmony with his/her community and the supernatural world. (S.H.)

Other interviewed healers believe that health is a balance of the body's humour that encourages the soul to return. Today, humour medicine remains the basic of lay beliefs about health and illness in much of Latin America, is also prominent in the Islamic world, and in India is a component of the Ayurvedic medical tradition. Humour medicine is still one component of the pluralistic medical system in Morocco, as described by Greenwood (1981, 13). Recently most of the lay theory of health and illness puts emphasis on two of the four humours: blood and phlegm, this lay theory of health and illness relates the inner working of the body to outside influences such as diet and environmental factors.

The aim of this healing is to restore a proper balance of the body's humours. (S.H.)

Massage and rubbing the patient's body helps to remove the illness out of the body and rejoin this body so as to encourage the soul to return. (Z.H.)

[*] It is a place (healing centre) where the healer treats the clients.

Some healers differentiate between the concept of the health that they want to restore according to the type and cause of illness. They suggest that for the patient with interpersonal conflicts, the aim of their healing methods is to restore the harmonious relationship between the patient and his life, but for the patient with misfortune the aim is to reduce the cause.

If there is illness, especially if blamed on witchcraft or sorcery resulting from interpersonal conflicts, this zar ceremony is to visibly restore the harmonious relationship between the patient and his/her life while for the misfortune patient this ceremony treats the effects of the misfortune and removes the causes. (Z.H.)

If the sorcerer defines illness as due to the intrusion of an object or spirit, extraction of the object is essential in returning the patient to the health. Healing may also be designed to placate or neutralise the sorcerer in order to ensure that the illness will not return. If illness is explained as due to a wandering soul that had no time to return from its dream world, its owner awakened, the cure will attempt to trap or otherwise cure the soul back to the body. (S.H.)

4.2.5.2 Importance of traditional healing

Most of those healers mentioned the importance of this type of healing which is well known, respected and trusted by all, also it offers good relation between healers and patients, based on confidence, effectiveness and respect, while they believe that the modern medicine has failed in offering these positive points to the patients.

Quran healing is well known, respected and trusted by all. Most of the people gave up medical medicine and this religious healing became necessary for them. I can say, this type of healing got its importance a long time ago and has it still nowadays because medicine has failed in treating ill people, most of them turn to our healing methods which are based on an Islamic religion. (Q.H.)

My relationship with all people, clients, patients or visitors, is based on the confidence, trust and respect between us. (Z.H.)

Some of the patients who come to this massed were patients who had attended the general hospitals, and they all expressed dissatisfaction over the treatment given them. Here we are able to solve their problems by our healing methods. Some of the patients who were demon possessed were being haunted day and night and were in constant fear. We used the avoidance preparation and rituals on such unfortunate patients to cast out the spirits. This is something the medical doctors cannot do and also cannot believe. (S.H.)

Some of those healers think that one of the positive things in traditional healing is that it is cheap and most of the healers do not ask for a special price, in addition to that those people who are asking for this type of healing are the people that believe in it.

I think cost obviously plays an important role in the choice of a doctor that one can consult for medical treatment. But here most if not all visitors believe in our religious healing, we never ask for a special price, people pay some money, which depends on them after finishing the healing. (Q.H.)

Most of the people coming here and looking for help because they believe in this healing. Some of those people are cases that need help from medical doctors. In this case I talk with the patient and ask him to go to a hospital or consult a medical doctor, but often they say that they do not have money for that, then I look for one of my doctor followers so as to send the patient to consult with him. (S.H.)

4.2.5.3 Purpose of consulting a traditional healer

People who cannot help themselves when they have problems usually seek advice or search for help from their families, friends, neighbours, healers, or other professionals. I found that there are various reasons for the clients when they come to a healer, such as health problems, social, business, or financial problems, or how to determine and deal with their fate. All interviewed healers mentioned that for most of the visitors, the main purposes of coming and asking to meet them is to seek help for a health problem or consult them about their families, business or financial problems, or looking for a blessing and fate determination.

*Most of the visitors who attend Quran sessions, either they are looking for healing or seeking help and advice for other problems such as family, business, or other social or financial problems. (*Q.H.)

At this village people frequently utilise my advice for health and social problems. (S.H.)

All people who live in this massed, either they are patients under treatment or followers to our religion method. (S.H.)

There is also another purpose that led people come and visits the sheikh: looking for a blessing or for forgiving sinfulness or determine the fate.

Most of the people who are in this massed are followers come to ask for blessing or advice to forgive their sin, and sometimes they have personal or social problems so they ask for determining their fate and find out exactly what is the problem, if it is bad fate, they look for bad fate treatment. (S.H.)

Most people who visit this massed are followers who look for blessing and ask for help. (S.H.)

Usually my visitors are patients seeking help for sickness and other problems that were caused by zar spirit. (Z.H.)

4.2.5.4 Methods of traditional healing

Three types of healers have been interviewed for this study: Quran, Sufi and Zar healers. These healers present and define different methods of healing. More interesting is that; one healer may use different procedures to help or to heal his/her patient.

a. Quran healing methods

Quran healing methods are based on the teaching of the prophet Mohamed (peace upon him) that depends on the Holy Quran and the prophet hadith. These methods of healing are known as Altib Alnabawi (prophetic medicine). Most of the interviewed healers mentioned the fact and the effectiveness of this type of healing. They believe that the Holy Quran can treat all types of diseases; they depend on prophet Mohamed's statement, when he said God did not create a disease without creating a treatment for it, except for one that is death. Ibn Gheyem in his book (Altib Alnabawi 1993, 367) also mentioned the hadith of prophet Mohamed in which he stated that all types of diseases, mental or physical, could be treated by Quran verses.

Our healing is based mainly on the verses of the Quran and prophet Mohamed hadith. Muslim people should be aware about their religion, which involves everything that helps them to live in peace and restore their health, because Islam encouraged the sick man to seek treatment. It was reported that Bedouins asked prophet Mohamed if they can seek treatment when they are sick, the prophet said, "you can" for God has not created a single disease without creating a treatment for it, except for one that the death. (Q.H.)

The interviewed Quran healers follow methods of treatment that were mentioned by the prophet Mohamed. These methods are divided into three main categories: honey, cupping* and cautory*.

Prophet Mohamed has limited the principal methods of treatment to three, the administration of honey, cupping and the actual cautory. The prophet recommended his followers to avoid or make sparing use of the latter. In our healing methods more or less we are following these Sunna[*]*. Principles* (Q.H)

Quran healing has three stages: First, when client is sick, sheikh applies Rughya. This is the method of healing (by religious healers) in which a religious person spits with full energy at the patient or the person who is seeking help. This is done during reciting Quran and speaking about favour and punishment. Second, when client shows some signs of recovery, sheikh prepares a mixture of herbs and honey, and then asks the client to use it in a specific way. Third and last stage, after the recovering of the client, the sheikh gives him some advice and information about how to prevent and protect him from danger.

[*] Sunna is the prophet Mohmed principles and methods.

I use to apply Rughya for all the people who come and ask for help, but for the person whose sickness is resulting from sin or breaking a religious taboo, I use to apply Rughya for him/her in individual sessions and I say, if they have time, it is better also to attend the Rughya group session, which helps the person to forgive sins and remove the fears. After the patient shows some signs of recovery, I ask him/her to drink everyday one spoonful of the mixture "honey with herbs". In some cases I ask them to apply this mixture to their sin or inhale it, because it helps the patient to reach the total recovering, then I can talk to my client and give him some useful information about how to prevent and protect him/herself from danger. (Q.H.)

I have found that not only the Quran healers give their patients, after feeling totally healthy, some advice and guide to prevent them from danger, but also other traditional healers follow the same way. They give the patients a paper with some guides written on it including the principles of Islam religion and the favours to obtain, if they follow these principles and do some other worship such as praying, fasting, reciting Quran and paying attention to thank God everyday. This paper also gives some advice such as how to be clean and avoid the body and place Nagasa[*] and other useful information based on prophet Mohammed Hadith. After the healer has discussed and declared what is stated on that paper, he asks the client to tell his experience to anybody he wants to, so as to extend the power of this healing. Furthermore, these clients will be welcome at any time to the healer.

When the client feels happy at the end of the healing process, usually I give him guides and advice concerning his general health life, written on a paper, I ask him to follow it if he wants to protect himself. Such as this is praying, fasting, and taking care of to follow all the Islamic worship; for example, thank God and recite some of the Quran verses everyday, be clean and avoid the body and the place Nagasa and how to avoid a danger which comes as a result of small mistakes such as sleeping before praying, deliver hot water on the ground, or moving without shoes especially at night, and other things that I used at the last of healing to speak with my client about. (S.H.)

At the last session of healing, when patient is cured, I ask him/her to tell his fruitful experience to other people also he/she is allowed to make a copy of the paper of guides, advice and information and give it to other people that spread the awareness about the Sunna and Islam principles and help the people not to forget their religion, as it extends the power of this religious healing. (Q.H.)

b. Sufi healing methods

Sufi healing is the famous traditional system of interpersonal healing which combined the religion with the super natural powers. This type of healing is very widespread in Africa, especially in the Muslim countries. People there believe that God gives a great power of healing to those healers who are using it to help and heal other people. Those healers are known in Sudan as "Fugura" which means Sheikhs, fakis and religious healers.

[*] Nagasa means unclean according to the Islamic concept.

Most of those healers believe that they have the important function of storing and transmitting information and knowledge about the tradition and the religion of their societies.
Fabrega (1997, 37) stated, "Traditional medicine is corresponding to cluster values, belief, norms, sentiments, social roles and relationship within the cultural system of the society performing the healing".

This type of healing is very famous in all Muslims' countries, it is considered as storehouse of traditional and religious knowledge. (S.H.)

To study this healing method is very important, because it reflects a clear picture about the Muslim people, how they deal with situations when they face any problem in their life. (S.H.)

- ## Techniques of healing

Most of the Sufi healers' techniques or methods are a type of spiritual healing, based on connecting the body, mind and the soul of the client. It depends on the interpersonal relationship as a healer characteristic. So for treatment, Sheikh has various ways of connecting spirituals, most interviewed healers mentioned and prescribed the following healing methods: Azima, Mihaya, Bakhara, Higab/Warga, food deprivation, chain, and flagging.

Azima

Azima is one technique of sheikhs healing, all interviewed healers described Azima as the recitation of specific Quran verses punctuated by breath blowing on the part while sheikh lays his hands on the head of the patient. The holy breath is directed towards the most aching or troubled area of the body that is then touched softly by the sheikh's hands or the sheikh's stick in the case of a female patient.

Elsafi & Bassher (1987) defined Azima as a type of therapeutic touch. It has proven to be safe and helpful in the treatment of a variety of conditions, because most people believe in the sheikh's healing power, and the secret power of Quran can be transmitted to the body when the healer puts his hands on the client's head and recites some Quran verses.

We use to do Azima for everyone, which is recite and repeat certain Quran verses and spiriting after each verses of the client's head and sometimes to the troubled area, while putting my right hand on the head of the client. (S.H.)

I use to put my hand on my client's head and recite some Quran verses which are related to his illness in it's contents and ask God to heal this person and solve his problems, sometimes during this ritual I touch the problem areas with this stick. (S.H.)

Some of the sheikhs mentioned the important of Azima method as type of blessing which protect person from possessing by supernatural power and helps to restore the patient's health, also they suggest the necessity of Tagawa* and Tahara*.
Alsafi adds that; Azima is either prophylactic or curative and all sheikhs administer Azima at any time and for all people, but the important things for the successful azima is Tagawa and Tahara on the part of sheikh and patient.

All the visitors when they come here, first they ask for Azima, because they know it protect them from possessing spirits and if they have problems, it brings them back to health. (S.H.)

Azima helps people to get rid of wrong and protects them from possessing problems, but without the Tagawa and the Tahara of the body and place of el sheikh and his client, this Azima will not be successful and it will serve nothing. (S.H.)

Mihaya

Most of the interviewed healers agree on the concept and nature of Mihaya as a technique of healing. To prepare Mihaya, special Quran verses are written on a loah*. The symbols are then dissolved in water and the resultant solution is called Mihaya, patient has to drink it.
Alsafi argued that Mihaya is a type of erasure healing because it rubs and cleans the body of the patient from possessed spirits. He added that healers use Mihaya as one form of preventive and curative religious medicine.

Mihaya is water of Quran verses after it is written in a loah. I give this water to some clients, and it relieves them of some disturbances. (S.H.)

At the big occasion healers prepare Mihaya, by writing the whole chapter of Quran on both sides of the wooden slate or the inner surface of a white bowl then the written text is washed off with ordinary clean water which is collected for drinking or pour it all over the body.

At the big ceremonies and festivals we prepare Mihaya for all people. We write the whole of the Quran verses on both sides of a loah and sometimes in the inner surface of a white bowl and dissolve it in clean water, so that all visitors at that day can drink from this holy water and rub their bodies with it. (S.H.)

Some of those sheikh healers mentioned the purpose of using mihaya, that is concentrated on the idea of drinking the holy water and to keep these holy Quran and names of God in

* Tagawa means piety.
* Tahara means purity on the part of sheikh and client and which is the opposite of Nagass.
* Loah means a board of wood used by khalwa students for handwriting the Quran verses.

the client's body so as to clean his/her body and also to protect and cure him/her from all types of spirits.

When you drink mihaya, that means the Holy Quran and all the secrets and power of God's name will be inside your body and serve to protect this body from any danger and clean the body from spirits in the case of possessed people. (S.H.)

Bakhara

All interviewed sheikhs apply this type of healing, which is a piece of white paper in which some Quran verses are written. This process of writing this Bakhara is known as Bakhara, which is putting that paper on red coal to burn without flames so that fumes of smoke rise as it burns. It is thus put just under the face of the patient who is enveloped by a tobe* to inhale much of the rising smoke.

Elmahi (1987, 33) defined Bakhara as one type of religious healers' treatment. Bakhara is a blank white sheet of paper in which certain Quran verses are written and symbolised in representative number. This sheet is folded in a special manner so that it is more portable. An insane who comes himself can administer Bakhara, that means he puts the Bakhara on fire, after he has covered himself with a tobe*. In such way that he is inevitably inhales much of the arising fumes.

Bakhara is well known by all people here, because they use it themselves. It is some Quran verses written on a piece of white paper, then the paper is folded in a special form, I ask my client to put this paper on mubkhar containing red coal to burn without flames, then he puts it below his head after being enveloped by a tobe and inhales this Bakhara's smoke. (S.H.)

Higab or Wraga

The interviewed sheikhs reported another form of treatment and protection method. Most of them described higab or wraga as a paper with Quran verses written on it and covered with thick leather.

This leather-covered paper is called Higab, certain Quran verses depend on the Higab function, I wrote them on a white sheet of paper and carefully I folded it in a rectangular and sometimes in a square shape and cover it with leather or another material. (S.H.)

Some of those healers differ in opinion between higab and wraga on the contents and size. Higab is agreed to have more contents and a larger size.

Higab or wraga are the same, both of them are made up of white paper, written in specific Quran verses, which depends on the reason that the client asks or needs for it. They are folded and worn almost the same, but higab is of more contents and larger size than wraga (S.H.)

* Tobe means a sheet of material that is traditional wear of Sudanese women.

Some of the interviewed healers mentioned that higab or wraga has many functions, such as to avoid malicious look, the influence of evil spirits and sorcery, to divert away weapons, and to ensure success; and the healers believe that the patients are thus fully protected.

I tell you one thing that higab has big functions in different ways even you can divert any weapons by specific higab and nothing will happen to you if you wear it around your neck. (S.H.)

People, who come here ask for higab to serve different aims such as to protect themselves from witchcraft and avoid the evil eye, incite love in someone or are successful in a specific thing in their life. This higab has other functions than in health purpose (S.H.)

Sometimes when a woman delivers a baby, parents and all the family get worried that malicious look or super natural power can possess this baby and cause a lot of problems for both of them, so they come and ask for special higab called Harasa, they wear it around the arm of the baby to protect him and the mother. (S.H.)

Some healers mentioned that this higab or wraga is used in certain ways according to its kind and functions. It may be worn around the neck, around the waist and between the breasts or it may be buried, hanged from a roof or inserted in the wall of a house or shop.

It should be all the time with the person or at the place where the person wants to avoid certain problems which are written for it, therefore the person wants to avoid the influence of witchcraft, spirits or wants to incite love in someone, he/she should wear the higab around neck or arm, some people hide it from view so they wear it around waist or between breast in case of women. (S.H.)

It may be buried if it's made for a place, some people hang it on the roof or sometimes they insert it in the wall of a house or a shop, but when it is made for the body, they wear it around the waist or under clothes. (S.H.)

The secret behind the efficacy of azima, mihaya, bakhara, wraga and higab according to the responses of different interviewed sheikhs is derived from their holistic origin; some of these healers relate such benefit to the person's belief and religion.

Everybody who believes in God as creator and controller of the universe should rely upon such religious methods, azima, bakhara, mihaya or higab and other religious healing techniques as they are made out of Aiat Allah[*]. (S.H.)

These methods of healing I used to apply them in different cases. They are very soft, effective and fruitful for all patients irrespective of their beliefs. I can prescribe and use most of them to un-possessed people as well, when we have finished I will give you a Higab that can protect you and make your life easy, the only thing to do is keep it all the

[*] Aiat Allah means the Quran verses, which are God's statements.

times with you or in a purity place near you then you will see and remember what I have said now. (S.H.)

Flogging

Flogging or lashing patients is an aversive technique of treatment by traditional healers. The results show that all the interviewed healers use to flog patients who are violent, disobedient and troublesome. The effectiveness of flogging or lashing these patients is to avoid or prevent undesirable behaviour, to make the patient's body an unpleasant place for the spirit that possessed him and to force this spirit to leave the client's body (to inhabit the spirit). They believe that the patient will not suffer from the lashing.
Foster & Anderson (1978, 74) argued that when illness is attributed to sin, taboo violation, or other forms of wrong doing, the treatment of illness as a consequence of socially unacceptable behaviour plays a major role in many societies in maintaining moral order.

In some cases I appreciate spirit's flogging to inhabit undesirable behaviour. (S.H.)

I use a whip to lash the disobedient or violent client who is possessed by strong and stubborn spirits until this spirit leaves the client's body. The importance of that is that the client will never get painful experiences again. (Q.H.)

Some of those healers suggest that the healing baraka* of some saliheen* might enter the patient's body through the whipping of a pure hand and whip the spirit directly.

*Alarifien** *and the sheikhs of deep insight hit the troubling devil directly and compel the spirit to leave the body of the possessed person; also baraka of these sheikhs might enter the client's body through the whipping of their pure hands.* (S.H.)

Usually clients are flogged on the legs or on the back in all cases and all interviewed sheikhs agreed on the hardness of the lashes, but they are differing on the average number of it.

It will not be more than six lashes on a single session, which are not heavy or hard and assure no damage on the client's body. (Q.H.)

This number of lashes bases on the type and the recurrence of misbehaviour that is caused by the spirit that possessed the client, but in all cases the average is between five to ten lashes. (S.H.)

* Baraka is Arabic word, which means the powerful and useful of somebody or place.
* Saliheen is word mentioned to divine healers or old religious people.
* Alarifien are those people who have more knowledge and shared information about religion and different things.

Chains and Fetters

The chains and fetters are called Algeid* and Algnzier*, the two of them are observed as a common phenomenon in all the masseds visited. Some of the interviewed healers argued that, when a patient is completely out of his mind and too excited to cope with the massed community, firstly he is tied by one leg to a pillar and sometimes they tie his feet or hands together with iron chains.
Almahi (1987, 37) mentioned that traditional healers use chains and fetters as a technique of cure and protection. An insane is believed to have enormous power.

When a client is unreasonable and cannot be responsible for his behaviours I ask my followers to tie his hands and feet with geids to protect him and the other people in the massed.* (S.H.)

Some sheikhs believe that being tied to a trunk of tree and placed in a desert will calm down the aggressive spirit that possesses the patient. When the patient comes to himself and proves to be quiet, he is allowed to move about in his geid till he proves that he has recovered.

Some clients are aggressive, therefore, we use to put them out in a desert place and tie one of their feet to a tree trunk, until the aggressive spirit calms down and the client shows and proves to be quiet and harmless. (S.H.)

When the client responds to other methods of healing and proves to be quiet, causing no danger to him and the other people around him, then he is allowed to move about in his feet geids. And when he is recovered, he is set free from his restraining geids. (S.H.)

Some clients continue in geid and genzeir for more than five years, till they show improvement, while the peaceful ones stay free in small rooms till they recover.* (S.H.)

Food deprivations

It is well known that the most common and simple art of healing is food regimes. It is based on forbidding patients from some sorts of food, which they believe to give power to the spirits.

In all the visited masseds, Sheikhs are found to deprive patients from milk, meat and the products thereof, also they forbid salts, because they believe the spirit which caused the client's madness can get power from such food.
Elmahi (1987, 79) noted that it is of great interest to mention that protein nutrients in blood were found to constitute the initial resource for catecholamines, including dopamine, adrenaline, noradrinalin and serotinine, all of which have been implicated in the aetiology of schizophrenia, manic depression and depression.

* Algeid is the iron bands for fastening the two legs or hands.
* Algnzier is the iron chains.
* Feet geids and handcuffs; genzeir is the metal band used for geids.

The client who is possessed by jinn is not allowed to eat any salty food, milk or meat, because such food help the jinn to grow bigger and be more strong and active to cause trouble. (S.H.)

It is well known that at this massed, salt is forbidden for all possessed patients, because most of the spirits have a good appetite for salty food. (S.H.)

Spirits get power and become strong from the food that the patient eats. (Q.H.)

Other interviewed sheikhs allow the normal food of a massed when they serve the diet food and that is Assida or kisras[*] and Mulah[*].

Patients who are not in geids are allowed to eat the normal diet of a massed, which is served to visitors and people living in a massed which is usually composed of Assida and Mulah. (S.H.)

In all these visited masseds it is observed that worship acts and religious rituals such as mass praying, zikir circles and Quran studies are carried out as the collective activities. Similarly meals are prepared and served in groups. It is also observed that even patients in geids are encouraged to some work inside the massed within the limits of each one's capacity and desire. Despite their constraint patients were observed, by the author, cutting wood into smaller pieces for cooking, rearing cattle, serving their sheikhs and their guests, ploughing soil, planting seed, mowing grass and gathering crops. The interviewed healers believe such activities and works help patients to clean their moral and soul as it develops their mental abilities, they enjoy the group work and their confidence is promoted.

Our system here is that a client is gradually encouraged to take part in all available religious group activities that play a big role in cleaning the soul and prove the mental abilities. Also there are some works such as cooking, cutting wood, gathering the crops or mowing the grass. The client can participate in one of them after he/she shows improvement or proves recovered, because such participation helps a client to forget his agony, enjoy the interaction with other colleagues and lifts up his mood and promotes his self-confidence. (S.H.)

c. Zar healing methods

Despite the fact that Islam technically prohibits the zar, which is the trance ceremony of North Africa and the Middle East, it continues to be an essential part of theses culture.
Zar is best described as a healing cult in which drumming and dancing is used in its ceremony. It also functions as sharing of knowledge and charitable society among the women of these very particular cultures. Most zar healers and most of the participants are women. Many researchers have noted that while the majority of the possessing spirits are male, the possessed are generally female. This is not to say that men do not contribute to

[*] Asida or Kisre are Sudanese's bread made of sorghum and water.
[*] Mulah is the sauce, which is composes of meat and any other fresh vegetables.

zar ceremony, they contribute with drumming, the slaughter of ritual animals or may themselves be a husband or relative required to make offerings to the possessing spirits. In fact, it is perhaps an unfortunate trend that in cultures where the zar becomes more visible, there is a stronger tendency for female to co-opt the ceremony, and for men to become healers.

Most of zar healers mentioned the concept of zar healing as a ritual participated long ago in Sudan, but Islamic law outlawed it in 1983. The essence of these rituals is to pacify the spirit "which is mentioned in Quran and called Jinn" by some demands like singing, dancing and sacrifice, for it is believed that if the spirits will be in the body of the persons, who most of the time are women, it causes sicknesses and some troubles if it will not be blessed.

Me'ira (1996) in her article notes that there has been actually a proliferation of cult groups in the republic of Sudan, and a dramatic increase in the type of demands made of the cult. She attributes this in part to a poor economic situations which encourages men to go outside of the country for work, leaving women as de facto heads of households, with all the resulting stress.

Diriye Abdullahi, a Somalia native, argued that zar is basically a dance of spirits, or a religious leftover dance-kind from the old African deities. He described it as a ritual dance, which is mostly done by women, especially old women. This corresponds to the practice of old African religion in which old women were the priestesses. He maintains that young women, especially unmarried women, are not generally thought to be worthy of a visit by the spirit of zar, who chooses domicile or residence in the person who is his choice.

The zar ceremonies were well established in Sudan since the 1820s, but Shari'a law outlawed them in 1983 and instead of decreasing the ceremony actually appears to have increased. The zar today is practised more as a relaxation and as spiritual healing for stressed or troubled persons, especially women in our restricted society. Islam itself has always believed in existence of spirits, which it called Jinn. In addition the zar has been officially banned in Sudan since 1992, but the drums still beat on, possibly because of the support of the wives of influential men. (Z.H.)

Healing the patients who are possessed by zar depends mainly on doing the zar ritual, which are usually made to appease the Jinn spirits by some means such as singing, dancing, gifts and sacrifices, not expelling or punishing them. These spirits will remain in this state for the rest of the life of the individual and continue to show up at moments of crisis in the individual's life. (Z.H.)

- **What a zar ceremony involves**

In Sudan, zar is usually set in a large room with an altar, which is covered with red cloth. In whatever place the zar occurs, it is important that the domestic living space be separated from sacred space, or the place of sacrifice to the zar. In some cases this may be a separate room of the house, or it may be a house built or rented especially for the purpose.

The Kodia[*] and her musicians occupy one side of the room, the participants the rest of the room. The guests are expected to contribute an amount of money appropriate to their station. Having a zar ceremony can be very profitable, but it is understood that the zar leader is someone to whom the women can go for help in time of need. Thus it also functions as a kind of charitable society in which members both give and receive help.

The interviewed zar leaders agreed upon the zar ceremony as a basic demand of zar spirit. The patient has to obey the order of the sheikha that concerns some preparations that should be done before the ceremonial day. They mentioned such preparations like special clothes and perfumes, the woman patient has to decorate her hands and feet with Henna dye, the room of the ceremony has to be decorated with red coloured curtains and some folkloric articles and preparations of food and drinks in addition to sacrificial sheep.
Me'ira (1996) mentioned that the woman, for whom the zar is prepared, wears white, often a man's jalabiya[*] or shirt. She wears Henna on hands and body, and kohl in her eyes; she may also be heavily perfumed, as she is the guest.

Duriye Abdullaha, a Somalia native says that perfumes "specially frankincense" are the most common offerings to zar spirits. At the beginning of the ceremonies a romantic censor is passed among the guests, so that they might purify their bodies by inhaling the fragrances.
Me'ira (1996) stated, "If an animal sacrifice is used, it might be a chicken, pigeon, a sheep, or even a camel if the woman is rich. In any case, providing some type of food or meal is an essential part of the ceremony". Ethiopian spirits are said to be very fond of coffee. Non-Muslim spirits may demand alcoholic drinks, while female spirits may prefer sweet drinks like cola. He added that in Sudan, in those areas where a sacrificial animal is considered necessary, the patient's recovery is not considered complete until the sacrificial meal is consumed on the final evening. This generally consists of meat, bread, rice and spicy broth.

The basic demand of zar spirit is zar ceremony, which is preceded by some preparations such as buying special clothes and perfumes. The possessed woman decorates her hands and feet with henna dye, the room where the ceremony is going to be held is decorated with red colour curtains and other folkloric materials, also the relatives of the possessed women prepare food and drinks in addition to the sacrificial sheep that will be slaughtered on the last day to complete all the spirit's demands. (Z.H.)

The interviewed sheikhs mention that the rituals of zar ceremony begins at midday with the arrival of zar leaders and her assistance with their musical traditional instruments in the form of a few drums known as Tar or Tabla[*]. Those who are known already to the zar and admitted to ceremony when they keep quiet form the bulk of the invitee, but at private rituals, only the patient's family forms the invitees' circle.

Usually I start zar rituals at midday when the invitees take place. Zar ceremonies have members that are expected to attend sessions regularly and other invitees are admitted to

[*] Kodia is a name for zar leader or zar sheikha.
[*] Jalabiya is a white dressing for Sudanese men.
[*] Tabla/Tar is a type of instrument use to play the drums.

the ceremony when they keep quiet, while in a private ritual only members of the immediate family may be involved. (Z.H.)

The musical instruments that we use are tars and percussion, the number of my helpers range from three to six that provide rhythmic backup. (Z.H.)

Usually Kodia start the quiet rituals of zar with certain khiet*, which is supposed to be preferred by the spirit that possessed the patient. The interviewed zar healers mention that they play the first khiet after keeping the patient in the centre of the procession.

I ask my helpers to sit the patient in the centre of the procession to do the rituals of the opening day of the ceremony, and then we sing the first khiet that I suggested to be the preferable one for the spirit that caused the patient's trouble. (Z.H.)

Also those healers mentioned that, when the patient starts to respond to his or her preferable khiet, dancing, jumping and enjoying the rhythm of the ceremony, or asks for demands such as jallabyia and walk-sticks in the name of Rugal Alarab* spirit or asking for a pipe and wine in the name of Khwage* spirit, or when patient shows strange behaviour such as hysterical fits, unintelligible speech, stomach inflating or loud laughing or crying, that means the patient becomes in trance while the spirit is taking place and asked for these demands which sometimes are not acceptable and/or women cannot ask for them if she herself is not possessed by this spirit.
Meíre (1996) described women in a zar ceremony; he noted, "Each woman moved to the pulse of the drum. The sick woman's movement increased in intensity and speed, her eyes half closed, she appeared totally oblivious of her surroundings, abandoning herself completely to the dance. Her movements flowed freely from the inside out, from her throat to her limbs, gaining strength and speed as she came full circle around the impressing altar to where the helpers were, till finally, she threw her arms up and was about to fall, but the kodia guided her to the floor". He adds that, smoking, wanton dancing, wearing male clothing, publicly threatening men with swords, speaking loudly lacking due regard for etiquette, these are hardly the behaviours of Hofriyati* women for whom dignity and propriety are leading concerns. In the context of a zar they are common and expected.

Littlewood & Lipsedge (1982, 171) argued that the abnormal behaviour or speaking in unknown tongues when a patient is in trance is believed to result from a supernatural power entering into the individual, with control of the organs of speech by the holy spirit, who prays through the speaker in a heavy language. It is a dissociate trance like state in which the participants tend to have their eyes closed, they may make twitching movement and fall, they flush, swear and many of them tear at their clothes. It is a feature of spirituality and religious practice.

Everybody in the ceremony knows that the possessed woman took place when she joins her Khiet and the spirit that possessed her asks for different demands according to its type, e.g. when khawaga khiet is played, the patient who was possessed by this khiet asks for a

* Khiet is word use by zar healers, which means tune or song.
* Rugal Alarab means the Arabic men.
* Khwaga means the European man or the white man.

hat, pipe and European soldier's dress. Rujal Elarab asks for jalabyia and stick, lolia Elhabishia asks for red dress of bright lady or white Ethiopian dress of a young woman and gold. Moreover woman in zar trance shows strange behaviour such as dancing and jumping in a quick movement, breaking in tears or laughter, inflating the stomach to a considerable size and the speech is not understandable to the participants. (Z.H.)

When our leader plays the Elturabi[*] khiet, the woman who is possessed by this Turabi spirit, throws herself to the ground and her stomach is inflating till the participants think it will gush out but it comes down after the trance. (Z.H.)

Behaviour of the possessed people, when they are in trance, could be characterised by aggressiveness or peacefulness. The interviewed healers mentioned that some participants of zar ceremony show self directed aggressive behaviour like girding their elbows against the floor, or show aggressive behaviours towards children which is expressed by Alsahaheer[*] spirit, while other participants show peaceful and happy behaviour. Foster & Anderson (1978) argued that it was not unusual to see individuals while entranced, express both in words and non verbal behaviour sadness, anger, fear, and other deep emotions. They felt relived and happy after trance.

Some patients in trance become aggressive, gird their elbows and hands against the floor till they bleed, others who are possessed by Alsahaheer spirit, hit children and do not like to see them around, while other participants did not merely trance, they dance, jump around, sing, exhibit glossily, and gave voice to strong emotion which was usually public behaviour. (Z.H.)

Zar leaders mentioned that the zar ceremony usually starts beyond a mid day, three or seven days for the ritual ceremony; singing and dancing continued till the sunset. The last day is the day of sacrifice in which the sacrifice animal will be slaughtered, but before that the participants do some ritual processes.

This ceremony continues for three or seven days, but the last day is a special day, where some of the ceremony participants decorate the lamb legs with henna and cover it with a red shiny cloth, then they carry lighted candles, dancing and singing around this lamb which is brought for the sacrifice day. After slaughtering this lamb some of its blood will be poured into a metal pot and mixed with special perfumes, then I ask the woman to whom this ceremony was made for, to smear the lips and forehead of the participants with it. (Z.H.)

To finalise the ritual of zar healing, the zar leader mentioned that, at the evening on that sacrifice day, the patient and some participants go with the zar sheikha and her group, in a musical procession to a nearby source of water where the patient and all the group washed their feet, hands and faces as a final ritual to get rid of the possessing spirit.

[*] Elturabi is the man who comes from the grave; Hofriyati is the woman who comes from the grave.
[*] Elsahaheer is the word mentioned to the people who are known with bad look or to have the evil eye.

The final ritual of this ceremony takes place in the evening of the sacrifice day, I go with my patient and all the invitees to a nearby water source, usually it is the River Nile, where we can sing and my patient washes her face, hands and feet to be free of the sickness and all the troubles which are caused by the zar spirit. The participants can share the patient in the same rituals. (Z.H.)

After the sacrifice day, zar healers sometimes ask their patients to stay a minimum of three days at home to relax and rejoin them. They believe during this time all the psychological and physical signs of possessing will disappear.

At the final day of the ritual, if the patient is still looking sick or suffering from frightening dreams, depressions, vomiting, fever, headache or bleeding I will ask her to start her normal life after three days from that day. During this time the spirit can relax on her body and all troubles and signs of sickness from which a patient suffered will disappear, also the patient can get time to relax with this peaceful time. (Z.H.)

4.2.5.5 Summary

Most healers believe that healing or curing is a power that comes from God. It has been written in the Holy *Quran* that 'Muslims are fatalistic' and hence most of the Sudanese people believe that health is in God's hand and they don't take care of their health. Although such beliefs reflex one of the patient's spiritual dimensions but of course is an obvious mistake, because Islam aims to offer health and peace for all the people.

Society decides what symptom patterns can be defined as 'deviant' or that special type of deviance 'mental illness', therefore, health is only defined relative to the society in where it is found and can not be said to have universal existence because it is usually influenced by the belief of the local culture. Those healers define health according to the type of illness that the patient seeks help for and what they want to offer. They said for the patient with interpersonal conflict, the aim is to restore the harmonious relationship between patient and his life, while for the patient with misfortune the aim is to reduce the causes.

Most healers mentioned the importance of the traditional healing which is well known, respected and trusted by most people. It offers a good relation between healers and clients because it is based on confidence, informality and respect. Some healers mentioned that most people gave up modern medicine and thought to be in need of traditional healing.

There are different methods of healing e.g. *Quran*, Sufi, and *zar* healing method. The methods of healing by *Quran* are based on the teachings of the prophet Mohamed (peace be upon him) in *Quran* and *Sunna* statement, this type of healing is known as *Altib Alnabawi* (prophetic medicine) and it was divided to three main categories, which are honey, cupping and cautory. The interviewed healers have three stages of healing: first, when a client comes and asks for treatment, the second after a client shows signs of recovery and the third stage after a client is completely cured.

Zar is known as rituals practised, the essence of these rituals is to specify the spirit by some demands like singing, dancing, gifts and sacrifices because *zar* healers believe that the spirits will be in the body of the possessed person and will make some troubles if the person does not bless them.

Zar ceremony is the basic demand of *zar* spirits, which is known as *Hfal-Elzar* (*zar* ceremony). Before starting the ceremony there are some preparations, which should be done such as food, drinks clothes and perfumes. Then the client decorates her hands and feet with henna. The zar room should be decorated also with red colour. The rituals of *zar* begin at midday with the arrival of *zar Sheikha* and her assistants with their musical traditional instruments in form of few drums. The highlight of sears is the impersonation of *Lolia*, *Turab*i, in which elaborated and strange behavioural changes take place. The participant believing that the patient comes in trance and the spirit that incarnated the patient's women asks for a pipe and glass of wine in the name of *Khawage*, or *Jallbyia* and walk-sticks in the name of *Rugal Elarab*. Each possessed person comes in trance when the healer sings his/her *khiet* and everybody can realise it, because the client's speech itself usually for the attendance is not easy to understand. Also the clients in trance don't look the same when he/she is in the normal situation, he/she shows strange behaviours that are suddenly beginning; such as laughter laughing, breaking into tears, developing paralysis, or showing self-directed aggressive behaviour like girding their elbows against the floor till they bleed, or showing aggressive behaviour towards children. The last day in the evening, all the participants go in a musical procession to a nearby source of water where the client washes his/her feet and hands as a final step to get rid of the possessing spirit.

Sufi healing is the most famous traditional system of interpersonal healing; it is based on a religious power. This type of healing is very widespread because most of the Muslim people believe that God gave some power to those healers and they are using this power to heal and help people. They can inform the client what was causing his/her problem and prescribe various therapies. People come to healers asking for different favours such as healing, blessing, fate determined or bad fate treated, or looking for consultation, because they have personal questions or family problems but most of them ask for treatment. Those healers have different methods of healing which reflect the values, belief and attitude of their community about what was causing illness, how to prevent it, and what is the meaning of health. They may prescribe *azima, mihaya, bakhra, waraga*, *chains, flagging*, *higab*, or diet.

Azima is one of the Sheikh's methods. Most of the Sheikhs describe azima as the recitation of specific Quran verses punctuated partly by breath taking and blowing while the Sheikh's lays his hand on the head of the client. This holy breath is directed towards the most aching or paining part of the body, which is then touched, softly by the Sheikh's hand or the Sheikh's sticks in the case of the female patients.

All the healers agree about the concept and nature of *mihaya* as a technique of healing, to prepare *mihaya* that specific *Quran* verses are written on the *loah* which is the tablet or writing board used by *Khalwa* students, the symbols are then dissolved in water and the resultant solution is called mihaya, patients are to drink it. At big occasions, healers prepare *mihaya* by writing the whole *Quran* verses at both sides of a *loah* or in the inner surface of

a white bowl, then they dissolve the written symbols in clean water, all visitors can drink from this holy water or rub their bodies.

Bakhra is another technique of religious healing utilizes *Quran* verses that are written on a piece of white paper and it is folded in a special form. This paper should burn without flames and the client inhales much of the rising fumes.
Higab is another form of the Sheikh's methods for treatment and protection. The word *higab* comes from *hagab*, which means to protect. It is made of *Quran* verses written on a sheet of paper and covered with thick material. All the time, the client should keep this paper with him. Some healers mention that *higab* has many functions such as to avoid malicious look, the influence of the evil spirit, sorcery, to divert weapons, or to ensure success. The secret behind the efficacy of these methods is derived from their holistic origin and the ultimate healers relate such benefit to the person's belief.

Flogging or lashing patients is an aversive technique of treatment by traditional healers who aim to make the patient's body an unpleasant place for the spirit that possessed him/her. The results show that all healers flog patients who are violent, disobedient and troubled by some spirit. The patients are flogged on legs and back in all cases by Sheikhs themselves, those Sheikhs divert on the average numbers of lashes, some of them said five to ten while others give less than eight lashes, but they are agree on the softness of flogging.

Chains and fetters are used as a technique of cure and protection. They are called *geid* and *genzier*, both are observed as common methods at all *masseds* visited. Some patients are kept outside the massed in a desert area and tied by one leg to a tree trunk, others are tied to a pillar in small rooms or have their feet and hands tied together. They use this method when a patient is completely out of his mind or too excited to cope with other people. All healers believe that tied patients will calm down the spirit that possessed him/her, and also this method protects the patient and the surrounding community.

It is well known that the most common and simplest art of healing is food regimes; it is based on forbidding patients from some sorts of food, which they believe to give power to the spirits. At all visited massed, it is found that healers used food deprivations as a technique of healing, they deprive patients of milk, meat and their products in addition to salt food, because most healers believe that there are some types of food, the spirit can get power from and then feels this body is a pleasant place until it grows and becomes big, strong and active to cause a lot of troubles.

4.2.6. Collaboration with psychiatric doctors

In this time, it is no longer valid to argue, as was done in colonial times, that medical doctors are few in number, and that therefore it was the traditional healers in the rural areas who were serving the needs of the people. Now it is time to provide the best possible service to all the people by professionalizing the services of the traditional healers, if they are willing. Traditional healers are a group that should not be left out .If they are left out; you are leaving out 80% of the total community.

Mburu (1977, 161-162) mentioned that traditional medicine evaluation is partly based on the beliefs of the society, partly on the value system, and partly on the actual behaviour of the needy client. But modern medicine falls short of this. It is something the people do not understand. It is as foreign as the white face, coats and buildings associated with it.

Traditional African medicine is shorthand in references to indigenous forms of healing that are practised all over Africa. Although traditional African medicine is based on the accumulated experience of ancient Africans, it's made of transmission by word-of mouth and this has hindered the emergence of a generally accepted theory and hence of the systematic development of traditional African medicine as a self-regulating profession. A major therapeutic objective in the treatment of illness in traditional medicine in Africa is the diffusion of emotional stress (Okpako 1999, 82).

4.2.6.1 Healers' attitude towards collaboration with professional doctors

All the interviewed healers are willing to collaborate with psychiatric doctors. They believe this step will lead to provide appropriate therapy that generates from culture and science, for the patient's benefit.

Collaboration will give us a chance to share power with the psychiatrists, in order to provide culturally appropriate therapy. (S.H.)

We believe that illness and health are in the hand of god, and maybe two hands will work better than one. (S.H.)

Traditional healers believe that God has given the doctors the knowledge of medical science as He gave them the secret of healing, and He directs the patient to seek the help of both practitioners. Therefore the healers will not face any problem neither with the workers in the field of medical science nor with the patient who seeks help of the medical health system.

I'm prepared to help the people who seek my help. Whatever they think or believe is fine and I will not argue with them since they believe in God. (Q.H.)

If someone goes to the doctor, I think God has directed his/her mind to go to the doctor. I believe that God has given these doctors the knowledge to help people and to cure them. Sometime this healing may come from both: that God has given them the knowledge and that he gives them the secret of the religious faith. (S.H.)

Some of the interviewed healers agreed that there are two types of illness: illness that only could be treated by the professional doctors and illness/problems that are difficult to be treated by doctors, and the interference of the traditional healing power will be needed in the later sickness. And they have experience with such problems. Westermeyer (1977, 102) mentioned that in his experience, a certain historical process evolves in which patients

make use of the modern health care worker. Briefly stated, "The process occurs as follows: (1). Acute trauma, acute infections with fever and signs of sepsis, and superficial tumours are the first to be transferred to the modern HCW. These are the problem in which the HCW has greatest success, and in which the patients and their families can observe the most dramatic result. (2). Chronic and sub-acute medical problems come to the modern HCW later, and then only after prolonged treatment by numerous traditional healers. Even where the assistance of the modern HCW is sought, patient and family often prefer to continue with the services of traditional healers and the HCW at the same time. (3). Psychiatric and psychosomatic cases tend to remain with traditional healers the longest, and do not seek help from the modern HCW except in severe cases (i.e. suicide attempts, prolonged psychosis). He added that his probably occurs because of (a) less of communication nuances between the patients an the modern HCW, (b) the frequent success of traditional healers in mild cases, (c) the greater time required by the modern HCW o treat such cases, and (d) the relative naiveté of many modern HCW in the care of such cases especially in the ethnic groups or social classes different from their own".

Some problems seem to be hidden in the fact that only professional doctors can do treatment and cure but there are also problems that are more difficult to heal with medicine and within the hospitals theoretic environment. When the doctor tries to treat the latter ones, he will be a blunder, not sure of what he is doing or why, and try to govern his failure, but actually he is not a powerful therapist for such problems. (S.H.)

I tried different methods of my own healing as we did the zar ceremony, for one of my clients, showing no sign of improvement and finally I sent her to see a professional doctor to look what is her problem. After three months she came back to say now she is much better. (Z.H.)

4.2.6.2 Summary

The integration of traditional healing, particularly the religious one with psychiatric medicine seems promising since all the interviewed healers have no problem to share their secret power of healing mental and social problems with the other partner in the field of mental health and illness. Traditional healers believe that illness and health are in the hand of God, and God gave the professional doctors the scientific knowledge as He gave them the secret of faith. Therefore, they believe that two hands are work better than one hand. Moreover, they have knowledge about mental illnesses as they agreed that illness has two types: one that can only be treated by the professional doctors and the other that needs their power of therapeutic healing.

4.3 Practitioners'Results: Discussion And Conclusions

4.3.1 Psychiatric doctors and traditional healers: A comparison

Introduction

After having done the operationalisation of the patients' tendencies and decisions, conceptual framework, defining and specifying the problems related to literature, as regards the mental health theories and practices of medical doctors and traditional healers in general and in Sudan particularly, attention was paid to describe theories, diagnostic processes and treatment methodologies of the two health systems. Simple measurements were designed and covered five categories: aetiology and causes of mental disorders, classification of mental disorders, diagnostic methods, treatment and tendency towards collaboration with counterparts in the field of mental health, in addition to practitioners' socio-cultural variables (Appendix 2).

To ensure achievement of the research objectives we put special focus on designing the questionnaire and we also oriented the practitioners of the two health systems to the research objectives and to the need of filling the literature gap in this area. For the survey, 16 respondents from both sampled psychiatric hospitals and massed centres were selected and interviewed in the Arabic (local) language. The psychiatric doctors, heads of departments and their assistants and the traditional healers, sheikhs' heads, were selected as respondents, as were their assistants if possible. The requirements of an in-depth interviewing procedure, close monitoring system using tape recording, and intensive individual analysis needed for the data justify our relatively small number of respondents.

The discussion in this chapter focuses on the interpretation of the results of the two practitioners in the field of mental health and illness (chapter 4) as well as the relevant clues obtained through systematic observation and casual discussions carried out by the author during the survey. The aim is to identify similarities and differences between the two health systems and summarise the major findings obtained from the results.

4.3.1.1 Practitioners' characteristics and qualifications

Almost all the interviewed Sheikhs were men; this makes sex a major criterion of being a mental healing Sheikh. The reasons for sex segregation in this area involve a century-old tradition of rural communities in the Sudan in which there is hardly any chance for a woman to compete for the post of the mentor of Massed, irrespective of her other relevant qualifications. Besides, the methods of treatment such as flogging, threat and chaining are associated with masculinity. However, it is worth mentioning here that women are equally specialised in *zar* traditional healing where *zar* leaders are almost exclusively women although some of the *zar* clients are men.
The study also showed that, as old healers and descendants of healers, Sheikhs are quite mature and highly experienced. The average age of the sampled sheikhs is 54 years. This

allows them easily to play the parental role for most of their mental patients. The Sheikhdom (a place where the body of the father sheikh lies) represents a form of apprenticeship where the older Sheikh hands over his knowledge and skills to his heirs to ensure the continuity of the family's spiritual heritage.

Formal education is becoming increasingly common among traditional healers. The youngest Sheikh in our sample completed two-years graduate study at *Quran* College; another two Sheikhs are university graduates. Sheikhs of formal education were found to be more liberal than normally educated traditional Sheikhs. They recognised and appreciated the role of psychological and psychiatric methods for successful treatment. They were found to be more co-operative with researchers and psychiatric units to the extent that they refer chronic cases to mental hospitals and encourage psychiatric units to visit their centres.

The types of traditional healers not only differ in their qualification but also in the way through which they obtained their qualification. For instance, Sufi healers who always come from a Sufi family learn the art of healing from their fathers - who teach them to respect the other, to participate in solving community problems and to follow certain religious rituals, e.g. prayers and fasting that aim to strengthen the personality and give them power to carry on. On the other hand, *Quran* healers do not necessarily have religious ancestors; they learn the art of healing by hard study, self-experience and religious rituals. Contrarily, *zar* healers differ from religious healers as they claim that they never intended to be healers but were chosen by the spirits to be so. The spirits give them the ability to treat people, and later experience and practice augment their skills. This was supported by a study of Teshome & Bahire (2000) that aimed to see how healers are initiated in Ethiopia and describes the position of traditional healers in the current situation of Ethiopia. It is found that most of spiritual healers believed that they are selected by divine power or spirit. A single way or a combination of ways manifests the selections, namely: through dream, escaping mortal accident, and miraculous healing from chronic illnesses. However, secular healers got the initiation through apprenticeship.

The result showed that for the entirety of psychiatric doctor their formal education takes place in universities under the direction of a group of faculty members. Their training based on scientific methods as their information and procedures are shared with colleagues and tend to be eclectic rather than irrevocably tied to traditional prescriptions. Their ways to treat patients are based on demonstrated knowledge and skills.
Comparing the personal characteristics of the traditional healers with those of psychiatric doctors who gained their profession and position through formal education and qualifications, we found that in spite of their differences some similarities do exist between them. There is an agreement that a successful healer or professional doctor must possess the following personal characteristics:

1) Ability to communicate with people.
2) Trustfulness.
3) Intelligence and broad mind.
4) Co-operation.
5) Responsibility.
6) Respect.

4.3.1.2 Causes and possession

All interviewed healers believe that insane people are invariably possessed by evil spirits which enforce themselves into the body and make the afflicted go mad against their will. So all traditional healers agree that the supernatural power in the form of spirit, magic, evil eye, envy and *zar* are the main cause of mental disorders. They have different theories of mental disorders. The first theory is based on the concept that there is a lack of harmony among the various body components, the second theory is based on the concept that mental disorders are not a form of disease but a possession, which results from misfortune or supernatural possession, the third theory sees these disturbances as a bad luck (fate) or God's punishment and in the later case, healers believe that the client is responsible for his/her health, and the last theory is based on the concept that an individual is composed of his or her physical body and immaterial souls or spirits that under some circumstances may become detached from the body and wander freely. It is clear that their classification of mental disorder causes differ completely from psychiatric medicine that relates mental disorders to organic, hereditary, psychological, and social causes. For instance healers think that a victim may unintentionally walk on *Naga'sa* (over a soul of spirit residing therein) resulting in spirits retaliation. This is quite different from the medieval concept of possession where the patient is virtually responsible for having the devil residing in him, either directly or as a result of sinful acts committed by the unfortunate individual.

However, the concept of demonology in religious theology is not confined to Sheikhs and their traditional believers. The famous Islamic thinker *Ibn Elghaym* in his book *Eltibb Elnabawi* (1993) supported this concept and illustrated it by narrating the story of the epileptic patient who had been brought to the Sheikh during coma. The Sheikh took a hard stick and started hitting the patient on the throat so hard that all the present people thought that he would kill him. To their great surprise, ten minutes later, the patient restored his normal functioning and assured that he had never felt that he had been hit. This story is consistent with the point of *Alkhalifa Osman (*the son of the famous Sheikh Wad Badur) as he suggested to the author, during the interviewing phase of this study, that *Al Arifien* (Sheikhs of deep knowledge) can hit the devil directly and force him to leave the possessed body.

Karenberg & Leitz (2001) studied the headache in magical and medical papyri of ancient Egypt. They noted that scattered references to headache are extracted from so-called magical papyri and from medical texts of the New Kingdom. Although little is known about the quality of headache and about accompanying symptoms and due to the lack of precise descriptions it is impossible to establish the retrospective diagnosis of migraine. The results of the study suggested that explanations of the origin and of the corresponding therapeutic actions differ according to the nature of the source. In magical papyri, headaches are attributed to the action of demons and supernatural forces, whereas medical papyri emphasize the role of head trauma and of pain matter occurring in the body. Treatment could be magical, pharmacological or surgical. The same belief about the causes of malaria was found in Mali. Vogel (2002) argues that before the *Bandiagara* Research Project (collaboration between professional medical doctors and traditional healers in the field of health care) began in Mali, malaria and its symptoms such as headache, fever and hallucinations and delusions were not associated with "the disease of the green season", the

local term for malaria. Seizures and coma were considered symptoms of *wabu* (type of spirits), caused by a bird that cries out at the same time a child cries and steals a child's spirit. Parents did not consult the local doctor but rather the traditional healers.

4.3.1.3 Scope of specialisation and classification of mental disorders

The interviewed Sheikhs in this study were found to treat virtually all-psychiatric causes including psychoses, neuroses, psychosomatic and personality disorders. They were also found to have a reasonable classification of mental disorders parallel to modern psychiatry. They have two classes of mental disorders named locally as Jinn. The first is *Arrih El Aswad* (black wind), which is believed to affect the mind, and the second is known as *Arrih El Ahmer* (red wind) that may attack other parts of the body. *Arrih El Aswed* stands for psychoses and *Arrih El Ahmer* seems to stand for all types of neuroses and psychosomatic disorders.

The link between fluid colours and mental disorders is prevalent throughout the different phases of understanding mental health in the present as well as in the past history. In the four humours of Hippocrates, (about 400 B.C.) depression was related to the predominance of black bile and irritability was related to the excess of yellow bile (Bassher 1994).

It was found that traditional healers diagnose all mental disorders as madness. Their diagnoses are based on signs and symptoms like disorganised speech, fugue, occupational failure, and negligence of hygiene. Although they can detect other signs and symptoms of mental disorders they don't relate them to mental illness. They classify, for example, *zar,* which is considered as somatoform or dissociates disorder, as spiritual possession. Also some sexual disorders like impotence are explained by magic and spirit possession.

Zar healers classify *zar* according to the type of the possessing spirit, which is identified by the style of clothes, demands from the patient and *zar* song (*Kheit*). The name given to the spirit indicates the site where the spirit is thought to come from. This classification is not based on the signs or symptoms of the patients' disorder. *Quran* healers' classification is also not based on signs or symptoms of the patients' disorder but differs from *zar* healers as they take *Quran* and *sunna* as their reference.

Finally we can conclude that the difference in classification of mental disorders between the traditional healers and the psychiatric doctors is that the former classification is based on assumed causes of mental disorders while the latter is based on signs and symptoms.

4.3.1.4 Interviews with patient/client

Ttreatments in all of the centres visited starts with interviewing the client first as all Sheikhs believe that the person coming for help is not necessarily sick. Usually the client or one of his relatives explains the problem in some details. From the very beginning the Sheikh tries to assure the patient that there is no threatening danger. Every word stated by the Sheikh is taken for granted. Sheikhs were observed to exhibit deep involvement with their patients. The language they use is full of concern and compassion; all through out the interview they were found to sustain friendly and comforting smiles. The language they use

invariably includes: *Inta walad mabrouk*, which means you are a blessed boy, patient or relative. As previously mentioned, patients were often reminded that there is no real danger: *Mafi awaja*. They were also reminded that *Alla* (God) is the ultimate healer who will cast his blessing and bring the final cure because he is the *Karim* and *Rahim* (the Generous and the Merciful).

It is worth mentioning that all Sheikhs believe in the concept of the *Nazra* (gaze) as a quick and assured method of treatment for some mental disorders. Sheikh Al bra'ai in this study stated that the *Nazra* of his own predecessor had successfully treated many patients. One of the interviewed patients in Massed Umm Dwanban stated that the only type of treatment he used to receive was to exchange sight with *Alkhalifa* Osman (his Sheikh) every morning. Another interviewed patient at Umm Dwanban *massed* believed that gazing at the tomb of the well-known Sheikh Wad Badur for seven successive days improved his health status.

The author, during one of her visits to Sheikh Albra'ai, had witnessed a hysterical case in which parents brought a 14-year-old boy. The father stated that the boy had been crying continuously for the previous two days and refused to take his meals, and recently has experienced nose bleeding. The Sheikh looked the boy right in the face and their eyes met. The Sheikh asked the parents to release the boy and bring him closer to him, and then he pressed the boy's nose with his fingers reciting *Quran* for five minutes. After that he kindly said, 'Ahmed *waldi'*, (My boy, Ahmed) don't be frightened anymore'. The boy nodded and calmly followed his parents back home. The author followed up this case for the subsequent 5 days and observed that the boy had completely recovered from the observed symptoms. The above story indicates the similarity between psychiatrists and healers in using patients' interviews as a therapeutic session.

During the interview with Prof. Dr. T. Bassher, the author mentioned the above story in order to know his view about this case. Prof. Dr. T. Bassher immediately commented by mentioning another story mentioned by Mell Hooks in 1986 of a neurotic patient who had been suffering for years from a stereotyped tearing behavior. His family took him, at last, to a creative psychiatrist. Putting his hand round the patient's shoulder the doctor said, "let us take a little walk". The pair went from one end of the tiny office to the other, the doctor was whispering in the patient's ear. At last they stopped and the doctor said, 'you can take him, he is cured'. It was discovered later that the psychiatrist had only said to the patient: 'Don't tear, baby'.
These two stories show one of the similarities between traditional healing and the recent development in the concepts of behavioural psychotherapy.

4.3.1.5 Abreaction and diagnostic methods

The Sheikhs in this study were found to make use of a commonly held belief that they know *Gheib* (the unseen). Within this concept the patient believes that the Sheikh can read his/her thought and so he/she is obliged to recall all of his/her past experiences. Sheikhs stated that patients give far more detailed history (no matter how shameful or fearful they may be) to them than to psychiatrists. The author suggests that the patients absolutely trust

and endlessly respect the Sheikh, and this might be the reason behind this tendency of confession.

Generally the diagnosis process in the field of modern medicine has two stages. The first deals with collection of signs and symptoms and in the second stage these signs and symptoms are grouped under certain mental disorders. Traditional healers follow similar diagnostic methods for both mental and physical illnesses. These methods are based on the traditional background of mental disorders causation, e.g. *Quran* healers diagnose mental disorders by repeating certain *Quran* verses which are supposed to evoke certain signs and symptoms that help in identifying and detecting the causes of mental disorders. The *zar* healers, however, evoke those signs and symptoms through fumigation, which is considered as a form of abreaction therapy. On the other hand, Sufi healers follow different rituals, e.g. incarnation and *Khayra* as their spiritual methods of diagnosis.

So there is similarity in some of the diagnostic methods followed by both traditional healers and modern medicine practitioners namely taking history of illness, detection of certain symptoms and examination for certain signs. Also they correlate certain signs and symptoms to certain mental disorders, e.g. talkativeness, neglect of personal hygiene, etc. are correlated to madness.

Finally we can say that diagnosis by healers is based on verbal confession beside observable symptoms this comparable to abreaction in modern psychiatry. However, unlike the psychoanalyst, the Sheikh doesn't have to exert a lot of effort in order to generate the rapport necessary for the opening phase of treatment.

- **Subsequent interviews**

In the case where *Khayra* is used in diagnosing the patient's problem and identifying the therapeutic method, the interviewed Sheikhs in this study stated that in such situations they need to carry out subsequent interviews. This is because *Khayra* requires a long procedure, which starts with taking clues from the patient. Then the Sheikh performs some rituals at night and the *Khayra* depend on his dream. In case of a bad dream the patient is advised to see another healer where as in a good dream the first healer takes the treatment responsibility. The Sheikh in this case plays the role of a psychologist, psychiatrist and counsellor and this is comparable to the priest of the Middle Ages of Europe who was a combination of a minister, magician, physician and legislator (Coleman 1980).

- **Symptoms of jinn/psychosis**

In this study, Sheikhs were found to describe a patient as *majnon* (psychotic) on the basis of perception, psychomotor dysfunction, speech and orientation that is similar to modern psychiatric diagnosis. Symptoms such as *Ziadat Alkalam* (talkativeness), *Adam Altarabot* (incoherence of speech), and *Shuroad Alnazar* (un-concentrated gazing) are considered to be the main characteristics of *jinn* (psychosis) by those healers.

- **Awareness**

It has been found in this study that all the psychiatric doctors correlate the patient's awareness to psychotic disorders as it is considered an important symptom to diagnose mental disorder. This is the same with traditional healing diagnoses. The majority of the interviewed Sheikhs believe that the insane awareness of behaviour, surroundings and environmental stimuli is considered as an important symptom of *jinn* possession. For instance in both psychiatric hospitals and *massed* centres, it is observed that many psychotic/jinn patients are not aware about their behaviour as they are more violent and more aggressive towards their accompanying relatives. However, when they received E.C.T. (Electro-Convulsive Therapy) treatment, were whipped or restrained, they calm down, stop their aggressive behaviour and become more aware.

4.3.1.6 Treatment/healing

This study proves that treatment with both, psychiatric medicine and traditional healing aims to cure patients from mental disorders and helps them adjust within their societies and resume their normal life. Also studying the treatment methods of mental disorders adopted by both groups reveals some similarities.

In modern medicine, drugs and E.C.T. are used to treat psychotic patients and recently other psychotherapeutic methods such as supportive therapy, behaviour therapy (a version of therapy) and group therapy proved their effectiveness in treating psychotic patients.
However, the traditionally healing "Sheikhs" in this study were invariably found to apply *Aziema*, *Mihaya*, *Bakhra*, *Warag* and *Hijbat*, all of which are believed to contain *Kalam Allah*, (the word of the God). These traditional methods are reported to exist since long time in Sudan despite the availability and accessibility of modern psychiatric units. Naturally these methods have survived because of their effectiveness. The question is then what makes them so effective?

Muslims have long since held the therapeutic value of the Holy *Quran.* In the *Quran* itself a number of verses suggest this value, for example:
Surah XV11 verse No. (82): "And we send down (stage by stage) from the *Quran* that which is a healing and a mercy to those who believe."
Surah X111 verse No. (28): "Those who believe, their hearts find rest in the remembrance of Allah. Verily in the remembrance of Allah do hearts find rest".

A relevant experiment has been carried out in the U.S.A. (in 1984), in which the recitation of the *Quran* on the alleviation of anxiety was investigated. The experiment measured the psychological indices of anxiety reactions including blood pressure, heart beat, muscular tension and skin resistively. It was found that audible recitation of *Quran* significantly reduces the anxiety that provokes physiological functions. In this context one has to mention that Professor Badry used *Quran* verses in psychotherapy. An astonishing illustration related to Badry's own experience was the case of a depressed anxious Moroccan woman referred to him in 1955 in the neuro-psychiatric section of the University of Rabat's Teaching Hospital. The patient showed no response to all types of psychotherapy techniques. When hearing *Quran* verses on the forgiveness of sinful behaviour she responded with unexpected tearful emotion. That was the first step towards recovery of the Moroccan patient.

A mechanism that means to strengthen the efficacy of the use of *Kalam Allah* is the in-depth knowledge of *Quran* and its secrets by the healer in addition to the believe and acceptance on the part of the patient. These are the main two factors that interact in the achievement of relief and recovery. The unique status of the Sheikh and his fatherly attitude towards the patient, as we have seen in the interviewing phase, increase his power of persuasion and ability to cure sickness. The therapeutic techniques applied by healers acquire its power from the religious atmosphere and the accompanied confidence of patients in their "honourable Sheikh". When a patient believes that his/her sickness and problem is now being handled by the *Kariem* (the most generous), *the Rahim* (the most

merciful) and the Ultimate Healer, then he/she will accept that there is no *Aawajah* (no obstacle for recover).

The significance of this factor for acceptance was highly stressed upon by the late Professor Elmahi (1953). He noted, "The criterion of acceptance is the most crucial element for a successful treatment, and whether this acceptance is achieved by magical, religious system, emotional reversal or any other method of conversion is immaterial" (Citation from Elsafi & Bassher 1987).
Beside their persuasion, Sheikhs have additional traits (skills), mainly *Taghwa* (piety) and *Tahara* (purity). The *Taghwa* of healers and *Tahara* of his body and souls are considered essential for a successful therapeutic treatment and the ultimate cure. Sheikh Algeile specifically stressed this point during the interview phase.

The therapeutic technique used by the traditional healers as described is somehow similar to psychoanalysis as practiced in modern medicine. The only difference is that in modern medicine the patient's mental disorders are attributed to his/her surrounding society. Whereas in religious therapy, the patient is held responsible for his sickness by committing sinful acts or breaking cultural taboos. Accordingly, a successful therapy in traditional healing methods requires an initiative on the part of the patient to abandon his misconduct In the Holy *Quran* it is reported, "Verily Allah never changes conditions of people until they change their attitude" (*surah* X111 verse X1).

The Sheikh's *Duaa*, the supplication for God to save and cure the poor patients, is found to be shared by all of the *masseds* visited by the author. *Duaa* is practiced following each prayer and is considered a powerful way in religious treatment as it performs a intermediary role between the patient and his/her God. An example from *Quran* supporting the alleged statement is quoted from the second *surah*-verse 186: "And when my salves ask you (Oh Mohamed) concerning me, then I am indeed near, I respond to the prayer of the suppliants when he calls on me. So let them obey me, and believe in me, so that they may be led aright".

Moreover it was found that *Mihaya, Bakhrat, Warag, Hijbat* and herbs are widely used tools of suggestion therapy. In general these methods are more effective in the treatment of neurotic patients than psychotic ones. The reason behind their success with neurotic patients probably is due to comparatively better awareness of a neurotic patient and his/her acceptance for the treatment. Also it might be attributed to low associated hazards or side effect in neurosis as compared to psychosis. The success of these methods largely depends on the patient's believe in the method used and his/her confidence in the healer. These techniques are not restricted to sick individuals alone, but even many healthy individuals have a strong belief in traditional healing and resort to these methods when they need them.

a. Rapport

The rapport a sheikh has with his/her patients plays a great role in the success of the treatment. Rapport is essential as it makes the Sheikh and his patients in complete agreement on the concept of mental disorders' causality and effectiveness of treatment. Rapport is considered an advantage in traditional healing compared to modern psychiatry. This was interpreted by the fact that speech and language play an essential role in relation between patients and their doctors/healers. Semela (2001) did a study in South Africa to examine the degree to which the traditional or/and faith healers diagnose and explain the nature of a child's problem with the parents. The results suggested that language is a function of culture. Within the African culture traditional and faith healers play an essential role in counselling the community on various personal and communal health and life related conditions. This kind of practice is particularly observed among the native populations, among those less affected by Western influences, and among those who have less opposition from Western and Asian religions.
All of the interviewed Sheikhs were found to rely on patients' religious belief, and on the absolute credibility with which they view the healing force of *Quran* verses.

Some psychologists also report the importance of religious belief of patients for a successful treatment. Professor M. Badri (1979) stated, "I have always found my patients' belief in Islam very useful for the success of the treatment". Among the relevant illustrations Professor Badri quoted from his own experience in behavioural therapy in this country was the successful treatment of a young man suffering from a crippling phobia of death and of severe hypochondriacs in which Professor Badri successfully utilised the concept of life, of death, and life after death in Islam.

All psychiatrists do not necessarily advocate this common conceptual ground. Perhaps the main reason for this dichotomy in the psychiatric field is the nature of training received by psychiatrists and their cultural background. Both Dr. T. Bassher and late Professor T. Elmahi also stressed this divergence. Bassher (1982): "It is not surprising for our pioneer psychiatrists, all being trained abroad, to be faced by practical difficulties of case identification, of clinical diagnosis and of choice of therapeutic modalities". The late Professor Elmahi (1953) also explained these practical difficulties when he wrote, "The gulf between the therapist and patient is so wide, and their concepts as to what constitutes illness and recovery so different, that rapport necessary for the opening phase of treatment never occurs".

b. Aversion therapy

Flogging (putting in chains) and food regimes as practiced by traditional healers are considered to be one form of behavioral therapy. These methods are used as a punishment therapy and they aim to associate aggressive patients with their society. These punishment techniques can be seen as parallels to aversion therapy used in modern psychiatry. However, these techniques of healing do not have a scientific base as in behavioral therapy, but healers justify their use as a way to hurt the possessing spirit *(Jinn)* and get rid off it.

We have seen that patients under traditional punishment therapy are supposed to stay under this treatment till they show signs of recovery. As we know treatment of mental sickness requires a long duration. Therefore, the continuity of these harmful techniques might lead to many side effects, e.g. nutritional deficiency problems that facilitate the spread of other infectious diseases. In addition, lashing and chaining might also cause skin damage. The possible occurrence of these side effects necessitates the collaboration between traditional healers and mental health professionals.

- **Flogging**

This study reveals that flogging is often used as a type of threat. It is either a threat to the troubling devil to leave the patient's body or a threat to the patient to modify his behaviour. This point is indicated by the responses of Sheikhs during the interview as they mentioned that flogging is applied under specific precautions. It is administered by one person in each healing center, that is the healer himself, in a limited number of strokes, not more than ten lashes in most cases and the majority give much consideration to the health status of the patient. Electroconvulsive Therapy (E.C.T.) in psychiatry is found to be the closest parallel to flogging in traditional healing. It has been theorized that E.C.T. is in a sense effective as a type of punishment (Bassher 1994).

During her visits to Umm Dawanban, the author observed that psychiatric teams from the mental hospitals of Khartoum North make regular visits to this religious center. Drugs and E.C.T. were observed been administered for both inpatients and outpatients. A more interesting point is that some patients believe that the drugs and E.C.T. of the *masseds* are more effective than those of the hospitals as they are full of *Baraka.*

Patients with strong belief in their Sheikh and his overwhelming *Baraka* were observed to be obedient and submissive to aversion therapy, they perceive it as a welcome punishment. The patients and their relatives know about the Sheikhs' techniques of mental healing including flogging and punishment methods, and they voluntarily accept his treatment. It has been postulated in other studies that when this treatment is chosen and accepted by the patient a 51% overall rate of recovery is reported (Badri 1979).

Nevertheless such types of harsh and harmful treatment must be looked upon with considerable precaution. A patient in Altigani Almahi Hospital was a victim of wrong diagnosis and reckless administration of treatment. When a native healer attempted to drive the devil away from his body, through heavy blows on the skull, this resulted in serious brain damage.

- **Chains and Fetters**

The scene of patients in chains wandering around or tied to a pillar in a room or out in a desert was found to be very familiar in Sheikhs *masseds.* They are considered as another type of aversion therapy in an attempt to abandon violence and aggression. The primary

aim of such techniques of healing according to Sheikhs in this study is the general safety of the patient himself or herself and the surrounding people. Through personal communication the author has been informed that in the *massed* of Umm Dawanban, an insane patient had once killed his inmate.
In this study it has been observed that some of these patients had been in chains for an average of six years. They seemed to have already adapted themselves to such type of living.
This indicates that Sheikhs also look after mental patients who in modern settings are confined to isolated units. However such patients in the Sheikhs *massed* were kept in the same place with the ordinary mental patients.

- **Food regimentation**

Food regimentation among Sheikhs' techniques of mental healing includes deprivation of protein containing food such as meat and milk products. It is of great interest to mention that protein nutrients in blood were found to constitute the initial resource for catecholamines. Coleman (1980) mentioned that these catecholamines including: dopamine, adrenaline, noradrenaline and serotinine, all of which have been implicated in the aetiology of schizophrenia (Farly *et al.* 1977), manic depression (Bunney *et al.* 1977) and depression (Orgen 1977).

However there is no clear evidence suggesting that there is a direct proportion between the consumption of protein-containing diet and mental hygiene. Thus it is difficult to say at this point whether the protein free diet of Sheikhs is therapeutically valuable. However Sheikhs may use food regimentation as aversion technique to extinguish undesirable responses of mental patients. This is consistent with old times treatment where mental patients were served with only water and dry *Kisra* bread. Nevertheless, most Sheikhs in this study still administer this food regimentation as indicated in the results. However, this type of food regimentation sometimes can be very harmful. In the interview phase one of the psychiatric doctors mentioned that one of his patients had been a victim of such a treatment. He was subjected to such a very poor type of food regimentation to the extent that he developed severe chest infection.

c. Group therapy

In this study it has been found that all the modern medicine professionals mentioned group psychotherapy as a method of treatment for some mental disorder patients. During her visits to the hospitals, the author realized that most of those professionals are not dealing with this method; only two of them who are practicing psychotherapy with some patients at their private clinics.

At all the visited centres it was found that certain group activities and healing methods are made imperative on most patients. They include mass prayer, *Zikir* and *Madieh.* All Sheikhs have indicated their awareness of the enjoyment and relaxation a patient gets from these activities. This is comparable to some forms of group psychotherapy in which the

group itself is a dynamic field of experience. Such activities help to promote the mental health of these patients by giving them the sense of equality and belonging, giving support, stimulation, self-insisted and putting the feeling into words and prevents loss of confidence. In the *massed* setting there is usually enough place and enough staff to manage and supervise group programmes. In this respect ordinary hospitals in this country seem to lack both place and staff to operate group therapy programmes. As such, the *massed* is superior to hospitals in this area.

In the same breath the *massed* have what might be described as social therapy. This method of therapy is directed to the patient's environment and can be differentiated into two types: The first therapy is the family support where the healer explains the patient's conditions to his/her family and they are always follow the healer's instruction. This obedience to the healer is supported by the patient's family's beliefs in the healer's abilities. The second therapy is the occupational support in which the healer assigns useful tasks and certain jobs to patients as their health improves. As shown in the result they are encouraged to participate in domestic activities like cultivation, wood cutting, brick laying, cleaning, cooking and other services inside the *massed*. This technique of therapy is used by the healer to divert stimulation entertainment and encourage the patient's activity and interest so as to improve the patient's self-confidence and to give him/her an opportunity to participate in other social activities.

Another form of this group psychotherapy by traditional healers that has been found in this study is *zar* treatment. *Zar* ceremony can be considered one type of group psychotherapy, *zar* patients responding to this healing in a form of suggestion therapy, fulfilling the demand and abreaction. After attending two of these *zar* ceremonies, the author indicated that *zar* practice can be helpful for certain groups of psychiatric patients (somatoform and dissociate disorder) as it acts a compensation for some demands, emotions, and it suppresses desires. So *zar* can be considered as an alternative therapeutic technique.
A study done in Sudan on people's attitudes towards *zar* showed that most of them considered *zar* as treatment acts through fulfilling desires and enjoyment. Some consider it as way for enjoyment leading to disappearance of normal daily life stresses. Others consider it as a method of pleasing and fulfilling the spirit's demands.
After this short experience in *zar* healing, the psychological sequences of *zar* performance are described as follows:

'During a *zar* performance the beating of the drums continues for hours on end and for fixed days. The rhythm gets faster and the singing becomes louder until the patient becomes emotionally stimulated and feels the impulse to move and dance. With the heightening of excitement, the patient manifests various behavioural reactions that are partly influenced by traditional beliefs and partly by healers, but mainly reflect the patient's inner conflicts. A state of psychological dissociation may take place and the patient may pass into a trance-like state. During such a trance, it is not uncommon to see the dramatisation of unconscious wishes and the acting out of pent-up emotions. The abreaction through which the patient passes usually brings about dramatic results, especially in psycho-neurotic patients".

Dr. Hasapw S., who worked as consultant at the head department of the psychiatry unit at Khartoum North Hospital (1995), stated that the technical psychotherapeutic features of the healing cult of *zar* could be summarised in ten points:

1) Good initial preparation of the patient for therapeutic techniques.

2) The confidence of clients in treatment.

3) The masterly ability of the practitioner and his unwavering faith in the *zar* practice.

4) The continuous group involvement.

5) The full use of all modalities of sensation especially auditory (musical stimulation) to the point of dissociation and even collapse.

6) Identification with saints and personality cult.

7) Use of mystical notions as vehicles for suggestion and persuasion.

8) Dramatisation and enactment.

9) Unloading of emotional feelings.

10) The meaningful utterances during the dissociate phase, which indicate the patient's conflicts are carefully noted and patient's needs are immediately fulfilled.

4.3.2 Major findings and conclusions

The major findings emanating from the above comparison between the result of psychiatric doctors and the result of traditional healers is presented in the subheadings below as well as summary and conclusions are presented in table 5.1.

Qualifications and specialisation of practitioners

Assessment of the two health systems with regard to qualifications of practitioners showed that the traditional healer and the psychiatric doctor share an analogous social role and similar modus operandi. They are accorded a special social status and have the social privilege to ask personal questions of patients and touch them in a fashion not accepted in any other kind of interpersonal relationship. They give names to disorders (that is, make diagnoses), predict outcomes of disorders (give prognoses), and make recommendations regarding treatment. According to the mutual consent of patient and healer, treatment may be instituted or may not be instituted or a referral be made to another treating person. In short there is a "doctor-patient relationship" of a kind that transcends time, social class, and culture.

Differences between the two practitioners has been realised on an earlier training, worldview and evaluation of treatment methods. The traditional healer training ordinarily consists of apprenticeship with an older healer and formal education is becoming increasingly common among the youngest healers. The conceptual basis for their practice is the theological-philosophical worldview of their cultural peers. Ordinarily their power to heal stems from supernatural powers possessed by or at the disposition of the healer. The knowledge and origins of powers possessed by the healer are ordinarily kept secret. By and large the healer can function only within his/her own ethnic group, since the healer and his/her patients are in complete agreement on the concept of disease causality and validity of treatment and that rapport and strong belief on healer and his/her healing methods plays a great role in treatment success.
On the other hand, the psychiatric doctors gained their ability to treat mental patients through a formal education, scientific training, certification by peer professionals, certain minimum experience and licensure by the state. Their powers to treat are based on demonstrated knowledge and skills.

Causes of mental disorders

The results and the above comparison between practitioners of the two health systems indicate that the both practitioners are differing in concept and causes of mental disorders. All traditional healers agreed upon supernatural power in the form of jinn, spirit, magic, evil eye, witchcraft and *zar* as the cause of diseases and other problems such as social and psychological ones. Also they consider this power as the only cause of mental disturbances, which they referred as madness moreover, they believe that the patient is responsible for having the devil residing in him either directly after doing sinful and breaking a taboo or as

a result of witchcraft acts committed by the unfortunate individual. However, the psychiatric doctors relate diseases and mental disorders to organic, hereditary, psychological, and social causes.

Classification of mental disorders

Classification of mental disorders by traditional healers has been found to be parallel to psychiatric doctors classification and is based on reasonable symptoms and signs. Jinn are the main class of mental disturbances in the traditional health system. It has two types*: Arrrih Elaswad* (black wind), which affects the mind and *Arrih Elahmer* (red wind) that attacks other parts of the body and causes psychosocial problems. Comparable to psychiatric doctors it seems *Arrih Elaswad* stands for psychoses, while *Arrih Elahmer* stands for neuroses and psychosomatic disorders. Disorganised speech, fugue, negligence of hygiene and occupational and familiar relationship failure are considered the main symptoms and signs to classify and diagnose patient's problems by some healers, while the other healers are based on supposed causes of disturbances, e.g. *zar* healers classify patient's problems depending on the type of the possessing spirit that is identified by patient's demands throughout the *zar* session.

Diagnosis of mental disorders

In both psychiatric and traditional system, interview with patients was found to be the first phase of diagnosing patient's problem and in continuation to be a therapeutic session as well. Indeed, some patients with traditional healers need no more than the first interview to restore their normal health. In this case patient with his/her endless respect and absolute trust on healer is more obliged to recall all of his past experiences and history to the healer than to a psychiatric doctor because he/she believes that the healer knows *Geheib* and can read his/her thought. Moreover there is a similarity in some of the diagnostic methods followed by both practitioners namely taking history of patient's illness, detection of certain symptoms and examination for certain signs. In addition to that both of them correlate certain signs and symptoms to certain mental disorders, e.g. excessive talking, incoherence of speech, poising of eyeballs aloft, and awareness are the main characteristics of jinn (psychosis) according to healers and this is strikingly similar to psychiatric doctors' diagnosis.

Treatment/healing of mental disorders

Finally, both the psychiatric doctors and the traditional healers reveal that the same goal compelled them to treat/heal patients with mental disturbances, that is to cure the diseased or to improve patients' condition so as to help them to adjust to their societies. Healing methods by most of traditional healers depend on using religious techniques and *Quran* verses. These techniques are considered as tools of suggestion therapy and they have survived over a considerable length of time in this country because of their effectiveness. The factors that may mediate the efficacy of the use of these therapeutic methods and the Holy *Quran* is suggestion and the level of suggestibility which is determined by the power

of persuasion on the part of the healer and acceptance on the part of the patient. Also the religious atmosphere of place and tremendous confidence and belief of patients in their healers and healing methods was found to be the basic agents in the achievement of relief and recovery by traditional healers. Beside patients' belief, healers have additional skills such as *taghwa* (piety) of healers and *tahara* (purity) of bodies and souls, of place and deeds on the part of both, healers and patients. These are helpful in the achievement of the right diagnosis, the fruitful choice of therapeutic and the ultimate cure. This rapport between healers and their patients is one advantage of traditional healing in comparison to psychiatric medicine.

Other healing methods such as flogging, food regimes and chains and fetters are found to be parallel to aversion therapy and behaviour therapy, which we find in psychiatric treatment. All these techniques aimed to associate either mental or physical disorders with unpleasant experiences but some traditional healing methods have side effects such as skin damages and nutritional deficiency problems that facilitate the spread of other infection diseases among patients.

In both health systems group psychotherapy was found to be one method of treatment and healing. Healers use to encourage patients to participate in certain tasks and activities such as cultivation, woodcutting, brick laying, cleaning, cooking and other services inside the *massed.* Also patients participate in certain group activities such as mass prayer, *zikir* and *zar* session. Such activities help to promote the mental health of these patients by giving them the sense of equality and belonging, giving support, stimulation, self insisted and puts the feeling into words and prevents loss of confidence. This indicates the healers' awareness of the emotional feelings and relaxation a patient gets from these activities.

Finally we can conclude that both practitioners (psychiatrist doctors and traditional healers) serve a function within the patients themselves and the community, the two of them aims to make the patients more responsive to the environment. And the major distinction, as a methodology, between traditional healers and psychiatrist doctors is that healers use a holistic approach that is basically a meditation process between the individual and the dominant cultural values, personal beliefs, power of social relationships and power of healers' social status and their institutions. However, the psychiatrist doctors focused on the diseases (adaptation and mal-adaptation) and not on the person. Moreover, you can find those who provide the psychiatric care may be of a different cultural tradition than their patients. In addition to that, after graduation their socialisation and professional training make them even more urbane in outlook and aspirations. Despite the fact that no method of treatment/healing can claim a total cure/health or a better way of life for mentally ill patients, and only to a certain extent control the symptoms and manage the patients to adapt to their lives. I want to point out that it is necessary to be psychodynamic in our thinking of disease and to think of mental illness as being multi-causal and to again join mind, soul and body when thinking to provide a total cure/health service. My own strong view would be that collaboration between medical and traditional health systems is the only possible way to provide a better life for mentally ill patients in such countries.

Collaboration between psychiatric doctors and traditional healers

Collaboration as a new system to help patients in the field of mental health is a contradiction in terms. This system is either never new, in the sense that its fundamental principles do not change over time, or it is always new, in the sense that it inevitably must address new problems, create new hypotheses, develop new methods. For the purpose of this study the author puts forward the question: How can the health of individuals and the well-being of this society be improved, including the question of what do the patients of this society want.

The collaboration between the medical and the traditional health system was suggested as one way to improve the health and well-being of the Sudanese people. The suggestion was made for scientifically valid reasons rather than for sentimental or revisionist reasons. The results indicate that the former question is answered, not perfectly but seriously so that both practitioners have a good will to comply with this new system if they are not already engaged in a private relationship with the other partner for the patients' benefit. Most of the interviewers who have had this private experience agreed that it has proved a useful experience and seems promising.
After examining the similarities of psychiatrists and healers, the differences between them and the contexts in which they operate, the issue of collaboration still remains open. What should be the relationship of the psychiatric doctors with the traditional healers? Perhaps we can address this urgent question more accurately in the Recommendations section, after examining the tendency of the patients towards medical treatment and towards traditional healing.

4.3.3 Summary of major findings and conclusions

Table 5.1 Similarities and differences between the two health systems in Sudan (psychiatric medicine and traditional healing).

Categories	Modern Medicine	Traditional Healing
Practitioners' characteristics and qualifications	1) Psychiatric doctors have formal education, which takes place in universities under the direction of a group of faculty members. 2) They obtained their qualification through a hard training based on scientific methods and their information and procedures are shared with colleagues and the methods of psychiatric medicine to treat patients are based on demonstrated knowledge and skills. 3) A successful doctor must possess these personal character-istics: ability to communicate with people, trustfulness, intelligence and a broad mind, co-operative, responsibility, and respect.	1) Most of traditional healers are illiterate, but formal education is be-coming increasingly common among them. 2) Traditional healers are differing in their qualification and in the way through which they obtained their qualification. Sufi healers always come from a *sufi* family and learn the art of healing from their fathers, whereas *Quran* healers do not necessarily have religious ancestors learn the art of healing by hard study, self-experience and religious rituals. *Zar* healers differ from religious healers they never intended to be healers but were chosen to be so by the spirits. 3) A successful healer must possess these personal character-istics: ability to communicate with people, trustfulness, intelligence and a broad mind, co-operative, responsibility and respect. 4) Almost all the religious healers are male, while women are specialized in *zar* traditional healing. 5) Sheikhs are quite mature and highly experienced.

Categories	**Modern Medicine**	**Traditional Healing**
Causes and possession	1) Psychiatric medicine relates mental disorders to the following causes: * Organic factors. * Hereditary factors. * Psychological factors. * Social factors. 2) Psychiatric doctors differentiate between two factors that cause or lead to mental disorders. a) Precipitating factors (actions or events) work on an individual who has already a tendency to mental illness, and they will be responsible for bringing the signs and symptoms of mental illness to the surface, e.g. sex and age factors, occupational factors or other immediate factors. b) Predisposing factors that are some factors, which are already on an individual and liable before the event to diminish the individual resistance some of these factors are hereditary, psychogenic and sociogenic, organic factors and physical illness.	1) Traditional healers believe in evil spirits, which enforce themselves into the body and make the afflicted go mad against their will, they invariably possess insane people. The healers agree that the supernatural power in the form of spirit, magic, evil eye, envy, and *zar* spirit are the main cause of mental disorders. 2) Traditional healing has different theories of mental disorders: a) First theory: based on the concept that there is a lack of harmony among the various body components. b) Second theory: based on the concept that mental disorders are not a form of disease but a possession, which results from misfortune, witchcraft or other supernatural power. c) Third theory: disturbances seen as bad luck (fate) or God's punishment. d) Fourth theory: based on the concept that an individual is composed of physic-al body and immaterial souls or spirits that under some circumstances may become detached from the body and wander freely.

Categories	**Modern Medicine**	**Traditional Healing**
Specialization and classification of mental disorders	1) Classification of mental disorders by psychiatric doctors is based on single criteria, such as symptoms of disorder, origin of illness or treatment aims. 2) Psychiatric medicine has different classes of mental disorders, e.g.: * Neuroses * Psycho physiological disorders. * Personality disorders. * Mental conditions due to brain damage or dysfunction. * Mental retardation. * Other mental disorders such as behavioral and emotional disorders that occur in childhood, adolescence and adult age.	1) Classification of mental disorders by traditional healers is based on assumed causes of these disorders. 2) Religious healers (*Quran* and Sufi Sheikhs) have two classes of mental disorders, named locally as jinn. * The first is *Arrih El Aswed* (black wind) which is believed to affect the mind and stands for psychoses. * The second is known as *Arrih El Ahmer* (red wind) that attacks other parts of the body and it seems to stand for all types of neuroses and psychosomatic disorders. 3) *Zar* healers have one class of mental disorders known as *zar* or *Arrih El Ahmer* (red wind) which is believed to cause psychosomatic and sexual dis-orders and it is considered as somatoform of dissociated disorders and most of its victims are women.
Interviews with patient/client	1) Psychiatric medicine uses assessment methods that provide information about patient's history and clinical status. Most of psychiatric doctors use to interview, observe and test the patient's mental status and they use to meet one of the patient's relatives. 2) Psychiatric doctors believe that the best way to know people is to meet with them in face-to-face interaction.	1) Treatment by traditional healers starts with interviewing the client first and one member of his/her family. 2) This step is considered as assessment technique, one of diagnoses process and treatment methods because healers believe that the person coming for help is not necessarily sick. 3) Traditional healers were observed to exhibit deep involvement with their patients. From the very beginning Sheikh tries to assure the patient that there is no threatening danger and every word stated by Sheikhs is taken for granted and the language they use is full of concern and compassion.

Categories	**Modern Medicine**	**Traditional Healing**
Abreaction and diagnostic methods	1) Diagnoses in the field of medicine has two stages: a) First: dealing with signs and symptoms collection and clinical tests. b) Second: these signs and symptoms grouped under certain mental disorders.	1) Diagnoses in the field of traditional healing is based on: a) Verbal confession beside observation, detection and examination of certain signs. Traditional healers are differing in the way of identifying the client's signs and symptoms, e.g. *Quran* healers diagnose mental disorders by repeating certain *Quran* verses which were supposed to evoke certain signs that help in identifying and detecting the causes of mental disorders, while *zar* healers evoke those signs and symptoms through fumigation and on the other hand, Sufi healers follow different rituals, e.g. incarnation and *khayra* as their spiritual methods of diagnosis. b) When the above stage is followed, it correlates the signs and symptoms to certain classes of causes. 3) During a diagnosis process Sheikhs are using a commonly held belief that they know *Gheib* (the unseen). Within this concept patient believes that the Sheikh can read his/her thought and so he/she is obliged to recall all of his/her past experiences, no matter how shame-ful or fearful they may be.
Symptoms of jinn/psychosis	1) Psychiatric doctors diagnose a patient as psychotic on the basis of perception, psychomotor dysfunction, speech and orientation. 2) They correlate the patient's awareness to psychotic disorders as it's considered an important symptom to diagnose most of the mental disorders.	1) Traditional healers describe a patient as *majnon* (mad) on the basis of certain signs such as *Ziadat Alkalam* (talkativeness), *Adam Altarabot* (incoherence of speech) and *Shuroad Alnazar* (unconcentrated gazing). 2) Majority of Sheikhs believes that the insane consciousness of his behavior, surroundings and environmental stimuli is considered as an important sign of jinn possession.

Categories	**Modern Medicine**	**Traditional Healing**
Treatment/ Healing methods	1) Treatment in a psychiatric field is methods of management that depend of a case diagnosis and attempt to help the patient to cope with him/herself and overcome his/her psychological problems as it prevents him/her to become ill again. 2) In psychiatric medicine the criterion of acceptance is the most crucial element for a successful treatment particularly in a suggestion therapy. 3) In psychiatric medicine, doctors use to deal with different types of psycho-analysis methods where patient's mental disorder attributes to his/her surrounding society. 4) Rapport is considered an advantage in traditional healing compared to the modern psychiatric. 5) Aversion therapy and behaviour therapy are some techniques used in psychiatric treatment and aimed to associate either mental or physical disorders with unpleasant experience. 6) Group psychotherapy in psychiatric medicine is a method of treatment that applies to some patients with certain disorders. 7) The both practitioners (psychiatric doctors and traditional healers) are function within the patients themselves and the community. Both of them aim to make the patient more responsive to his/her environment, but the major distinction is that the psychiatric doctors focus on the diseases (adaptation and mal-adaptation) and not the person.	1) Traditional healing aims to cure patients from different disorders and helps them adjust within their societies and resume their normal life. Sheikhs believe that cure is from God and prophet Mohamed (peace upon him) gave special instructions on various aspects of caring and curing, which include both preventive and curative measures. 2) Therapeutic techniques such as *Mhaya, Bakhra, Higab* and *Waraga* applied by healers are widely used tools of suggestion therapy and acquire its power from the word of God, the religious atmosphere and the accompanied confidence of patients in their honorable Sheikh. When a patient believes that his/her sickness and problem is now being handled by the *Karim* (the most generous), the *Rahim* (the most merciful) and the ultimate healer, then he/she will accept that there is no *Awajah* (no obstacle to recovery). Also Sheikhs have additional traits (skills) mainly *Tagwa* (piety) and *Tahara* (purity). The *Tagwa* of healers and *Tahara* of his body and souls are considered essential for a successful therapeutic healing and the ultimate cure. Moreover Sheikh's *Duaa*, the supplication for God to save and cure the poor patients is considered a powerful way in religious healing as it performs as mediation role between the patient and his/her God. 3) Sheikhs use to deal with different therapeutic techniques, nsible.

5 Results and discussion of patients' tendency towards medical and traditional treatment

5.1 Descriptive statistics of the sampled patients

In the following, simple descriptive statistics are presented to explore the accuracy of the patients' data set and to give a general overview of the variables concerning the characteristics of the sampled patients that were used in the analysis. Three cases were dropped because these data were found to be inconsistent or inadequate. The main features of our sampled patients are accessible in table 5.1.

Table 5.1 Characteristics of the sampled patients

Variables / Categories	Gender N=50	Age N=50	Religion N=50	M. Status N=50	Residence N=50	Region N=50	Education N=50	Occupation N=50	Treatment N=50
% Of category	Male 52	(18-30) 42	Muslim 96	Married 42	Urban 62	Northern 14	Less 24	Student 10	Traditional 50
	Female 48	(31-50) 38	Christian 4	Single 44	Rural 38	Southern 12	Medium 52	Worker 22	Medical 50
		(Above 50) 20		Others 14		Eastern 2	High 14	Employed 24	
						Western 14		Merchant 26	
						Central 58		Others 18	

The sample size used for the analysis is 50 patients of which 50 percent are under medical treatment and the other half of the patients are under traditional healing. Both groups have been exposed to the two types of treatment. A simple statistical analysis of characteristic variables hypothesised as determinants of patients' tendency and health decision towards the two health systems (psychiatric medicine and traditional healing) was carried out using SPSS software package (Version 10). The percentages in the above table report summary statistics from sampled patients who were exposed to the two health systems in Sudan.

There is no difference between the sample sizes of the two groups of patients as is mentioned above. The results do not reflect a distinction of the sampled patients in regard to gender variable. The percentage of the sampled male patients is found to be 52% compared to 48% of the female patients. Almost all of the sampled patients (96%) have the same religious belief 'Islamic religion'.
The age of the sampled patients starts at 18 years. The majority of the patients (42%) are aged from 18-30 years, 38% of the sampled patients are aged from 31-50 years, while 20%

of the entire patients are more than 50 years old. The majority of the sampled patients either are single (44%) or married (42%), compared to 14% of the patients who are divorced or widowed.

The percentage results reflect a difference between the sampled patients with regard to the educational level indicators between high, medium and low. Patients who reached high/university level are 14%, while 52% of the patients have primary to secondary education and 24% showed low education level (illiterate or *Khalowa*). However, for the variable "occupation" the percentages showed that 10% of the sampled patients are students, compared to 22%, 24%, 26% and 18% of workers, employees, merchants, and patients who have no work, respectively.

The analysis mirrors a distinction among the sampled patients with regard to regional origin; the majority of patients are originally from the study area: central Sudan "inner and around-urban Khartoum" (58%) compared to 14%, 12%, 2% and 14% for the northern, southern, eastern and western regions, respectively. This is also made evident in the result of percentages with regard to the residence variable, as it indicates that the percentage of the sampled patients who are living in urban areas (62%) is different from the percentage of those who are still in rural areas (38%). Some of these characteristic variables were expected to have an impact on tendency and decision towards health plan with regard to the two groups of the sampled patients (see the next part).

5.2 Patients' tendency towards the two health systems in Sudan

The empirical problems of studying tendency towards medical and traditional health systems are compound by complexity of explaining people's beliefs and behaviours in general, particularly in developing countries. The tendency towards the two health systems is influenced by different factors and the preferences of both sides as reflected in their objectives and approaches. Patients and their families generally pursue a set of objectives, like to be healthy, to obtain satisfying treatment and good understanding, to get sustenance and other needs; moreover, to achieve an adequate balance between body, mind and soul in leisure. The patient will seek to choose one of the two health systems or a combination of these systems, which may provide maximal utility. On the other hand one can find patients who start treatment under one of the two health systems and suddenly change their health plan decision to the other one. This study deals with the later patients who were exposed to two health systems: psychiatric treatment and traditional healing in Sudan.
Chapter 5 presents the results and discussion of data obtained from a sample of 50 patients who represent two groups; the first group are patients under medical treatment and the second group are patients under traditional healing (both groups have been exposed to the two types of treatment) using the structured questionnaire (Appendix 1). The research procedures and the basic assumptions are described in chapter 3.

The objectives of this chapter are six-fold: first, to study the patients' tendency towards the two health systems; second, to reveal the patients' perception on health and illness; third, to reveal the patients' perception of the origin and source of traditional healing and whether the patients' belief positively affects the success of the treatment; fourth, to identify and discuss the factors which influence the patients' tendency towards the traditional healing

and the effect of patients education level and their experience with the treatment as measured by the duration of stay under the treatment of their choice . Moreover, in the fifth fold the author analysed whether a variation in tendency exists between men and women; and if so, what are the factors behind this variation.
The ultimate objective of the analysis in fold six is to highlight and discuss what are the reasons and motives that cause the observed patient's treatment dilemma and influences the decision of switching between the two health systems.

To achieve the above-mentioned objectives, the software package SPSS (Statistical Package for Social Sciences, Version 10) was used in analysing the patients' data that collected during the field survey in Sudan. To display the deviation of the observed data from the expected ones, a test of association between two variables is used. We applied cross tabulation technique using chi-square test to analyse the nominal data. To assess the significance of the hypothesis, Pearson chi-square test (>= 0.05) was used for the general analysis and in case the expected value in the output cells is less than five we refer to Craddock-Floods tables* to correct as well as to assess the significance levels (See Boehnke, B. L. (1990, 139). At this point, it is very important that the reader has to be careful when he/she goes through these results and the discussion, bearing in mind the problem of our data (small number of the sampled patients). So these results have been interpreted in a very cautious view.
The following are the results and discussions of patients' data with respect to the specific hypothesis (in bold face and italic face).

5.2.1 Tendency towards medical and traditional treatment

This section presents the results and discussions of patients' tendency towards psychiatric treatment and traditional healing. The importance of studying the patients' tendency that the tendency influence the congnitive construction of health action plan. Schwarzer and Fuchs 1996 mentioned that the self-efficacy beliefs influence the cognitive construction of specific action plans, for exmple by visualizing scenarios that may guide goal attainment. They added that these post-decisional preactional cognitions are necessary because otherwise the person would act impulsively in a trial-and-error fashion and would not know where to allocate the available resources. Moreover, people with an optimistic sense of self-efficacy, however, visualize success scenarios that guide the action and let them persevere in face f obstacles. When running into unforeseen difficulties they quickly recover (Conner & Norman 1996, 178-179).
The research hypothesised that: ***The patients in Sudan have a positive tendency towards traditional healing***. To assess the tendency of Sudanese patients towards the two health systems we formulated two open-ended questions, which were included in the structured questionnaire:

- Question one: What tendency do you have towards traditional healing?
- Question two: We just assume that one of your relatives will become ill and asks you for advice. Which type of treatment would you recommend to him or her?

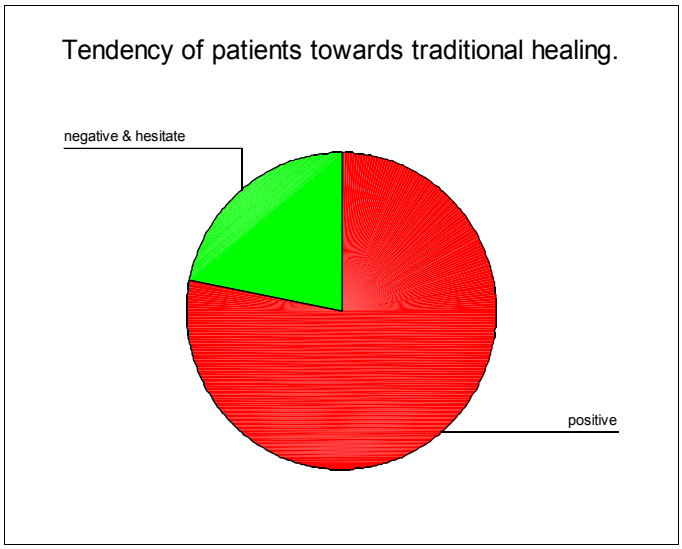
* For smaller tables with less df, the empirical Chi-square test – distribution subject to the null hypothesis can be approximated by simulated Monte-Carlo methods (cf. Craddock, 1966; Craddock u. Flood, 1970) (Boehnke, B. L. 1990, 139).

These two statements were believed to measure the patient's attitude and tendency towards mental health systems. Moreover, a cross tabulation of the first question and the two groups of case samples was undertaken to show the differences in tendency between the group of patients who are under medical treatment and the other group of patients who are under traditional healing. The frequencies and percentages were postulated as shown in table 5.2.1a, 5.2.1b and 5.2.1c. All the statements that included have the expected consequence.

Table 5.2.1.a Differences in indicators of tendency towards traditional healing

Categories	**Frequency**	**Percent**
Positive tendency	39	78.0
Negative & hesitate	11	22.0
Total	50	100

Figure 5.2.1.a Differences in indicators of tendency towards traditional healing

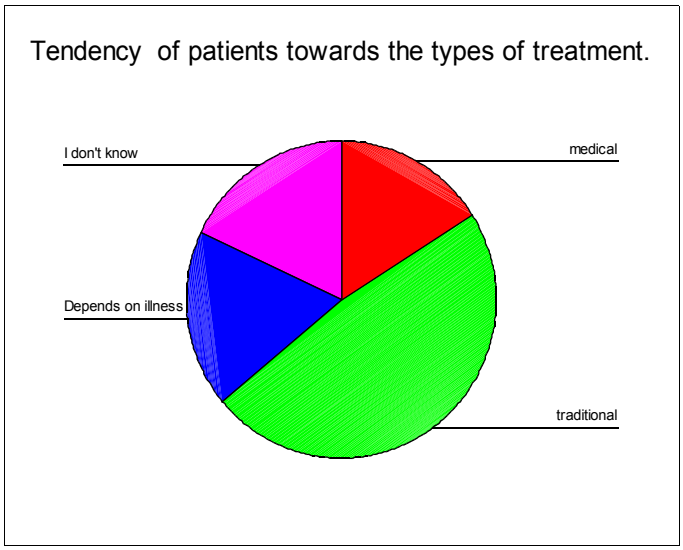


The above table shows difference in indicators of patients' tendency towards traditional healing. The results show that 78 percent of the sampled patients have a positive tendency towards traditional healing, compared to the other group of patients who are 22 percent, either hesitate or have negative tendency towards traditional healing. This indicates that patients who have a positive tendency towards traditional healing are more numerous than patients with a negative tendency towards this type of healing (see figure 5.2.1a).

Table 5.2.1.b Treatment recommended when the patient asked for advice

Categories	Frequency	Percent
Medical treatment	8	16.0
Traditional healing	24	48.0
Depends on the illness	9	18.0
I don't know	9	18.0
Total	50	100

Figure 5.2.1.b Treatment recommended when the patient asked for advice



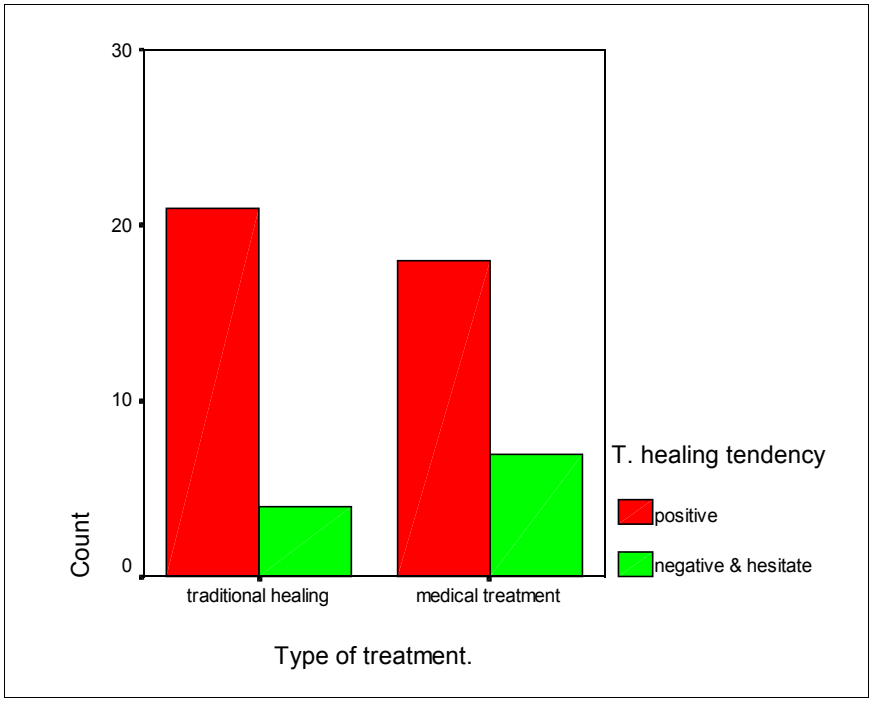
The above table aims to evaluate the patient's response when he/she was asked to recommend one type of treatment according to his/her experience in the field of mental health and illness as an advice to another person. The finding of this study has shown that 48 percent of the patients recommended traditional healing, which indicates a positive tendency towards this type of healing, whereas 16 percent of the patients recommended medical treatment. 18 percent of the patients said it depends on the type of illness. The last group of patients do not know which type of treatment could be recommended (18 percent) (see figure 5.2.1.b).

Table 5.2.1.c Differences in indicators of tendency towards traditional healing by patients' groups.

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Type of treatment.	traditional treatment	Count	21	4	25
		Expected Count	19.5	5.5	25.0
		% within Type of treatment.	84.0%	16.0%	100.0%
		% within Tendency towards traditional healing.	53.8%	36.4%	50.0%
		% of Total	42.0%	8.0%	50.0%
	medical treatment	Count	18	7	25
		Expected Count	19.5	5.5	25.0
		% within Type of treatment.	72.0%	28.0%	100.0%
		% within Tendency towards traditional healing.	46.2%	63.6%	50.0%
		% of Total	36.0%	14.0%	50.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Type of treatment.	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 1.049$, df = 1, $p > 0.05$, n.s.

Figure 5.2.1c Differences in indicators of tendency towards traditional healing by patients groups



The above table shows the tendency of each patients group towards traditional healing and the relation of this tendency to the type of the treatment. The cross tabulation of the two groups of the sample and their tendency towards traditional healing shows that there is no association between the type of treatment and the tendency towards traditional healing. The Pearson chi-square test is not significant ($x = 1.049$, $p > 0.05$). The analyses show that 84 percent of the patients under traditional healing have positive tendency and 16 percent of the patients either have negative tendency towards traditional healing or hesitate in their answers. For patients under medical treatment, the results show that 72 percent have a positive tendency, while 28 percent have a negative tendency or hesitating.

Although the sample included only patients who were exposed to both medical and traditional treatment, the results indicate that patients in both groups have a relatively positive tendency towards traditional healing. This highly positive tendency towards traditional healers and their healing methods can Probably be attributed to the way of communication between healers and their clients as well as to the speech and the language that is used by those healers. Since we know language is a function of culture and it plays an essential role in counselling the community on various personal and communal health- and life-related conditions. It is in this context that a general positive tendency can grant harmony and, moreover, agreement between the patients and the healers about aetiology and causes of mental disorders and furthermore about the diagnosis and treatment process. Belschner (2000, 77) postulated an essential model of communication that contains four channels: (1) [Parasprachlich] “Para-grammatical language”, (2) [Sprachlich] “language-master”, (3) [Mimisch-Gestisch] “Art of behaviour speech”, (4) [Energetisch-Kommunikativer Kontext] “Energetic-communication con-text”. This communication modell has been suggested to solve the difficulties of translated the transpersonal

experiences. He noted that "[*]As a result of the interwoven historical and individual developmental processes we nowadays do attribute not just dominance to speech, but raise it into the position of a monopolistic communication medium. We are used and educated towards a world view of ultimately verbal communication. And we are continuously skilled with respect to a concept of man – and reinforced for it – that presupposes we could by means of speech canals communicate with our contemporaries in a comprehensive and successful manner (Conversion by the author). Makanjuola (2000) studied the current status of traditional mental health practice in Nigeria. The result supported this hypothesis that the patients in Sudan have a positive tendency towards traditional healing. He found that most of the patients' relatives expressed the belief that only traditional healers can understand the supernatural aetiological basis of mental disorders and can therefore offer more effective care than psychiatrists. Hence these findings are not surprising since this kind of practice is particularly observed among the native population: among those less affected by Western influences, and among those who have less opposition from Western and Asian religions (Semela 2001, 128).

However, there is no significant relation between the two groups of the sample in tendency towards traditional healing, but the percentage of differences observed between the two groups (Table 5.2.1c) shows that more patients under traditional treatment have positive tendencies towards traditional healing (84%), compared to 72% of the patients who are under medical treatment. Probably, an explanation for the latter group that has positive tendencies towards traditional healing despite the fact that they are under medical treatment is that this group may be subject to some factors that influenced their health plan decision.

The author supposes that one of these influences could be the family or relatives influence, as we know exist in such cultures of extended families, play a big role in a person's decision towards everything concerning his or her life. The frequency analysis supports the above suggestion (see table 6.2.1.d and table 6.2.1.e. Appendix 4). Table 6.2.1.d shows the patients' ability to make a decision about his/her new health plan. The patient was asked how he/she knows this place of treatment. The results show that patients who still have a strong power and made their own decision on the new action-plan to recover from illness are 10%. However, 90% of the patients could not decide without external help at that time. Table 6.2.1.e presents the external influence on patients' health decision. The findings show that a few patients (10%) decided themselves to leave the last treatment and seek help of the other one, 18% of the patients made the decision with the support of one friend, whereas the majority of patients (72%) were dependent on their families or one of the relatives' support. Both results show that the role that the external influences plays in a patient's health decision is alarming, particularly the family/relatives' influence.

The interpretation of the result of the former group who are under traditional treatment and have a positive tendency to this healing methods are that this group has more contact and communication with traditional healers. In addition to that, living in the area of healers with hospitality and receiving help made patients to have a positive tendency towards traditional healing. Moreover, patients, who live in this environment are responsible for

[*] Als Ergebnis der ineinander verwobenen historischen und individuellen Entwick-lungsprozesse sprechen wir heute der Sprache nicht nur Dominanz zu, sondern wir er-heben sie in den Rang eines monopolistischen Mediums der Kommunikation. Wir werden eingeübt in ein Weltbild der alleinigen sprachlichen Kommunikation. Und wir werden kontinuierlich in ein Menschenbild eingeübt und fortwährend darin bestätigt, das von der Annahme ausgeht, wir könnten mittels des sprachlichen Kanals mit unseren Mit-menschen umfassend und erfolgreich kommunizieren" (Belschner & Gottwald 2000, 77).

their answers; as a result, they may be more cautious of inadequate comments towards traditional healing when they are under healing situations.

However, discussions with patients in the study area showed that patients inside *masseds* "under traditional healing" as well as patients inside hospitals "under medical treatment" have a positive tendency towards traditional healing. Locke and Latham 1990 stated, "The stronger people's efficacy beliefs, the higher are the goals they set for themselves, and the firmer their commitment to engage in the intended behaviour, and the firmer their commitment to engage in the intended behaviour, even in the face of failures" (Citation from Conner & Norman 1996, 169). This positive tendency and belief on traditional healing can be attributed to the wide spread of this kind of healing in Sudan. Moreover, these interesting findings indicate that traditional healing offers help to the general population and not solely to those individuals who have psychosocial problems. Traditional healers believe that most people need assistance in problem solving and that what they give by providing information and advice about a client's problems, encourages the use of their methods in the community, supports the individual's religious sense of competence, and gives patients the sense that they are not alone. Shumaker & Brownell (1994, 11) stated that social support usually occurs between people who are members of the same social network. These, it can be concluded that this further social support by Sheikhs is one advantage of traditional healing.

5.2.2 Influence of patient's perception on health and illness on decision making towards the type of treatment

I would like to highlight here some factors that are supposed to affect as well as influence the patient's tendency towards medical treatment and traditional healing. Bassher (1994) explains in his paper that there is a great need to measure the impact of health awareness programmes at the individual level and that as yet research in this area is lacking. As previously mentioned, this section aims to investigate the perception of the patients on health and illness and, moreover, reveals the association between the two groups of patients in their tendency towards traditional healing using the indicator of how the patient thinks about his/her illness as well as the meaning of health.

A relationship between perception on health and illness and patients' tendencies towards health systems was hypothesised as follows: ***The tendency of patients towards the type of treatment depends on their thinking about health and illness***. Initially, the following variables were assumed to be predicting/explaining the observed illness-health perception of the patients. These are: perception on symptoms, assumed name for the illness, perception of the cause of illness, and perception of health state.

To test whether the tendencies of patients towards the type of treatment chosen depends on their thinking about health and illness, we formulated seven items/statements believed to view the patient's perception on health and illness (see patients' questionnaire in the appendix 1) and analysed the responses to these items/statements with the tendency towards traditional healing using cross tabulation. Chi-square test was applied as the method of analysing the postulated hypothesis for each cross tabulation. The results of the Chi-square tests show according to Graddock's tables that in all the above-mentioned variables the association was not significant. These results reject our hypothesis and indicate that patients' perception of health and illness has no significant effect on patients' tendencies towards traditional healing.

Table 5.2.2.a Relationship of tendency towards traditional healing indicators with patient's perception on symptoms

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Perception on symptoms.	Psychosis & Neurosis symptoms	Count	7	1	8
		Expected Count	6.2	1.8	8.0
		% within Perception on symptoms.	87.5%	12.5%	100.0%
		% within Tendency towards traditional healing.	17.9%	9.1%	16.0%
		% of Total	14.0%	2.0%	16.0%
	Psychosomatic symptoms	Count	19	9	28
		Expected Count	21.8	6.2	28.0
		% within Perception on symptoms.	67.9%	32.1%	100.0%
		% within Tendency towards traditional healing.	48.7%	81.8%	56.0%
		% of Total	38.0%	18.0%	56.0%
	Others	Count	13	1	14
		Expected Count	10.9	3.1	14.0
		% within Perception on symptoms.	92.9%	7.1%	100.0%
		% within Tendency towards traditional healing.	33.3%	9.1%	28.0%
		% of Total	26.0%	2.0%	28.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Perception on symptoms.	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 3.9$, df = 2, $p < 0.05$, n.s.

The above table shows the association between patients' perception of their illness symptoms and the tendency towards the traditional healing. The patient was asked to describe his/her illness in form of symptoms. The majority of the sampled patients (56%) reported psychosomatic symptoms such as headache, fever, physical pains, bleeding and other forms of symbolism, and reaction formation with dissociation, 67.9% of this group have a positive tendency towards traditional healing. While 16% of the group who described their symptoms in relation of psychiatric illness: psychosis symptoms such as memory weakness, less of concentration, loss of personality unity and other severe behaviour disturbances, e.g. hallucinations, illusions and delusions or neurosis symptoms such as anxiety, hyperactivity aggressiveness, scared, frightened dreams, less appetite and no interest to see other people, 87.5% have positive tendencies. Twenty-eight percent of the group reported other symptoms such as social conflicts, daily life problems and maladjustment behaviours, which are evaluated by their cultural patterns; the majority (92.9%) have positive tendencies towards traditional healing. The Pearson Chi-square test suggests an insignificant correlation between the above-mentioned two variables, which was found to be 3.9 (<6.01).

Table 5.2.2.b Relationship of tendency towards traditional healing indicators with patients' assumed name for the illness

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Percived illness name.	Supernatural illness	Count	21	8	29
		Expected Count	22.6	6.4	29.0
		% within Percived illness name.	72.4%	27.6%	100.0%
		% within Tendency towards traditional healing.	53.8%	72.7%	58.0%
		% of Total	42.0%	16.0%	58.0%
	Psychosocial illness	Count	14	1	15
		Expected Count	11.7	3.3	15.0
		% within Percived illness name.	93.3%	6.7%	100.0%
		% within Tendency towards traditional healing.	35.9%	9.1%	30.0%
		% of Total	28.0%	2.0%	30.0%
	I don't know	Count	4	2	6
		Expected Count	4.7	1.3	6.0
		% within Percived illness name.	66.7%	33.3%	100.0%
		% within Tendency towards traditional healing.	10.3%	18.2%	12.0%
		% of Total	8.0%	4.0%	12.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Percived illness name.	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 3.03$, df = 2, $p < 0.05$, n.s.

To explore patients' assumed name for the illness, the individual patient was asked to assume a name for his/her illness, particularly what name it has. The responses towards this variable were cross-tabulated with patients' tendency towards traditional healing to reveal the association between the two variables. As a result, a greater proportion of patients (58%) indicated supernatural illnesses as a name for what they suffered from. Thirty percent suggested psychosocial problems, while 12% of patients couldn't address their illness (see the above table). Chi-square tests according to Craddock's tables indicate no significant relation between the assumed name for the illness and the tendency towards traditional healing ($p>0.05$).

Table 5.2.2.c Relationship of tendency towards traditional healing indicators with patient perception on the cause of illness

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Perception on the cause of illness.	Psychosocial problems	Count	12	7	19
		Expected Count	14.8	4.2	19.0
		% within Perception on the cause of illness.	63.2%	36.8%	100.0%
		% within Tendency towards traditional healing.	30.8%	63.6%	38.0%
		% of Total	24.0%	14.0%	38.0%
	God willing & fate	Count	4	1	5
		Expected Count	3.9	1.1	5.0
		% within Perception on the cause of illness.	80.0%	20.0%	100.0%
		% within Tendency towards traditional healing.	10.3%	9.1%	10.0%
		% of Total	8.0%	2.0%	10.0%
	Supernatural forces	Count	23	3	26
		Expected Count	20.3	5.7	26.0
		% within Perception on the cause of illness.	88.5%	11.5%	100.0%
		% within Tendency towards traditional healing.	59.0%	27.3%	52.0%
		% of Total	46.0%	6.0%	52.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Perception on the cause of illness.	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 4.109$, df = 2, $p < 0.05$, n.s.

The table above shows the association between perception of cause of illness and tendency towards traditional healing. The patients were asked about the main cause of his/her illness. The percentage results show that patients are differing in perception on the cause of illness. The majority of the patients (52%) conceived supernatural forces as the main cause of illness, 88.5% of this group have a positive tendency towards traditional healing, while of the group (38%) who addressed different psychosocial problems as the main causes of illness, 63.2% have a positive tendency. And of the 10% of the patients who indicated the fate is the main cause of their illness and it is perceived as gift from God, 80% have a positive tendency. According to Craddock's tables, Chi-square test shows no significant relation between patient's perception of the causes of illness and his/her tendency towards the two health systems.

Table 5.2.2.d Relationship of tendency towards traditional healing indicators with patient perception of health

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Perception on health	Resume normal life	Count	8	5	13
		Expected Count	10.1	2.9	13.0
		% within Perception on health	61.5%	38.5%	100.0%
		% within Tendency towards traditional healing.	20.5%	45.5%	26.0%
		% of Total	16.0%	10.0%	26.0%
	Get ride of illness	Count	22	3	25
		Expected Count	19.5	5.5	25.0
		% within Perception on health	88.0%	12.0%	100.0%
		% within Tendency towards traditional healing.	56.4%	27.3%	50.0%
		% of Total	44.0%	6.0%	50.0%
	God blessing	Count	9	3	12
		Expected Count	9.4	2.6	12.0
		% within Perception on health	75.0%	25.0%	100.0%
		% within Tendency towards traditional healing.	23.1%	27.3%	24.0%
		% of Total	18.0%	6.0%	24.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Perception on health	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 3.573$, df = 2, $p < 0.05$, n.s.

The above table aims to test the relationship between the patients' perception of health and their tendency towards the traditional healing. To test the patients' perception of health, the entire patients were asked: what does it mean for them to become healthy. Patients perceived three meanings of becoming healthy again. The percentages show that patients who perceived health as getting rid of illness and its symptoms are half of the whole group of patients. Whereas there is no great difference in the percentage of the patients' numbers in the two other groups: patients who perceived health as resuming the normal life (within the family, work/study, hobbies, and other ways of social life) are 26%, while the other patients who perceived health as God's blessing or favour of God that brings happiness are 24% of the total sample. Moreover, the result shows that the majority of patients in the three groups using the indicator of perception of health have a positive tendency towards traditional healing. This result is in line with the earlier results that reveal an insignificant relationship between perception of health and illness and tendency towards health systems; Pearson chi-square value is less than 6.01, which is not significant according to Craddock's tables.

However, it is surprising to note that perception of health and illness has no significant relation with patients' tendency towards health systems. This implies that tendency towards traditional healing has other influences which make it preferable to other health systems. To assure the last suggestion, we made the same analysis to further three questions. These three questions access how the patient thinks about the cause of his/her illness and how illness originates in general (Is it hereditary? Is it a result of a general weakness in the body? Is it part of fate?). The responses to these questions were cross tabulated with the patients' tendency towards traditional healing. Similar results were obtained when testing whether the perception of origin of illness has an influence on patients' tendency towards traditional healing. Pearson chi-square test results are shown in table 5.2.2e, 5.2.2f and 5.2.2g (see the Appendix 4). They suggest an insignificant relation between the patients' perception of health and illness and their tendency towards traditional healing. The analysis of all the items/statements conform to the researchers' prior expectation implying that the researchers' assumption in the above hypothesis was not significant.

The above results suggest that no relation exists between the patients' perception of health and illnesses in general and their tendency towards traditional healing. These results indicate that the patients rely more or less on optimistic self-beliefs when facing self-imposed challenges, while in contrast the awareness plays not a crucial role in such issues. In the health action process approach (HAPA; Schwarzer 1992; see figure 3.1) this critical state is explicitly considered as part of a decision process. It is labelled "action plans" individuals prepare for the intended behaviour by imagining scenarios of how and under which circumstances they could perform specific acts. The reasons for this were very apparent from the interviews and discussion with patients, a recognized number of the interviewers denied that they have mental or psychological disorders as they confirmed that the Sheikh is the one to consult for everything, although some of these patients are under medical treatment. It seems therefore that patients conceive of other factors that influence their tendencies and these have more power compared to the above studied factors. Probably personal and social consequences have a great influence on patients' tendencies towards the two health systems. It might also indicate that the patients are less likely to opt for medical and scientific treatment for their illness in a context where the society think, the patient who seeks help of psychiatrists is *majnon* (a person who lost his mind and becomes mad) and most of people follow this thinking when they communicate with this person. Such societies consider psychiatric illness as a shame for the patient's family. In addition to that the influence of an extended family is relatively high (see table 6.2.1.d & table 6.2.1.e. Appendix 4). However, there was no significant explanation of tendency towards traditional healing by the above-included predicting variables in each analysed table. Nevertheless, the nature of the social relationship will determine whether or not the sickness is revealed to other people, how it is revealed, and what is the nature of the response to it. Lewis (1989, 151) stated "the expectations of the sufferer are important, particularly the likely response to his pain, and the social costs and benefits of revealing it: 'Possibilities of care, of sympathy, the allocation of responsibility for sickness in others, affect how people show their illness'".

Several studies have investigated plausible reasons for the tacit conspiracy of silence on the patient's part. Wickramasekera (1988, 75) suggested many reasons that the patient may prefer to think he or she has a somatic illness, or to have a medical diagnosis rather than a psychiatric or psychological diagnosis. A medical diagnosis avoids the stigma of mental illness and the consequent negative social and vocational consequences. A medical diagnosis often reduces the cost (the deductible) to the patient for tests and treatments. Medical diagnoses, unlike psychiatric diagnoses, have more and longer health insurance

benefit periods and are more readily and richly reimbursable. Hence the presentation of psychosocial conflicts as physical symptoms by a high percentage of the sampled patients (table 5.2.2a) is reinforced by potent personal, social, vocational, and financial consequences. The somatic packaging of psychosocial conflicts increases their reimbursement and social acceptance. Osler's statement is very relevant to this point: "Sometimes it is more important to know what kind of patient has a disease, than what kind of disease the patient has" (Straus 1968). For instance, Karenberg & Leitz (2001) present a comprehensive and detailed overview on this subject. They noted in a paper about "Headache in magical and medical papyri of ancient Egypt" that headaches are attributed to the action of demons and supernatural forces, whereas medical papyri emphasize the role of head trauma and of 'pain matter' occurring in the body. Treatment could be magical, pharmacological or surgical. Also Vogel (2000) studied cerebral malaria in traditional and modern medicine in Bandiagara, Mali. He argued that before the Bandiagara Research Project began, cerebral malaria was not associated with "the disease of the green season," the local term for malaria. Seizures and coma were considered symptoms of *wabu*, caused by a bird that cries out at the same time a child cries and steals a child's spirit. Parents did not consult the local doctor but rather the traditional healers. This indicates the importance of getting historiographical knowledge about symptoms and diseases besides understanding the patient's culture before the processes of diagnosis and treatment in a medical health system may be started.

5.2.3 Influence of the level of education and the experience duration under treatment on the tendency towards traditional healing

This section shows that the level of education and the experience indicators with duration under treatment as factors affect the patients' existing tendency towards traditional healing. The research hypothesised that ***the differences in the patients' level of education and the duration they spend under the treatment influence their tendency towards traditional healing***.

To test the above hypothesis two evaluation questions emanating from the patients' questionnaire were cross tabulated with patients' tendency towards traditional healing. These are:

1) What is the level of your education?

2) Since how long have you been here?

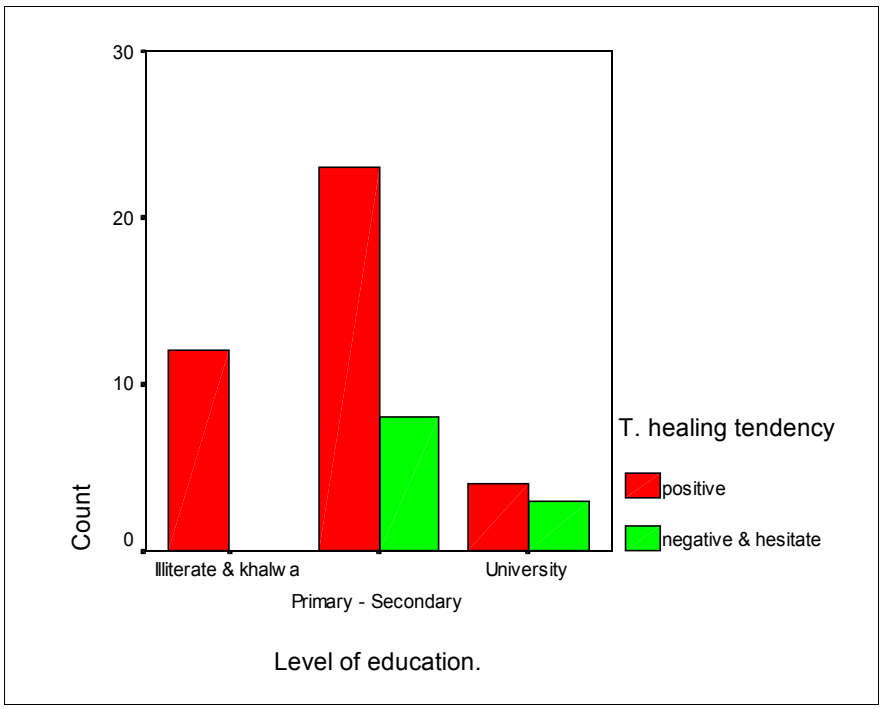
It is expected that, as the level of education increases, the attitude and tendency towards traditional healing will decrease, as well as the long duration under treatment will decrease the tendency towards these healing measures. Schwarzer and Fuchs 1994 mentioned that the context and one's personal experience play a role in the self-efficacy beliefs and may change the pattern of weights.
As mentioned earlier, to assess the influence of the level of education and the duration under treatment on the tendency towards traditional healing, respectively, a cross tabulation for each variable using the Chi-square test was made. The results are shown in the following tables:

Table 5.2.3.a Effects of education level on indicators of tendency towards traditional healing

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Level of education.	Illiterate & khalwa	Count	12	0	12
		Expected Count	9.4	2.6	12.0
		% within Level of education.	100.0%	.0%	100.0%
		% within Tendency towards traditional healing.	30.8%	.0%	24.0%
		% of Total	24.0%	.0%	24.0%
	Primary - Secondary school	Count	23	8	31
		Expected Count	24.2	6.8	31.0
		% within Level of education.	74.2%	25.8%	100.0%
		% within Tendency towards traditional healing.	59.0%	72.7%	62.0%
		% of Total	46.0%	16.0%	62.0%
	University	Count	4	3	7
		Expected Count	5.5	1.5	7.0
		% within Level of education.	57.1%	42.9%	100.0%
		% within Tendency towards traditional healing.	10.3%	27.3%	14.0%
		% of Total	8.0%	6.0%	14.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Level of education.	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 5.421$, df = 2, $p < 0.05$, n.s.

Figure 5.2.3.a Effects of education level on indicators of tendency towards traditional healing



The above table shows the cross tabulation of the educational level and the tendency towards traditional healing. The percentages show a relation between the patients' level of education and tendency towards traditional healing, but still have no significant correlation according to Craddock's tables. The first group of the patients who are totally illiterate or with *Khalwa* (*Quran* School) education (24%) are completely homogenised in tendency towards traditional healing, they showed a positive tendency of 100%. This positive tendency is rather decreased in the other two groups of the patients who show primary to secondary education level and highest university level, they report 74.2% and 57.1% of a positive tendency towards traditional healing, respectively. The percentages reveal that patients, who are slightly more positive in the tendency towards traditional healing, are lower in the level of education when compared to other patients. However, the educational level variable and the tendency towards the traditional healing variable proved to have no significant relation, but still the difference between the test value and the significant value is not so great, the value of Pearson chi-square test is found to be 5.421 (<6.01).

Table 5.2.3.b Effects of experience duration under treatment on indicators of tendency towards traditional healing

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Duration of treatment "experiences".	Less than one year	Count	16	2	18
		Expected Count	14.0	4.0	18.0
		% within Duration of treatment "experiences".	88.9%	11.1%	100.0%
		% within Tendency towards traditional healing.	41.0%	18.2%	36.0%
		% of Total	32.0%	4.0%	36.0%
	1-2 years	Count	18	4	22
		Expected Count	17.2	4.8	22.0
		% within Duration of treatment "experiences".	81.8%	18.2%	100.0%
		% within Tendency towards traditional healing.	46.2%	36.4%	44.0%
		% of Total	36.0%	8.0%	44.0%
	More than 2 years	Count	5	5	10
		Expected Count	7.8	2.2	10.0
		% within Duration of treatment "experiences".	50.0%	50.0%	100.0%
		% within Tendency towards traditional healing.	12.8%	45.5%	20.0%
		% of Total	10.0%	10.0%	20.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Duration of treatment "experiences".	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 5.99$, df = 2, p = 0.05, sign.

This table reveals the association between the duration of stay under the treatment and the patient's tendency towards traditional healing. Chi-square test appeared to have a significant relation between the two variables as the value of Pearson chi-square test is found to be 5.99 (P = 0.05) as shown in the above table. Contrarily this value produced the sign of an insignificant relation when using the Craddock tables' value (6.01) to correct the sample error ($p<0.05$). Despite the slight deviation of the Chi-square test value from the exact value of the significance in the later tables, one can say there is a little association between the patient's duration of stay under the treatment and his/her tendency towards traditional healing. This means the respondents' answers to the former item are not very much related to the author's expectation, while the result of the latter item slightly conforms the expected relation between the period of treatment experience and patients' tendency towards traditional healing.

Based on the above results it could be suggested that the variation in tendency towards traditional healing can be explained by the patient's personal experience with the treatment as measured by the duration of stay under treatment. The result shows the percentage of

patients with positive tendencies towards the traditional healing decrease with the duration of stay under treatment. While 88.9 percent of the patients who spend less than one year under treatment showed positive tendency towards traditional healing and 81.8 percent of the patients who spend between 1-2 years reflected the same tendency, the patients who spend more than two years under treatment responded with the lowest percentage of positive tendency towards traditional healing (50%).

This was not surprising as the patients in the early stage of the illness have a positive tendency towards traditional healing as proved by the result of the first hypothesis. However, with the pass of time and the patient's experience with both treatments without signs of recovery, the personal belief in traditional treatment gradually diminishes. Probably the experience duration under treatment is regarded as a learning process for the patient. Schwarzer and Fuchs 1996 noted that under conditions where individuals have no experience with the behaviour they are contemplating, we assume that outcome expectancies may have a stronger direct influence. Only after a sufficient level of experience is attained does self-efficacy receive the lion's share of the intention variance (Conner & Norman 1996, 177). The author conceptualises that the patient passes through a multi-stage decision making process from the time he/she decides to start with one of the two health systems until he/she finally accepts or rejects it. This indicates that the patient looses hope, as he sees no signs of recovery, and also the original tendency that only arises from the influence of different factors without having a personal experience with the treatment became unfastened.

A comparison of the tendency towards traditional healing indicators between high, medium and low educational level concerning the patients shows that 100% of the patients who have positive tendencies towards traditional healing are illiterate, while 74.2% of the patients with primary to secondary education have positive tendency and only 57.1% of patients who reached university level have positive tendencies (Table 5.2.3a) However, the results reveal that patients education level has no significant influence on their tendency towards the traditional healing, nevertheless, the percentage of patients with positive tendencies appeared to decrease with the increase in educational level. This result supported the finding in section two that the awareness and perception of health and illness has no significant effects on patients' tendencies towards traditional healing. Moreover, the findings of investigating factors influencing patronage of traditional bonesetters (TBS) at Ogun State as stated by Thanni (2000, 220) prop up these results. He found that basic beliefs about TBS in particular and traditional healers (TH) in general are likely to be responsible for their continuing popularity. Education did not seem to influence these beliefs as the expressed opinion on the indispensability /desirability of TBS by the ones who had no formal education was similar to the one of those who had primary education, $p>0.5$, and college/University education, $p>0.1$.

5.2.4 Relationship of patient's belief on traditional healing indicators with the effectiveness of healing

In this section the author demonstrates that the naturalistic belief in and tendency towards traditional healing have spiritual values, which affect the success of the treatment. Although the author knows that an extended definition of spirituality could not be equated with these narrow religious beliefs. But in such societies, the religiousness is defined to mean participation in particular beliefs, rituals, practices, and activities of traditional religion. Therefore, it is possible to affiliate the meaning of spirituality with traditional religious beliefs. Friedman (1985) noted, "In our view a humanistic approach to spirituality is not an attempt to invalidate religion. Religion has been the mother of the world's greatest spiritual giants, the 'best of the species' in the area of spirituality. At its best, religion is the incubator and reservoir of the world's most vital spiritual values. A humanistic approach to spirituality is at variance only with a narrow concept of religion that would claim a monopoly on spirituality and would refuse to recognize its human and universal nature." At the end of this study he formulated a definition that spirituality, which comes from the Latin, spiritus, meaning "breath of life' is a way of being and experiencing that comes about through awareness of a transcendent dimension and that is characterised by certain identifiable values in regard to self, others, nature, life, and whatever one considers to be the Ultimate.

In this section of this wide study it will be strived to emphasise the role that beliefs play in the patient's tendency towards traditional healing and its affect on the treatment success, under the following hypothesis: ***Belief in traditional healing affects the success of the treatment.***

The ultimate goal of this hypothesis is to address some important clinical dimensions of spirituality: Belief involves traditional religion and other spirituality that is considered to be 'personally relevant' has positive influence in the success of traditional healing. The concept of belief was first clustered into three main research variables, which are the patients' view of the ability of the traditional healers, patients' perception of the religious origin of traditional healing and patients' perception of the cultural origin of traditional healing methods (see patients' questionnaire, appendix 1) in order to test the above hypothesis. Then each response to these three questions was cross-tabulated with patients view about the effectiveness of traditional healing. The later view was evaluated by asking the patient what he/she would say, if he or she heard some people say: the traditional treatment is more efficient and successful than others. Person Chi-square test was used to evaluate the association of the above attitudinal variables with the effectiveness of the traditional healing.

Table 5.2.4.a Effects of belief in the abilities of traditional healers on indicators of effectiveness of traditional healing

			Belief of the effectiveness of the traditional healing.				
			Completely agree	Partial agree	Completely not agree	Don't know	Total
Belief on the abilities of traditional healers.	Completely agree	Count	24	3	1	4	32
		Expected Count	17.3	5.8	4.5	4.5	32.0
		% within Belief on the abilities of traditional healers.	75.0%	9.4%	3.1%	12.5%	100.0%
		% within Belief of the effectiveness of the traditional healing.	88.9%	33.3%	14.3%	57.1%	64.0%
		% of Total	48.0%	6.0%	2.0%	8.0%	64.0%
	Partial agree	Count	2	5	2	2	11
		Expected Count	5.9	2.0	1.5	1.5	11.0
		% within Belief on the abilities of traditional healers.	18.2%	45.5%	18.2%	18.2%	100.0%
		% within Belief of the effectiveness of the traditional healing.	7.4%	55.6%	28.6%	28.6%	22.0%
		% of Total	4.0%	10.0%	4.0%	4.0%	22.0%
	Completely not agree	Count	1	1	4	1	7
		Expected Count	3.8	1.3	1.0	1.0	7.0
		% within Belief on the abilities of traditional healers.	14.3%	14.3%	57.1%	14.3%	100.0%
		% within Belief of the effectiveness of the traditional healing.	3.7%	11.1%	57.1%	14.3%	14.0%
		% of Total	2.0%	2.0%	8.0%	2.0%	14.0%
Total		Count	27	9	7	7	50
		Expected Count	27.0	9.0	7.0	7.0	50.0
		% within Belief on the abilities of traditional healers.	54.0%	18.0%	14.0%	14.0%	100.0%
		% within Belief of the effectiveness of the traditional healing.	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	54.0%	18.0%	14.0%	14.0%	100.0%

X^2 = 25.590, df = 6, p > 0.05, sign.

The above table shows the cross tabulation results of the patients' belief in traditional healers abilities and perception of the effectiveness of their healing. The patient was asked about his/her opinion when he/she knows that some people completely believe that the Sheikh is the one who can diagnose and treat the illness. The majority of the total sampled patients (64%) positively agreed, and a greater part of them (75%) are in harmony with people who believe the traditional treatment is more successful than others, while 3.1% clearly disagreed. While among 22% of patients who partially agreed upon the abilities of the traditional healers, 18.2% agreed upon the effectiveness of traditional healing, and the same percentage of the patients disagreed. Of the last group of patients (14%) who responded negatively towards the abilities of the traditional healers, 57.1% showed a similar response towards the effectiveness of traditional healing. The Pearson chi-square test reports a significant relation between patients' belief indicators of abilities of traditional healers and the success of this type of healing. This is found to be 25.590 (>12.5).

Table 5.2.4.b Effects of belief in the religious origin of traditional healing on indicators of effectiveness of traditional healing

			Belief of the effectiveness of the traditional healing.				
			Completely agree	partial agree	Completely not agree	Don't know	Total
Perception on the traditional healing religion origin.	Completely agree	Count	24	5	1	5	35
		Expected Count	18.9	6.3	4.9	4.9	35.0
		% within Perception on the traditional healing religion origin.	68.6%	14.3%	2.9%	14.3%	100.0%
		% within Belief of the effectiveness of the traditional healing.	88.9%	55.6%	14.3%	71.4%	70.0%
		% of Total	48.0%	10.0%	2.0%	10.0%	70.0%
	partial agree	Count	2	3	3	0	8
		Expected Count	4.3	1.4	1.1	1.1	8.0
		% within Perception on the traditional healing religion origin.	25.0%	37.5%	37.5%	.0%	100.0%
		% within Belief of the effectiveness of the traditional healing.	7.4%	33.3%	42.9%	.0%	16.0%
		% of Total	4.0%	6.0%	6.0%	.0%	16.0%
	Completely not agree	Count	1	1	3	2	7
		Expected Count	3.8	1.3	1.0	1.0	7.0
		% within Perception on the traditional healing religion origin.	14.3%	14.3%	42.9%	28.6%	100.0%
		% within Belief of the effectiveness of the traditional healing.	3.7%	11.1%	42.9%	28.6%	14.0%
		% of Total	2.0%	2.0%	6.0%	4.0%	14.0%
Total		Count	27	9	7	7	50
		Expected Count	27.0	9.0	7.0	7.0	50.0
		% within Perception on the traditional healing religion origin.	54.0%	18.0%	14.0%	14.0%	100.0%
		% within Belief of the effectiveness of the traditional healing.	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	54.0%	18.0%	14.0%	14.0%	100.0%

$X^2 = 19.286$, df = 6, $p > 0.05$, sign.

The cross tabulation shown in the above table aims to investigate the relation between perception of the patients towards traditional healing with religious origin and the effectiveness of traditional healing. Results in this table are in harmony with the earlier findings. This result reflects a dimension of patient beliefs, which can be best described as a "spiritual dimension" or "spirituality". The percentage results show that the group of patients who expressed their inner agreement with the religious origin of traditional healing amounts to 70%, and 68.6% of the entire total of this group believe that traditional healing is more successful than other methods. However, patients who showed disagreement with this spiritual dimension amount to 14%, and most of the patients out of this group (42.9%) expressed a negative belief in the effectiveness of traditional healing. The Chi-square test assured that there is a significant relation between the two variables as the Person value is 19.286 (> 0.05).

Table 5.2.4.c Effects of belief in the cultural origin of traditional healing on indicators of effectiveness of traditional healing

			Belief of the effectiveness of the traditional healing.				
			Completely agree	partial agree	Completely not agree	Don't know	Total
Perception on the traditional healing culture origin.	Completely agree	Count	20	6	4	4	34
		Expected Count	18.4	6.1	4.8	4.8	34.0
		% within Perception on the traditional healing culture origin.	58.8%	17.6%	11.8%	11.8%	100.0%
		% within Belief of the effectiveness of the traditional healing.	74.1%	66.7%	57.1%	57.1%	68.0%
		% of Total	40.0%	12.0%	8.0%	8.0%	68.0%
	Completely not agree	Count	0	0	2	0	2
		Expected Count	1.1	.4	.3	.3	2.0
		% within Perception on the traditional healing culture origin.	.0%	.0%	100.0%	.0%	100.0%
		% within Belief of the effectiveness of the traditional healing.	.0%	.0%	28.6%	.0%	4.0%
		% of Total	.0%	.0%	4.0%	.0%	4.0%
	Don't know	Count	7	3	1	3	14
		Expected Count	7.6	2.5	2.0	2.0	14.0
		% within Perception on the traditional healing culture origin.	50.0%	21.4%	7.1%	21.4%	100.0%
		% within Belief of the effectiveness of the traditional healing.	25.9%	33.3%	14.3%	42.9%	28.0%
		% of Total	14.0%	6.0%	2.0%	6.0%	28.0%
Total		Count	27	9	7	7	50
		Expected Count	27.0	9.0	7.0	7.0	50.0
		% within Perception on the traditional healing culture origin.	54.0%	18.0%	14.0%	14.0%	100.0%
		% within Belief of the effectiveness of the traditional healing.	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	54.0%	18.0%	14.0%	14.0%	100.0%

$X^2 = 13.832$, df = 6, p > 0.05, sign.

The above table shows the cross tabulation of the patient's beliefs in traditional healing, the cultural origin and the effectiveness of the treatment. However, this table and the previous one give the feeling of testing the same variables, they are belief in the religious origin and cultural origin of traditional healing, and their effectiveness on healing success. Despite the high illiteracy proportion in our society, where most of the sampled patients are illiterate (see section 3), there is complexity in understanding religion, culture and tradition. Most of the people mix-up between these three aspects as they behave towards many traditional things as they are parts of their Islamic religion and most of the time this base has no sufficient evidence, although religion is a part of culture.

The result in the above table indicates the existence of a significant relation as Pearson chi-square test is found to be 13.832 >12.5. The majority of patients who agreed upon the traditional healing success (58.8%) are 68% of the total patients who believe in the cultural

origin of traditional healing. The entire group (4%) of the patients who did not believe in the cultural origin of traditional healing showed 100% of disagreement with the effectiveness of these healing methods.

The ultimate finding in this section is that the personal belief was the primary source of patients' tendency towards traditional healing, as it has a positive effect on the success of healing methods. This positive relation is not surprising when one knows that the perceived self-efficacy has also proven to be a powerful personal resource in coping with stress (See Lazarus & folkman 1987, 141-170). Conner and Norman argued that there is evidence that perceived self-efficacy in coping with stressors affects immune function (Wiedenfeld et al. 1990, 1082-1094). Subjects with high efficacy beliefs are better able to control pain than those with low self-efficacy (Manning & Wright 1983, 421-431; Litt 1988, 149-160; Altmaier et al. 1993). Self-efficacy has been shown to affect blood pressure, heart rate and serum catecholamine levels in coping with challenging or threatening situations (Bandura et al. 1982, 1985, 1988). Recovery of cardiovascular function in post-coronary patients is similarly enhanced by beliefs in one's physical and cardiac efficacy (Taylor et al. 1985, 635-708). Cognitive-behavioural treatment of patients with rheumatoid arthritis enhanced their efficacy beliefs, reduced pain and joint inflammation and improved psychosocial functioning (O'Leary et al. 1988, 527-542). Bandura 1992 stated, "Obviously, perceived self-efficacy predicts degree of therapeutic change in a variety of settings" (Citation from Conner & Norman 1996, 166).

Probably this finding explains the hidden secret of a higher positive tendency towards traditional treatment as compared to the medical one (section one). Also this finding is in line with the results that were obtained in an earlier study of psychologists and spirituality published by Shafranske and Malony (1985). They found that 71% considered spirituality to be personally relevant; yet only 9% reported a high level of involvement with traditional religion, and 74% indicated that organized religion was not the primary source of their spirituality. In an early study, Shafranske and Gorsuch (1984) have also noted the personal spirituality of psychologists, along with their non-involvement in traditional religion. As we found in the present study, the patients' personal belief in religion and cultural origin of traditional healing methods influences their belief in the abilities of the healers and positively affects the success of the treatment (Citation from Elkins, et al 1988, 6). In response to what is visible seen inside this relation is the commitment to confidentiality. Probably the beliefs that patients generated from a spiritual dimension is a source of the patient's secrecy as it gives depth to the patients and provides him/her with an existing expectancy towards traditional healing methods and trustful seriousness towards healers, particularly the religious ones. Furthermore these points can assist in the effectiveness of traditional healing. As Friedman (1985) argued that the spiritual person is able to 'sacralize' or 'religionize' everything in life. (See Elkins, Hedstrom, Hughes, Leaf & Saunders 1988, 5-18)

This result has a big meaning for this study. It brings to light an essential factor that has great influence on patient's tendency towards the two health systems as it confirms our own informal observations that a growing number of people are developing their spirituality and beliefs in traditional healing on the basis of traditional and religious sources. To change the tendency of such people, their belief in these healing methods, based on religion and cultural origin, is a topic of improving the nature of humanity.
These findings have a big pointed to a large group of well-educated professionals who found such beliefs in traditional and religious treatments. They became relevant to their

lives and culture but they do not actively recommend this type of treatment.

We can also argue our result here confirms the findings in section two, as the patients' general conception of health and illness does not influence the decision to choose the type of treatment. It has been suggested by several psychiatrists that the patients' willingness and reception of the treatment and the practitioners affects the success of the treatment.. We also obtained similar result as regards the traditional treatment since a significant relation exists between the belief in traditional healing and its effectiveness from the patients' perspective.

5.2.5 Differences in indicators of tendency towards traditional healing by patient gender

The aim of this section is to investigate the correlation of the indicators of tendency towards traditional healing between men and women and between patient groups in each treatment analysed and, where possible, the reasons for the differences/similarities are presented.

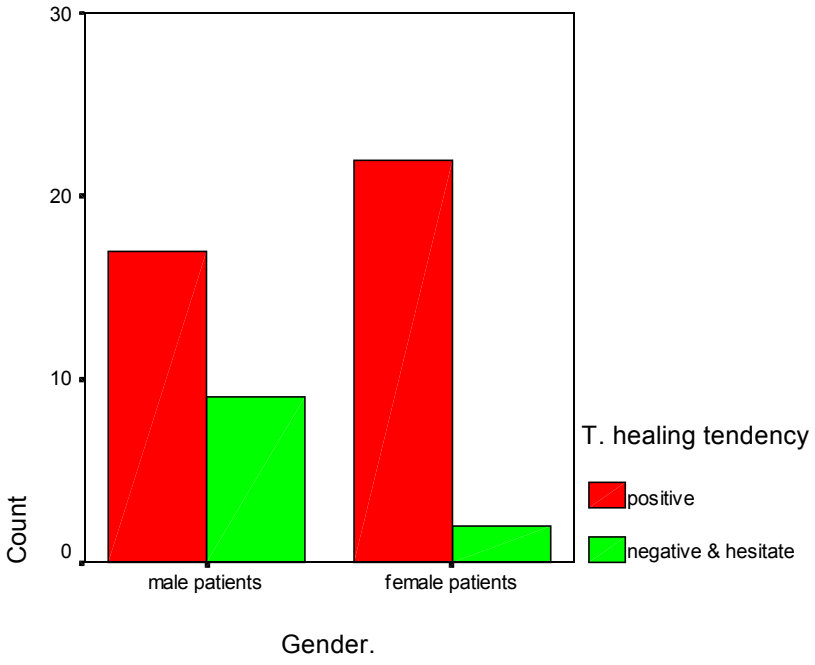
The two variables, gender and tendency towards traditional healing were cross tabulated, using Chi-square tests to reveal the significant correlation as well as to accept or to reject our hypothesis: ***There are differences between the male and the female patients in their tendencies towards traditional treatment; female patients are expected to be more responsive to traditional treatment than male patients***. The results obtained are to be seen in the following tables.

Table 5.2.5.a Gender differences with respect to tendency towards traditional healing

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Gender.	male	Count	17	9	26
		Expected Count	20.3	5.7	26.0
		% within Gender.	65.4%	34.6%	100.0%
		% within Tendency towards traditional healing.	43.6%	81.8%	52.0%
		% of Total	34.0%	18.0%	52.0%
	female	Count	22	2	24
		Expected Count	18.7	5.3	24.0
		% within Gender.	91.7%	8.3%	100.0%
		% within Tendency towards traditional healing.	56.4%	18.2%	48.0%
		% of Total	44.0%	4.0%	48.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Gender.	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 5.024$, df = 1, p > 0.05, sign.

Figure 5.2.5a Gender differences with respect to tendency towards traditional healing



The above table shows the gender differences in the entire sample with respect to tendency towards traditional healing. The results obtained are in line with our expectation. It is found

that male and female patients showed a difference in tendency towards traditional healing. Out of the female patients 91.7% have a higher positive tendency towards traditional healing than compared to 65.4 of the male patients. Chi-square test proved a significant correlation between the two variables, with a value of 5.024 (>3.84 (see the above figure)).

Table 5.2.5.b Comparison of gender tendency towards traditional healing indicators between patients groups

Type of treatment.				Tendency towards traditional healing. positive	Tendency towards traditional healing. negative & hesitate	Total
Patients under traditional treatment	Gender.	male	Count	9	2	11
			Expected Count	9.2	1.8	11.0
			% within Gender.	81.8%	18.2%	100.0%
			% within Tendency towards traditional healing.	42.9%	50.0%	44.0%
			% of Total	36.0%	8.0%	44.0%
		female	Count	12	2	14
			Expected Count	11.8	2.2	14.0
			% within Gender.	85.7%	14.3%	100.0%
			% within Tendency towards traditional healing.	57.1%	50.0%	56.0%
			% of Total	48.0%	8.0%	56.0%
	Total		Count	21	4	25
			Expected Count	21.0	4.0	25.0
			% within Gender.	84.0%	16.0%	100.0%
			% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
			% of Total	84.0%	16.0%	100.0%
Patients under medical treatment	Gender.	male	Count	8	7	15
			Expected Count	10.8	4.2	15.0
			% within Gender.	53.3%	46.7%	100.0%
			% within Tendency towards traditional healing.	44.4%	100.0%	60.0%
			% of Total	32.0%	28.0%	60.0%
		female	Count	10	0	10
			Expected Count	7.2	2.8	10.0
			% within Gender.	100.0%	.0%	100.0%
			% within Tendency towards traditional healing.	55.6%	.0%	40.0%
			% of Total	40.0%	.0%	40.0%
	Total		Count	18	7	25
			Expected Count	18.0	7.0	25.0
			% within Gender.	72.0%	28.0%	100.0%
			% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
			% of Total	72.0%	28.0%	100.0%

The above table reveals the male and female tendency towards traditional healing within the two groups of the patients (patients under medical treatment and patients under traditional healing). The percentage results show that there are differences between men and women's tendencies. Great differences are observed in the group of patients under

medical treatment, 100 % of the female patients have a positive tendency towards traditional healing compared to 53.3 % of the male patients. While in the group of patients who are under traditional healing 85.7 % of the female patients were observed with positive tendency compared to 81.8 % of the male patients who have a similar tendency towards traditional healing. This result is expected as well as in line with the previous result in Table 6.2.5a. Again, these findings are supported by the study of Ahmed, Bremer, Magzoub and Nouri (1999, 79-85). This study aimed to assess the characteristics of visitors attending traditional healers in central Sudan. The results showed that children under ten years did not take part in visits; most of the visitors were between 21 and 40 years (61%) and were women (62%). Visitors were less educated compared to the general population in the area. The main reasons given for attending traditional healers were treatment (60%) and blessing (26%). Visitors did not mention any disadvantages to visiting traditional healers (see table 5.1, 'Characteristics of the sampled patients).

As the author has mentioned earlier, Sudan, like many developing countries, has a high illiteracy rate particularly among females. In addition to that, the greatest part of the health awareness and educational programmes are either non-existing or limited, especially in the rural areas. Probably these facts can be an explanation for the generally high positive tendency towards traditional healing, and mainly among female patients. Another interpretation of this result is that women in Sudan are suppressed and marginalized because of the male dominant society. The oppression of women makes them more liable to psychosocial stresses and they seek ways to express and release their frustration in a way that is culturally and socially acceptable. Traditional healing methods such as *zar* healing represent an appropriate method in such situations, as it is traditionally accepted by the Sudanese culture, and offers a good environment for women to relieve their stresses, for instance in dancing ceremonies that last for several days. At this point, one can say that these and other criticisms that were not clear at the beginning of this study, have now become clear: traditional healing has become acknowledged by Sudanese women.

Moreover, women in Sudan are more concerned with their family affairs and spend most of their time socializing with female friends and relatives. Within this socialization process discussion of their personal psychosocial problems as well as possible and accessible remedies takes place. These discussions, in turn, facilitate the spread of knowledge about and acceptance of traditional healing methods among the female patients.

5.2.6 Reasons for switching between the two health systems

Switching within/between health systems by rural people in most developing countries is not new. In Sudan, switching between health systems is practised in its simplest concept in rural areas particularly where there are no medical health facilities. Patients first look for folk medicine and ask the Sheikh who is the consultant in this area what to do for these problems/symptoms. When the symptoms begin to increase, then patient and his/her family move to other areas to consult other healers or doctors if they are available. Even urban people behave in this way of change between health systems, a widespread phenomenon in most big cities where the medical health system works well. Furthermore, this health dilemma has recently been noted in research and, as mentioned above, the present research deals with patients who were exposed to the two health systems (group one is the patients who left the traditional healing system and is now under psychiatric treatment, group two is the patients who left the psychiatric treatment and is now under traditional healing). At this point it is worth mentioning that Schwarzer and Fuchs described their extension of the health action process approach (HAPA), which is in particular influenced by social cognitive theory. Its basic idea is that the adoption, initiation and maintenance of health behaviours must be clearly conceived as a process that consists of at least two stages, a motivation phase and a volition phase. The latter might be further subdivided into a planning phase, action phase and maintenance phase. It is claimed that self-efficacy plays a crucial role at all stages, which in contrast other cognitions are of limited scope. For example, risk perceptions serve predominantly to set the stage for a contemplation process early in the motivation phase but do not extend beyond. Similarly, outcome expectancies are chiefly important in the motivation phase when individuals balance the pros and cons of certain consequences of behaviours, but they lose their predictive power after a personal decision has been made. However, if one does not believe in one's capability to perform a desired action, one will fail to adopt, initiate and maintain it (Conner & Norman 1996, 174).

This section aims to study the patients' health dilemma and to investigate the reasons that lead patients to leave their last treatment as it affects patients' decision of switching between health systems. Moreover, it reveals the correlation between the two groups of patients in the indicators of reasons behind these behaviours. Where possible, the reasons for the differences/similarities are presented. The main concern of the whole study lies in this section: what can be learned from patients' switching between/within health systems and eventually how they can be helped in making good health decisions.

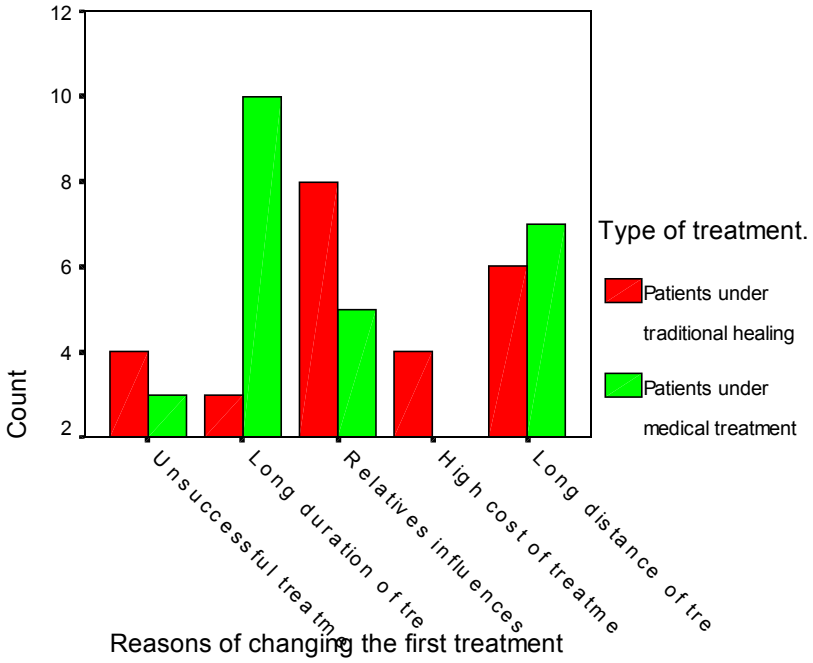
To highlight and discuss the above-mentioned phenomena, it hypothesized that **the reasons that influenced the decision of changing the last treatment / switching between the two health systems are different in the two groups of the sampled patients.** All the sampled patients were asked clearly about the main reason of changing the last treatment. Responses to this question were cross-tabulated with the two groups of the case sample (type of treatment variable). Chi square tests were used to assess the significance of the relation between the two variables.

Table 5.2.6 Differences in indicators of reasons for switching between the two health systems by patients groups

			Type of treatment.		
			Patients under traditional treatment	Patients under medical treatment	Total
Reasons for changing the first treatment	Unsuccessful treatment	Count	4	3	7
		Expected Count	3.5	3.5	7.0
		% within Reasons for changing the last treatment	57.1%	42.9%	100.0%
		% within Type of treatment.	16.0%	12.0%	14.0%
		% of Total	8.0%	6.0%	14.0%
	Long duration of treatment	Count	3	10	13
		Expected Count	6.5	6.5	13.0
		% within Reasons for changing the last treatment	23.1%	76.9%	100.0%
		% within Type of treatment.	12.0%	40.0%	26.0%
		% of Total	6.0%	20.0%	26.0%
	Family/Relatives influences	Count	8	5	13
		Expected Count	6.5	6.5	13.0
		% within Reasons for changing the last treatment	61.5%	38.5%	100.0%
		% within Type of treatment.	32.0%	20.0%	26.0%
		% of Total	16.0%	10.0%	26.0%
	High cost of treatment	Count	4	0	4
		Expected Count	2.0	2.0	4.0
		% within Reasons for changing the last treatment	100.0%	.0%	100.0%
		% within Type of treatment.	16.0%	.0%	8.0%
		% of Total	8.0%	.0%	8.0%
	Long distance of treatment place	Count	6	7	13
		Expected Count	6.5	6.5	13.0
		% within Reasons for changing the last treatment	46.2%	53.8%	100.0%
		% within Type of treatment.	24.0%	28.0%	26.0%
		% of Total	12.0%	14.0%	26.0%
Total		Count	25	25	50
		Expected Count	25.0	25.0	50.0
		% within Reasons for changing the last treatment	50.0%	50.0%	100.0%
		% within Type of treatment.	100.0%	100.0%	100.0%
		% of Total	50.0%	50.0%	100.0%

$X^2 = 8.681$, df = 4, P < 10, sign.

Figure 5.2.6 Differences in indicators of reasons for switching between the two health systems by patients groups



The above table reveals the reasons for changing the last treatment in each group of the patients, as is shown by the percentages and Chi-square results of the association. The patients who changed medical treatment for traditional one, mentioned five reasons and the percentage answers given were as follows: patients who seek help from traditional healers for the reason of unsuccessfulness of the last medical treatment amount to 8.0 %, 6.0 % of the patients left the medical treatment because of the long duration and slow effectiveness of the treatment which led them get fed up with this type of health system, whereas patients who changed the treatment against their will and for the reason of family/relatives' influence amount to 16.0 %, patients who gave the reason of the high costs of the medical treatment and the medicine amount to 8.0 % , and 12.0 % of the entire group of the patients who are under traditional healing said they left the medical treatment because of the long distance to the treatment place, which cost money and time and in some cases no one was available to help the patient to reach the area where medical services are accessible.

However, the group of patients who are under medical treatment mentioned four reasons that led them to leave traditional healing, and the percentage answers given were as follows: 6.0 % of this group of patients left traditional healing because they are not satisfied with the outcome of the healing methods. 20%, which is the majority of this group of patients gave the reason of long duration of the traditional healing and that indicates the effectiveness of these methods but in an uncontrollable time. Ten percent of the patients mentioned the influence of the extended family on their decision of switching the last treatment. While 14.0 % of this group of patients seek help from psychiatrists because of the reason of long way and distance to their healers (see figure 5.2.6). The analysis of the above table signifies the relation between the two groups of patients in reasons that led them switch the last treatment. Person Chi-square test is found to be significant as the value is 8.681 ($p < .10$).

Both groups of patients mentioned four similar reasons that pushed them to switch the last treatment and opt the new one, but they differ in one reason, namely "the high cost of the treatment" that is reported by the group of the patients who switched from the psychiatrist to traditional healing. The result points to a significant correlation between the two groups of patients as regards reasons for switching between the two health systems in Sudan.

Based on the above results, there is clearly a dilemma, the patient forms an intention to change risk health behaviours in favour of other health behaviours. This has also been conceived as a decision-making stage by some authors (See Fishbein & Ajzen 1988; Ajzen 1988; Eiser 1983). Today, it is known that self-efficacy and outcome expectancies are the major predictors of intentions (Schwarzer & Fuchs 1994). The later authors noted that the action phase could be described along three levels: cognitive, behavioural and situational. The cognitive level refers to self-regulatory processes that mediate between the intentions and the actions. The volitional process contains action plans and action control and is strongly influence by self-efficacy expectancies, but also by perceived situational barriers and support (Citation from Conner & Norman 1996, 180).
To clarify this dilemma, one can summarise three central factors/reasons that play a major role in the patients' decision of switching one treatment and turning to the other one: (1) Patient's personal experiences with the treatment, (2) Social/cultural factors, (3) Economic factors.

The first factor is **the personal experience** with the treatment and it might consider as outcome expectancies. The effects of outcome expectancies on performance motivation are partly governed by self-beliefs of efficacy. Schwarzer and Fuchs 1996 noted that outcome expectancies could be seen as precursors of self-efficacy because people usually make assumptions about the possible consequences of behaviours before enquiring whether they can take the action themselves. They added that if self-efficacy is specified as a mediator between outcome expectancies and intention, the direct influence of outcome expectancy on intention might dissipate (Citation from Conner & Norman 1996, 176). A patient's personal experience offers good knowledge, trail, advice and evidence associated with the evaluation of the consequences of the treatment to adopt. The alternative outcomes of the experience evaluation are acceptance or rejection the treatment. The later decision to abandon the treatment becomes very understandable, when patients give reasons such as not being satisfied with the outcome of a treatment, e.g. "unsuccessfulness of the treatment" or the long duration of the treatment. This implies that the patient has compared the expected benefits of the treatment with those of his/her own experience. Generally the expected benefit of the treatment is influenced by the patient's tendency towards the two health systems as well as by the factors that influenced his/her decision of adopting a special treatment, e.g., because of cultural beliefs. On the other hand, the former decision of an acceptance could be presumed when the patient completely adopts one of the treatments and this acceptance was based on consideration of the possibility of facing advantages and weaknesses in the treatment or if it was based on the patient's satisfaction with the treatment as well as with the practitioner. This interpretation is supported by Scheibler (2002, 137) who says, "All the four questioned groups of different nationalities have in common that a good practitioner should primarily have sociocommunicative competences"*, when she asked in four different European nations: What you will expect from a professional doctor, when you are ill? According to the core dimensions, a patient expects three things: Social, specialist's and role competence from a good doctor. The

* "Gemeinsam ist allen vier der hier befragten Nationalitätengruppen, dass ein guter Arzt an erster Stelle sozial-kommunikative Kompetenzen aufweisen sollte" (Scheibler 2002, 137).

result showed that the interviewers reported the social-communication competence as the first dimension that can be expected from a good doctor (Conversion by the author). Also, the result in section three shows that the duration of stay under treatment appeared to have a significant effect on the patient's tendency towards traditional healing. This could be another support for these analyses. However, the treatment of psychiatric and somatic disorders requires long duration, and note that most of our sampled patients report psychosomatic symptoms (see table 5.2.2a). Lindberg (1997) studied the psychological processes in somatic disease; the results showed there were indications that favourable results from psychotherapy could be sustained for a very long time. Probably the earlier interpretation of differences between the views of patients and the views of practitioners could be an explanation for a patient's behaviour, when he/she switches between the two health systems.

Scheibler (2002) stated, "Several studies have investigated the issue of doctor-patient interaction in different cultures. Grol, Wensing & Mainz (1999, 10) by the means of an international comparison, noted that some differences were to be seen between the views of patients from different countries. Examples of patients' statements: "A GP should be able to relieve my symptoms quickly, a GP should not only cure diseases but also offer services in order to prevent diseases, a GP should be willing to check my health regularly, or it should be possible to see the same general practitioner at each visit". She added that such differences may partly reflect actual differences in the different health care systems: the patients may value the care they are used to get or the care, which they would like to get and which is not provided. On the other hand, these differences may also reflect cultural differences between patients in different countries, such as the extent to which they value an authoritarian or democratic relationship with their practitioner, the extent to which they are oriented towards technology and curing methods for diseases or towards prevention, or the extent to which they expect that a quick solution to each health problem is provided (Citation from Scheibler 2002). Standing of the earlier analysis, one can say these differences between the views of patients can also be seen between patients within one country as well as in one culture where there are different beliefs, various preventive methods and diverse health systems.

In addition to that, there is another suggestion that could be an explanation for ineffectiveness of psychiatric medicine from patients' perspective. Although the majority of the sampled patients present their symptoms in a content of psychosomatic disorders and denied psychiatric illness (section 2), this kind of patients "the somatizers" is unlikely to accept and complete a conventional psychiatric referral and evaluation. Probably any typical psychological or psychiatric investigation has zero face validity and effectiveness for a patient with such symptoms, and perhaps such a referral will provoke scepticism, at best, or even anger. Wickramaseker (1988) discussed the issue of the somatizer and the psychological referral. He noted, "The somatizing patient remains committed to a medical definition and resolution of his/her somatic complaints, and any referral to a 'shrink' is seen as an insult or challenge to the authenticity of his/her obviously somatic symptoms". He added that a psychological referral is unacceptable to the somatizing patients who (a) keep mind and body in separate cognitive compartments, (b) do not believe that his/her mental emotional changes can alter biological functions, and (c) may not subjectively feel physiologically or muscularly braced or stressed. In order to engage such a patient productively and efficiently in any therapy, there must occur certain minimal changes in his/her perception of the clinical situation. First, the patients need to see and experience personally and repeatedly, in objective and quantitative terms, in perhaps a psycho-physiological laboratory situation, that the mind can alter biological functions. Second,

he/she may also need to be shown and recognize that his/her body is chronically on red alert, at work or at home, or both. Subjectively, the patient is often totally unaware, for example, that those parts of his/her body are chronically vasoconstrictor (e.g., cold or wet hands and feet) or muscularly braced in specific psychosocial situations at work or at home, or both. Third, he/she may need to recognize that he/she is subjectively unaware or has psychologically habituated or adapted to this abnormal chronic red-alert status, which may be contributing to his/her somatic complaints. On the other hand, Helman (1986, 99) studied the presentation of pain. He argued that each culture or group has its own "language of distress"; its members have their own specific way of signalling, both verbally and non-verbally, that they are in pain or discomfort. The *form* that this pain behaviour will take on is largely culturally determined, as is the *response* to this behaviour. These two different languages of distress may have negative effects on the type of medical treatment so that these patients must be given care, - especially by clinicians from a different cultural background or who are not considering these differences.

Additionally, Elkins, et al (1988) mentioned that many existential psychologists like Frankl (1963) have emphasized that spiritual conflict and distress are at the root of many of the clinical "pathologies" of our days. Ignorance of the patient's spirituality and belief by some psychiatrists could be one reason for ineffectiveness of the psychiatric health system. At this point, it is worth mentioning that if the psychiatric health medicine failed to help such a patient or produces other psychological problems, and then also the recovery, from a traditional healing perspective, would seem to be the most obvious cure.The later authors stated, "Jung (1933) recognised this point since noted that he was able to cure only those midlife crises patients who recovered a spiritual orientation to life. Also in our own days, transpersonal psychologists such as Wilber (1980, 1984), Vaughan (1986) and others have attempted to call attention to this important dimension but neglected area in psychology. Maslow (1962) argued that "the human being needs a framework of values, a philosophy of life, a religion or religion-surrogate to live by and understand by. In about the same sense he needs sunlight, calcium, or love" (Citation from Elkins, et al 1988, 8). And from our views, this is what traditional and religious healers offer to most of their clients. Hence, the patient's resistance against psychiatric treatment could be suspended and hanged on the characteristics and mentality of those patients because of the previous interpretation. It is even more of interest that the later academic professionals in the field of psychology are now occupied with the issue of integrating the transpersonal perspective into the field of health psychology. Belschner (2000, 107) argued that there is no denying of imagining such results in other, further and more numerous studies concerning the spiritual crisis area. "Further studies showed that a successful work on spiritual crises (Belschner & Galuska 1999) and the positive effects of stationary psychotherapeutic treatment can be better explained by combining them with the transpersonal perspective than solely by the so far used health-psychological concepts (Bantelmann, Galuska & Belschner 1999; Belschner 1999a). The evaluation of the cure from a crisis or the degree of the positively assessed changes in the life of a person happening in the course of treating the crisis can be better explained by the two constructs of 'Generalised Self-Efficiency' (Schwarzer & Jerusalem

1997) and 'Transpersonal Confidence' together than by one of the two constructs alone"* (Conversion by the author).

At this point its important to postulate that this result supports the above interpretation of other studies concerning treatment/handling of spiritual crisis and the positive effects of psychotherapeutic stationary treatment, rather through the transpersonal perspective than through the health psychology concept.

Second, **the social factors** that result from the strength of the extended family's influences. However, 26.0% out of the patients of the whole sample gave reasons for family/relatives influence on their decision to switch the last treatment. This result was not surprising when we look at the structure of the family and the social relations in Sudan. The structure of the Sudanese society relations is very strong, particularly within one family. An extended family comes within the frame of ownership and authority over family members (Badri, El Nagar & Pitamber 1997, 18). Concerning the household decision-making, literature has shown that Sudan is considered a 'men's affair' and women have little say in it (See Badri, B. 1990; Musa, S. 1999).

This point for a position of men as the head of households might indicate the decision issues, which are directly related to or contribute to aspects of an individual life, the domain under extended family empowerment. Thus, it is questioned whether the patients' health and illness issue can actually be categorised under the individual life aspects or as empowered family decision-making. The percentages of the patients who mentioned the family/relatives influence as the main reason for switching the last treatment, can answer this question. Note, that half of the patients' sample is women. At this point it worth mentioning that the patient's personal believe and tendency might be different from his/her relatives' believe. Furthermore, this result could point to the stigma of an extended family as well as draw attention to negative effects of the social relationships, which results in the patient's self-confidence with prospects for the future and decision-making capabilities as regards the health issue. However, the ultimate outcome of this study is improving the patient's health situation.

Schwarzer and Fuchs 1994 argued that a specific subset of outcome expectancies, namely social outcome expectancies, should also be considered explicitly as determinants within the motivation phase, as proposes in the theory of reasoned action and the theory of planned behaviour, where this has been called subjective norm or normative beliefs. People often develop intentions because they perceive social pressures to do so. Individuals comply with the perceived expectations of significant others in order to receive gratifications or to avoid conflicts or disregard, or because of naïve trust in the opinion of others. Previous findings on the predictive value of the subjective norm (or normative beliefs) have not been overwhelming, which is possibly because of limited measurement and theoretical elaboration. The perceived social expectation factor should be viewed from two additional points: (a) from a social comparison perspective which suggests that our

* "In weiteren Studien ließ sich nun zeigen, daß die gelingende Bearbeitung von spirituellen Krisen (Belschner & Galuska 1999) und die positiven Effekte von stationären psychotherapeutischen Behandlungen durch die Hinzunahme der transpersonalen Perspektive besser erklärt werden können als durch die bislang verwendeten gesundheitspsychologischen Konzepte alleine (Bantelmann, Galuska & Belschner 1999; Belschner 1999a). Die Einschätzung der Heilbarkeit einer Krise oder das Ausmaß der bereits im Gefolge der Bearbeitung einer Krise eingetretenen und positivbeurteilten Veränderungen im Leben eines Menschen werden durch die beiden Konstrukte Generalisierte Selbstwirksamkeit (Schwarzer & Jerusalem 1997) und Transpersonales Vertrauen gemeinsam besser erklärt als durch eines der beiden Konstrukte alleine" (Belschner & Gottwald 2000, 107).

intentions and actions are governed by our desire to maintain or enhance self-esteem or self-consistency within normative reference groups; and (b) from social support perspective which suggests that people draw on their social networks and resources when making decisions, e.g. the intention to quit smoking being facilitated by a network of non-smokers (Cohen et al. 1988). They added that the link between social outcome expectancies and intentions has to be reconsidered with the research perspectives in mind (Citation from Conner & Norman 1996, 177)

Third, **the economic factors**: Before analysing and discussing the role of the economic factors in a patient's health decision, one can highlight the general economic situation of our country Sudan. The agricultural sector is mainstay of Sudan's economy and generally provides the livelihood for the great majority of the Sudanese people. Moreover, the agricultural sector produces about ninety percent of the country's foreign trade exchange goods, as it provides almost all export goods and a significant portion of the raw material for local industries (FAO 1993). During the last decade, Sudan faced a big economic problem because of the civil war, drought, and international economic sanction (SSR 1997, 150), which have up till now not ended. The latter problems reflect other serious problems such as inflation and poverty growth. This situation is steadily working against all the sectors' position.

Schwarzer and Fuchs 1994 argued that situational barriers as well as opportunities have to be considered in health action plan. If situational cues are overwhelming, meta-cognitive skills fail to protect he individual and the temptation cannot be resisted. Actions are not only a function of intentions and cognitive control, but also influenced by the perceived and the actual environment. They mentioned one example that a social network that ignores the coping process of a quitter, by smoking in his presence, creates a difficult stress situation which taxes the quitter's volitional strength. If, on the other hand, a spouse decides to quit too, then a social support situation is created that enables the quitter to remain abstinent in spite of lower levels of volitional strength (Conner & Norman 1996, 180).

The health sector is the main core of this study. Although only thirty-four percent of the total sampled patients emphasized the issues of cost as reasons for switching the last treatment, several indicators show that the medical health situation may actually have deteriorated. Increase of hospital fees, increase of private doctors' charges, expensive price for medication or its non-availability, lack of skilled physicians since many of professionals in medical health are engaged in various forms of economic activities or left the country to meet the growing poverty status of their families. The general picture and the common situation of the biggest hospitals affect the most important deterrent, which is the feeling of hopelessness in finding professional help. These factors together, which result from the steady deterioration of psychiatric medicine in Sudan, probably explain the percentage of the patients who left the treatment on the basis of the high cost of psychiatric medicine and the long distance to hospitals. Moreover, these factors could play a big role in the patients' tendency towards the medical health system as it explains the high percentage of the patients who have positive tendencies towards traditional healing (see section one).

Concerning the patients' group who are under medical treatment, one can realise that all the patients who addressed the economic factor as a reason of switching the traditional healing, formed this factor under a specific reason, the "long distance to healers", which means "the cost of transportation". This is in contrast to the patients in the other group who

mentioned other reasons such as high fees or expensive medicine. An explanation for the patients who stated this reason is entirely lying in the patient's economic situation. As mentioned earlier, the poverty and the high inflation rate in Sudan could be the main hidden ground for this reason, as the characteristics of the sampled patient suggest this interpretation. Moreover, the result of this group of patients implies that traditional healing, in general, remains stable concerning the price, compared to psychiatric medicine, and absolutely it is still ongoing even without costs. However, some patients pay nothing for services. This was not surprising, as it has been realised in the field survey that most of the healers accept what the patient gives and never ask for an individual price or fees. Nevertheless, the mystery about the traditional healers' economic situation is still not clear and it is still questionable.

5.3 Major findings and conclusions

This chapter has presented the results and discussions of patients' tendency towards the medical treatment and traditional healing as well as the reasons behind patients switching between these two health systems and the uncertainty of health plan decisions. The importance of these investigations that "the patients' treatment dilemma", which results in movement of patients between types of treatments and within the practitioners' group for each treatment might influence and hamper the effectiveness of treatment and delay the patients' recovery.

The patient interview phase was administered using a structured questionnaire, which was constructed according to Schwarzer's Model in Self-efficacy and Health Behaviour: "Sozial-Kognitives Prozessmodell gesundheitlichen Handelns, Schwarzer 1992". Fifty patients who were exposed to the two health systems, "the psychiatric medicine and the traditional healing" were interviewed. The data were carried out using SPSS software package (Version 10). Chi-square test, cross-tabulation of variables and percentages show that many of the hypothesized variables are significant.

The main findings and conclusions from this chapter can be summarised as follows:

The results indicate that there is a high positive tendency towards traditional healing in Sudan. In the two sampled groups, the tendency towards traditional healing was found to be significant and positively related to the patients under traditional healing as well as to those under medical treatment. This can easily be attributed to the wide spread of traditional and religious healing methods in Africa generally, and in Sudan particularly. In the last decade, most of the old ultimate healing centres were realised to provide psychological and social counselling in a community. Healers are community-oriented and place emphasis on educational, healing and preventive goals, because education has become increasingly popular among them. This is thought to be a reason for a positive tendency towards those healers. Also the way of communication and language used by healers and the agreement between patient and healer about aetiology and causes of disorders and furthermore about the treatment process and methods might result in this recognisable harmony.

Analysing the factors that are expected to influence the patient decision towards health systems and his/her tendency towards traditional healing, it is found that patient's perception of health and illness neither affects patient's decision on which treatment to choose nor his/her tendency towards traditional healing. These factors were measured by a set of statements: (1) perception of symptoms, (2) assumed name for the illness, (3) perception of the causes of illness, (4) perception of the illness origin in general (Is it hereditary? Is it a result of general weakness in the body? Is it fate?). These statements were cross-tabulated with patients tendency towards traditional healing. The Person chi-square tests show an insignificant relation in all the results of the above statements.

However, there was no significant relation between the patient's tendency towards health systems and his/her perception of health and illness. And, moreover, a recognised number of the sampled patients denied the psychiatric disorders that they are suffering from, as the result reveals that 58% of the sampled patients address their sickness under supernatural illness. A further 56% of the sampled patients report psychosomatic symptoms. This result

was not unexpected in a society where most of the people, if not all, have a low awareness of psychiatric health and look upon mentally sick people as a shame or stigma for their family. Thus patients might be conscious towards psychiatric diagnosis to avoid the stigma of mental illness and the consequent harmful social and vocational consequences. Also such negative attitudes and behaviour towards mental sickness might mislead patients, when identifying their symptoms and the assumed names for their problems and it might also make them reluctant in opting for the psychiatric health system.

However, the patients' education level is found to be insignificantly rejecting the hypothesis of a positive relationship between tendency towards traditional healing and education. Nevertheless, the percentage of patients with positive tendency appeared to decrease with the increase in education level. This supports the result in the former hypothesis, as it revealed a sudden result with regard to the tendency towards traditional healing and the perception of health and illness in general.

The duration of stay under treatment is found to have a significant influence in explaining the variation of patients' tendencies towards traditional healing. Person chi-square test confirms the hypothesis of a relationship between a patient's experience duration for treatment and his/her tendency towards traditional healing. This is thought to be due to the long duration experiences of patients concerning treatment, sometimes without a sign of recovery, which results in a different stage decision and process, from the time when the patient decides to adopt one of the health systems until he/she is totally satisfied with it or rejects it and turns to the other one. The result shows that the percentage of patients with positive tendency towards traditional healing decreases with the duration of stay under treatment. Probably as time passes with little and limited success of the treatment chosen first and with no signs of recovery, the patient starts to loose hope and his/her expectation from this treatment decreases. Therefore, one can say the personal experience with the treatment affects the patient's health plan decision as well as the patient's original tendency that only arises by influence of other factors.

Responses given to the three clustered variables that measure personal belief in traditional healers and their methods are: (1) patient's view on the abilities of the traditional healer; (2) patients' perception of religious origin of traditional healing, and (3) patients' conception of the cultural origin of traditional healing were cross tabulated with responses on patients views about the effectiveness of traditional healing. The results of chi-square test are found to be significantly confirming the hypothesis of a positive relationship between belief, as the one dimension of spirituality, and the effectiveness of traditional healing methods. This result highlights important clinical dimensions of spirituality: religious and traditional factors that are originated from the personal belief in healers as well as belief in the effectiveness of rituals and practices that are used by those healers as cure methods. Probably these findings explain the hidden secret of a high positive tendency towards traditional healing, as compared to the medical one (see section one), that the personal belief was the primary source of patient's tendency towards health systems. Also the findings indicated that the patient's willingness and reception to the treatment and its practitioners has a great effect on the treatment effectiveness. Furthermore, almost all the Sudanese people have developed their spirituality and beliefs in traditional healing on the basis of tradition and religious sources. It can also be argued that this result confirms the findings in other sections, as well the patients' general perception about health and illness as the educational level do not influence the decision to choose one of the health systems.

It results also that gender influences the patient's tendency towards the chosen types of

treatment. Both men and women are found to have positive tendencies towards traditional healing. Female patients, however, proved to have a higher tendency. This result is strongly supported by direct observation in the field survey, since the majority of traditional healers' clients were female. Women's tendencies towards traditional healing probably are attributed to the women's high illiteracy rate and their limited access to health awareness and education programmes in Sudan. Also it might be due to the low social position of women and the prevailing male dominance in cultural and decision-making processes as well as in the fact that women in Sudan are suppressed and marginalized in that male dominated society. Furthermore, the way of women's daily-living might facilitate the spread of these traditional healing methods, particularly when known that women are more concerned with their family affairs and spend most of their time socialising with female-friends, so within this environment, discussion of psychosocial problems as well as of possible and accessible remedies sure will take place. The author suggests that the same interpreted reasons that led women to have a positive tendency towards traditional healing and seeking help from healers are those that also cause their psychosocial problems.
Finally, a significant correlation is found between the two groups of patients and the reasons that influenced patients' decision of switching the first chosen treatment. Results have shown that patients who left the traditional healing for the medical one, report four reasons behind their decision: (1) Frustration and dissatisfaction with the treatment results, (2) Long duration of the treatment, (3) Influence of the extended family in patient's decision of changing the last treatment, and (4) Reason of long way and distance to the treatment place. However, the other group of patients who exchanged medical treatment for traditional healing mentioned the same four reasons in addition to another one that is the high price of medication as well as the doctor's consultation fees.

To clarify the patient's treatment dilemma, the reasons that were mentioned by the whole sampled group are related to three clusters: (1) Patient's personal experience with the treatment, (2) Social/cultural factors, and (3) Economic factors. These might generally explain the phenomena of patients' switching between medical and traditional treatment. The first cluster views the patients who switch between the health systems as seekers of psychological help. By doing so, there are different evaluation stages that a patient experiences after accepting psychological help from one of the health systems. These stages will end by decision of acceptance or rejection of the treatment. The later decision could be presumed when the patient had a negative outcome experience with the treatment, such as ineffectiveness of treatment or long duration of treatment and, as is known, psychiatric illnesses need a long time of treatment. These analyses are supported by the earlier result that the duration of stay under treatment has a significant effect on the patient's tendency towards the type of this treatment.

There are different suggestions that could explain the reason of ineffectiveness of psychiatric medicine. First, the result revealed that a growing number of the sampled patients denied their psychiatric illnesses. Therefore those patients could be unlikely to accept and complete any psychiatric evaluation or treatment. Second, ignorance of the patient's spirituality and personal belief by psychiatrists could be a reason for ineffectiveness of psychiatric medicine. Here it should be beard in mind that the recovery of a traditional healing perspective would seem to be the most obvious cure. This latter suggestion is supported by the most central finding in section three that the patient's personal belief in the origin of traditional healing "as one dimension of the spirituality" has a positive effect on the patient's tendency as well as the successfulness of the healing methods from the patient's perspective.

The second cluster presents the social/cultural factors as one reason for patient's switching between the health systems. This suggestion was not surprising when we look at the structure of the family and social relations in Sudan, which results in the level of the extended family's influences. The general situation in Sudan indicates that the decision issue, which is directly related to or contributed to aspects of an individual life, is a domain under the extended family empowerment. And the result confirmed that this extended family empowerment is even enlarged to involve the patient's health and illness issue.

The last cluster suggests that the bad economic situation in Sudan, which resulted from the civil war, drought, and the international economic sanction, up till now has not ended, has affected the general medical health situation as well as the decision of seeking help from this health sector. Many indicators demonstrate the fact that this sector is actually affected and deteriorated: increase of hospitals fees and private doctors' charges, expensive price for medication, if it is available, and lack of skilled physicians, since most of them left the country to meet the growing poverty status of their families. Probably these factors could explain the situation of the patients who left the psychiatric medicine due to its high cost or the long distance to hospitals, which costs also for the transport. Also this economical situation, which results in the steady deterioration of psychiatric medicine in Sudan, might explain the percentage of the patients who left the psychiatric health system on the basis of dissatisfaction with the practitioners as well as with the ineffectiveness of the treatment.

Contrarily, the result reveals that the traditional healers and their healing medicine are stable in price. As for the patients who exchanged this traditional sector for the psychiatric one, they never mentioned reasons of expensive medicine or high price or cost concerning traditional healing. Patients at this group who mentioned the reason of economic factors particularly confirmed this factor under specific reasons, such as the long distance to healers, which clearly indicate that either the cost of transportation "due to patient's economic situation" or that there is no person free to transport/combine the patient, are the main reasons of switching the traditional healing. The notes during the field survey confirm this result, as it is realised and noted "healers never ask for individual charge or fees".

In the end, one can say this result suggests that the same unobservable factors and characteristics of patients that led the group of the patients who are under psychiatric treatment turn to traditional healing are those that also directed the patients who are under traditional healing to seek help from psychiatric medicine.

6 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

Matters of health and illness and their cultural interactions have attracted widespread attention throughout the world and among the health development community in general. This has led health researchers and socio-cultural anthropologists to expand their research efforts to study the cultural dimensions of health and illness. The aim of this study is to analyze the tendency of patients towards medical and traditional treatment in Sudan by identifying the socio-cultural factors that influence a patient's tendency and health decision towards one of the two health systems. The study intended to explain also the role of a patient's personal belief, perception of health and illness, level of education and experience of duration under treatment, in decision of adopting or abandoning one of the two health systems. In addition to this, special focus was put on highlighting the reasons that led patients to swerve and switch between the two health systems, which results in a patients' treatment dilemma and the accompanying negative consequences. At this point, in general, one can say that the movement of patients between the types of treatments and within the practitioners' group of each treatment might influence and hamper the effectiveness of treatment and delay the patients' recovery.

Moreover, the study attempted to underline theories and models of mental disorders in regards to psychiatric medicine and traditional healing in general, and in Sudan particularly. Nevertheless, the study neither ignores nor underestimates the importance of the collaboration between the two health systems, "the psychiatric system and the traditional one".

A general conclusion from this research is that the qualitative approach of studying two groups of patients: "patients under psychiatric treatment and patients under traditional healing", who both were exposed to the two health systems is useful in drawing a meaningful conclusion regarding to patients' tendency and uncertainties in making health decisions. Also the application of content analysis according to Mayring (1996, 1997, 2000) and Coolican's (1994) methods of qualitative analysis is a positive and practical approach to minimize and reduce the huge data into labeled categories, so as to be susceptible to the statistical significance testing "Chi-square test". The data were carried out using SPSS software package (Version 10).

In addition, the research has demonstrated the use of an intensive analysis approach in understanding theories and models of mental disorders, based on direct contact with psychiatrists and healers in Sudan. The major findings, similarities and differences as well as conclusions with respect to the theories and models of the two health systems have been presented in chapter 4. part 3. Also the major findings and conclusions with respect to patients' tendencies towards the two health systems and reasons for switching between them as well as uncertainty towards health plan decisions were presented in the previous chapter (chapter 5). The followings are the main conclusions to the specific objectives and hypothesis concerning the study.

The results have revealed these some similarities between the psychiatric doctors and traditional healers: personal characteristics and social status, specialization and classification of mental disorders based on symptoms, concept of interviewing patient and one of his family as well as other subsequent interviews, abreaction and diagnostic stages, the goal of both health systems and, moreover, similarities in the concept of some methods of treatment/healing, namely a suggestion therapy, aversion therapy –behavior therapy, and group psychotherapy.

Another finding is that the both practitioners serve a function within the patients themselves and the community, but the major distinction between them as a methodology is those doctors focused on diseases (adaptation and mal-adaptation) and not on the person, whereas traditional healers use a holistic approach in their healing methods that is basically a mediation process between the individual and the dominant cultural values, personal beliefs, powers of social relationships and powers of healer's social status and their institutions. A further essential finding is that the rapport between healers and their patients plays a great role in the success of the treatment and is considered to be an advantage of traditional healing in comparison to psychiatric medicine.

Concerning the patients' data analysis, both descriptive statistics and the chi-square test reveals a high positive tendency towards traditional healing compared to medical treatment in Sudan. The tendency towards traditional healing was found to be significant in the two-sampled groups, however the patients under traditional healing have higher tendency than those under medical treatment.

An analysis was made of the factors that were expected to influence a patient's decision towards health systems and his/her tendency towards traditional healing. It is found that patients' perception of health and illness neither affects patients' decision on which treatment to choose nor his/her tendency towards traditional healing. Moreover, the patients' educational level is found to be insignificant. This rejects the hypothesis of a positive relationship between tendency towards traditional healing and education, although the percentage of patients with positive tendencies appeared to decrease with the increase in educational level.

The duration of stay under treatment is found to have a significant influence in explaining the variation of patients' tendency towards traditional healing. Chi-square test confirms the hypothesis of a relationship between the patient's experience duration with the treatment and his/her tendency towards traditional healing. Also the result appears that the gender variable influences the patient's tendency towards the chosen type of treatment. Both men and women are found to have positive tendencies towards traditional healing, however, female patients proved to have a higher tendency.

The results of chi-square test are found to be significantly confirming the hypothesis of a positive relationship between the personal beliefs "as the one dimension of spirituality" and the effectiveness of traditional healing methods on the patients' perspective. This result highlights important clinical dimensions of spirituality such as religious and traditional factors that originated from the personal belief in healers as well as belief in the effectiveness of rituals and practices that are used by those healers as cure methods.

Moreover, this finding explains the hidden secret of a high positive tendency towards traditional treatment as compared to the medical one.

Studying the patients' treatment dilemma regarding reasons of switching between the two health systems, a significant correlation is found between the two groups of the patients and the reasons that influenced patients' decision of switching the first chosen treatment. The result showed that patients who substituted traditional healing by the medical one report these four reasons to do so: dissatisfaction with the treatment results, long duration of the treatment, influence of the extended family in patient's decision of changing the treatment, and the long distance to the treatment place. However, the other group of patients who substituted medical treatment by traditional healing mentioned the same four reasons in addition to another one that is the high price of medicine as well as the doctor's consultation charges.

Based on the above four reasons, important conclusions can be drawn from this section. **First,** in both groups of the sampled patients, the results reveal that educational level and perception of health and illness has no role to play, neither in patients' tendency towards traditional healing nor in health plans decision-making. The prime conclusion of the study confirms that the prevailing belief system in Sudan is the main factor that influences health plans decisions and explains the high positive tendency towards traditional healing. This is so mainly because traditional healing is considered as part of the Sudanese culture and is perceived originating from Quran, which is the main reference to Muslims in Sudan who represent 75% of the population (Sudan net, 2003). Also the result reveals that this dimension of spirituality has a long history since it is connected to the belief in "God" and "Fate" as supernatural powers that control people and their health nature. This belief is wide spread in Africa and particularly in religious countries like Sudan. It is surprising when we look at the fact that this dimension of "spirituality" is not involved or either considered in the academic sciences nor is the nature of people's health. **Second**, results of analysis and observations through direct contact with traditional healers confirm that asking traditional healers for healing are in the form of a non-committal, brief investigation (inquiry), anonymous methods, which some of it is harmful, and no commitment in time and money is entailed in therapy. However, consulting traditional healers in social problems, mild disorders and dealing with spiritual healing methods has a positive recognizable effect on most of patients' health. Despite these and other significant results such as patients' positive tendency towards traditional healing, patients' expectations clearly remain a pertinent issue in the evaluation of positive and negative aspects of traditional healing. **Third**, these results indicate that a patient's tendency to adopt one treatment perspective may meet with their family preferences and that facilitates greater intimacy between patient, family members and the practitioner of the treatment, which helps the effectiveness of the treatment. The patient's tendency may in some cases come across or differ from his/her family preferences and that might create a new and sometimes unbridgeable schism between the patient and family, until he/she changes the treatment. Taken together, these results and the society construction do indeed suggest that a decision of adopting one type of the treatment is not only a patient's decision as it affects not only the patient, but the family as well. These factors, in addition to other factors, namely the patient's personal experience with treatment, the availability and infrastructure to the place of treatment, the general economic situation of the patients as well as the high price of

medicine and the doctors consultation fees, explain the patients' treatment dilemma and their instability under one of the two health systems.

Fourth, it is not surprising that the results of this study have linked with different approaches in the field of mental health and illness, such as clinical, cultural, social and the most new essential approach of transpersonal psychology and spirituality dimensions. Since the earlier definition of "psychology" is the science of studying the mind and its process matter. As Belschner (2000, 72)* noted, "For a specialist discipline, here psychology, such an assumption results in consequences for the self-concept. In general, psychology is conceptualized as an empirical discipline, which offers statements on lawful relations between observed events. The experiential data then are "not only the observations mediated by the sense organs, but also personal experiences, sensations, memories, thought, moods, and so on"* (Conversion by the author)

Finally This research is inviting us "as academic researchers in the field of medical and social psychology" to look for a new science studying the individuals within the three dimensions of humans in different cultures: the daily normal life, the unconscious life and the supernatural life. At this point one can realize that the latter dimension of the personal life "spirituality" has been ignored in the last decades of science, and that this study is urgent and inquires to involve this dimension in modern science as well as consider the role this dimension plays, particularly when we plan to study human events or investigate the other social and psychological phenomena.

6.2 Recommendations

Based on the conclusions derived above, recommendations regarding the method of analysis, areas for further research and policy implications are made in the following section.

Recommendations on methods of analysis

Some important lessons emanating from this research concern the application of the qualitative research methods in studying tendency and risk decision towards health plan using the content analysis approach. The approaches produced results that are either generally consistent with other studies carried out elsewhere or the researchers in the field of psychology are still busy with it. Experiences gained, showed that the difficulty in the elicitation process and the time taken for the respondents as well as the translations of the Arabic and local terminology to the English was enormous. The time taken is aggravated by the need for setting a common understanding between psychiatric doctors and

*Für eine Fachdisziplin wie die Psychologie hat eine solche Annahme Konsequenzen für ihr Selbstverständnis. Die Psychologie wird in die Regel als eine erfahrungswissenschaftliche Disziplin konzipiert, die Aussagen über gesetzmäßige Zusammenhänge zwischen beobachteten Ereignissen anstrebt (Laucken & Schick 1971, 21). Als Erfahrungsdaten werden dabei nicht "nur solche durch die Sinnesorgane übermittelten Beobachtungen verstanden", " sondern auch persönliche Erlebnisse, Empfindungen, Erinnerungen, Gedankengänge, Stimmungen und dergleichen mehr" (Belschner & Gottwald 2000, 72).
*

traditional healers regarding the theories and models of mental disorders, putting a clear picture about the position of the two health systems, the psychiatric health system and the traditional one in Sudan, and also getting the reasons of the patients' uncertainties on health plan decisions and their treatment dilemma.

The author faced another difficulty, namely the experience of how to reach the working areas of traditional healers, how to have enough time and to get an appointment with them and how to find out the secrets and ways of their healing methods, inclusively whether they took photographs and used a video-camera. The same problems were faced with the psychiatric doctors, particularly the problem of making appointments and discussing clinical topics.

Educational surveys are necessary before the actual data gathering. However, as pointed out in chapter 3, the use of a tape-recorder during the interview phases was not apparent because patients were not familiar with the data gathering procedure beforehand. With the SPSS soft package, data analysis is made simpler and descriptive statistics, frequencies and Chi-square test "with the emergence of using Graddock-Floods tables to assess the significance levels" can be estimated. The packages can also be useful for extensive researches and policy making in educating and assisting patients in decision-making as well as professionals for improving the mental health system. However, the first and foremost thing is to ensure that the elicitation processes provide reliable data, and the sampled number is enough not to present problems in later analysis.
Experience from this research shows that the triangle study (psychiatrist, healers and patients), which based on the empirical approach is a closed and a reliable way of understanding a general situation of patients who suffered from mental disorders in Sudan.

Areas for further research

There is a need for extending this research to other areas in order to ascertain the extent to which the results obtained in this research are applicable in other areas with or without similar conditions as in the research area. In addition, the time frame needs to be considered to know whether the results will change over time. However, it is important to note that as time passes by there may be changes in the decision environment as well.

Long history and widespread traditional healing methods in Sudan play a role in patient's uncertainty towards health plan decision. Taking into consideration that the medical health system in Sudan is still underdeveloped, there is a need for carrying out research and getting more information on the structure, general situation, conduct and performance of practitioners with respect to both health systems.
Awareness as the main sources of tendency towards traditional healing and decision making towards health plan shows that the perception of health and illness factors is important. As a result there is a need for putting more research efforts on studying these factors and why the factor of the educational level does not affect the tendency as well as the decision-making before the duration of experience with treatment. Furthermore the results showed that the extended family have a big influence in the patient's decision of switching between the health systems, which emerge from the involvement of the sector "family members" in further research.

This research selected the psychiatric health system and the most widespread system, traditional healing, particularly the religious methods "*Quran* and Sufi" in addition to the *Zar* healing method as a case study. Thus still more research is needed on the impact of traditional healing methods compared to the psychiatric ones, also to extend the area of the case study because there are other traditional healing methods and health care systems ignored/not involved in this research. These areas are closely related because consequences of uncertainty behaviour may adversely affect the decision and lead patients to seek help from other health-care methods.

Further research is required in determining the optimal choice of a traditional healing system based on personal spirituality and beliefs generated from the religious and cultural origin. Research is also required in investigating the reasons behind switching between the health systems, focusing in the patient's personal experiences with treatment, economic and socio-cultural factors.

The patients' questionnaire approach that raised by Schwarzer (1992) and developed by Belschner (2000) on Self-efficacy and Health Behaviour needs to be further explored, especially in transpersonal psychology applications. This enables to investigate the spiritual dimensions in the field of health psychology.

Policy implications and recommendations

Adopting a traditional healing system can both reduce and increase the risks to the security of a patient's health life. Health in general is of strongly positive benefit to the patients as well as to the community compared to illness. However, there are risks associated with traditional healing methods as with switching between/within the health systems, for example, physical damage, poor nutrition, waste of time and money, disappointment of the treatment, deterioration of health situation, which may even lead to death.

However, the results of the research show those patients have a high positive tendency towards traditional healing compared to the medical one. To support the role of traditional healing in fulfilling its role in health risk management, various policy interventions are possible. The first category is the development of healers' education and qualifications (extension and training) regarding general health-illness awareness, improve the situation of traditional healers and their institutions (electricity, water, schools, medical health centres and infrastructure to near cities). In addition to that, an increase and extension of the role of traditional healers in their communities as well as the benefit of their healing methods by rejecting the harmful methods. At this point, one can say that the use of information, education and communication intervention techniques can lead to more positive and less hazardous forms of practice among traditional healers. Pre-training should assess in the area of knowledge, attitude and practice of mental health methods. Another policy intervention needed is to control this sector and involve it under the government legality and responsibility such as Health Ministry in Sudan.

The second category of the policy interventions is related to the development of the general situation of the medical health sector, particularly the psychiatric health system, and to minimising the impacts of risks and uncertainties that result from patients' switching

between the health systems. Improvement of hospitals' situations regarding the general outer appearance; buildings, services, and offering beds, food and medicine, noting the level of the general people's economic situation in Sudan. In addition, improvement of physicians' qualifications through professional training, exchange inside and outside the country, participation in schemes and upgrading their economic situations as well as controlling the private consultation charges is certainly needed.

Interventions towards technology development in medical health will have an impact on patients' decision of rejecting/switching this system. Such interventions are, for example, breeding and selecting techniques for assessment, diagnosing, treatment and disease resistance or prevention.

In addition, integration into the field of traditional healing, "spirituality and transpersonal psychology", in the new sciences of medicine and psychology is needed to serve more aspects about culture and health in the academic institutions as long-term options in dealing with integration methods in the field of health psychology. Furthermore, an improvement in information dissemination regarding health technologies such as equipment, machines and tools is advocated.

The third category of interventions policy is related to increase the patient's knowledge and perception towards mental health and illness as well as to improve the general awareness of the Sudanese community. This will optimise the negative thinking about psychiatric medicine and the negative thinking towards people who seek its help. The approach to achieve these goals could be made through health awareness programmes and training for all the people, public counselling, giving a chance to those patients to participate in public media by telling their experiences with health and illness, encouraging the medical health centres, namely the psychiatric care in rural areas and where the healers are far away and also the development of the infrastructure and other transport measures that help patients to reach the areas where the medical health care is available. There is also an urgent need to set up a health insurance system, since the result showed that the high rate of doctors' consultation charges and the price of medicine have a role to play in patients' health decision, taking into consideration that there are no health insurance systems in Sudan. Thus the introduction of a health insurance scheme in Sudan may make it easier for individuals and families to be able to afford proper fracture treatment in hospitals

Traditional management that concurs with psychiatric practices could be a starting point for both discussion and cooperation. Based on the above-mentioned reasons there is a need for collaboration between the psychiatric health sector and the traditional healing sector in Sudan for minimising the risk incidences of a patient's uncertainty decision when each sector ignores the other and works separately. However, the high positive tendency towards traditional healing, which influences the effectiveness of healing methods, also the high level of similarities between the two health systems found in this study indicate a bright chance for future collaborative activities between psychiatric doctors and traditional healers. Moreover, the results of this study suggest that the traditional healers in the Sudan may contribute to promoting the appropriate personal spiritual management of mental disturbances by using a holistic approach of treatment that includes mind, soul and body "despite that, their perceptions and practices need to be upgraded to ensure success". Another advantage is that those traditional healers are available and attend to patients with

mental disorders, both in rural and urban areas, so efforts should be made to promote cooperation between traditional and medical health care providers, in order to improve the patients' health.

The choice of collaborative ways should be considered among the country's economic properties as well as the patient's health priority. The author suggests a collaboration between the two health system, where doctors and traditional healers, exchange visits and friendships, try to build a model of joined clinics or referral systems, they can also be benefit from the experience of other countries with more success in the field of mental health.

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Appendix

Appendix 1

Patients' questionnaire

This questionnaire includes (42) questions to study the patients' tendencies towards the medical treatment and traditional healing in Sudan. Please can you help us by answering these questions, without mentioning your name?

General Information:

Gender: Male ( ) Female ( )

Age: 18-25 ( ) 26-35 ( ) 36-50 ( ) above 50 Years ( )

Religion: Muslim ( ) Christian ( ) Others ( )

Marital status: Marriage ( ) Single ( ) Divorced ( )
Widow ( ) Others ( )

Region: Northern ( ) Southern ( ) Eastern ( ) Western ( ) Central ( ) Khartoum ( )

Residence: Urban ( ) Rural ( )

Education level: Illiterate ( ) Khalwa ( ) Primary school ( )
Secondary school ( ) University ( )

Occupation: Student ( ) Worker ( ) Employed ( ) Merchant ( ) Household wife ( ) Others ( )

Case: Traditional treatment ( ) Medical treatment ( )

1. How did you know this place?
2. Who supported your decision to come here for the treatment?
3. Please try to describe your feeling as you entered this place of treatment for the first time?
4. Since how long have you been here?
5. Please try to describe your illness (symptoms)?
6. What do you call your illness/What name does it has?
7. What do you think has caused your illness?
8. To what extent will your illness affect your social surrounding?
9. To what extent the expectation about your illness, affected you personally?
10. How do you protect yourself in a difficult situation?
11. Where did you start your treatment?
12. Whom did you consult at that time?
13. Please try to describe your feelings as you entered that place of treatment for the first time?
14. Do you think your illness can be treated and you will become totally healthy again?
15. If yes; what kind of treatment do you think you should receive?
16. What do you feel when you are thinking about you illness?
17. What does it mean for you to become healthy again?
18. What are the most important things from your inside that can help or support you to become healthy again?
19. What do you believe; how long would be needed to recover from your illness?
20. What were the reasons of changing the last treatment?
21. What do you do if El-Sheikh/Doctor said; it is not easy to solve your problem?
22. What tendency do you have towards the traditional healing?
23. Some people think that; their illness is hereditary. What about your illness?

24. Some people think that; the sickness comes as a result of a weakness in the body. What do you say about this?
25. Some people think that; the sickness is a part of their fate. What do you say about this?
26. Which type of treatment (the medical or the traditional) do you think is faster?
27. Which type of treatment (the medical or the traditional) do you think is cheapest?

What do you say, if you know some people saying that;

28. El-Sheikh is the one who can diagnose and treat the illness
29. This kind of traditional treatment, which is practiced nowadays, is founded in Islam religion?
30. The traditional treatment is a part of your culture?
31. The traditional treatment is more efficient and successful than others?
32. If somebody would advice you to practice the tow types of treatment at the same time, to avoid the critical situation in your illness, would you agree?

Now you made some experience in the field of treatment, due to your illness:

33. What has changed in your previous idea about illness and treatment?
34. What did you learn from your experience?
35. Which things let you feel dissatisfaction from the last treatment?
36. What is your feeling from the first time you met your doctor/Sheikh and now?
37. To which group of patients do you have a pleasant feeling?
38. Did you believe that you could positively influence your recovery from illness?
39. Which kind of social environmental support can help you to make control for treatment progress?

40. Perhaps you have been ill for several times and you developed the strong conviction that you are a person that is becoming healthy in any case. Did you have this experience and this feeling that you will become healthy this time, too?
41. What is your plan to recover fast (totally) from your illness?
42. We just assume that; one of your relatives will become ill and ask you for advice, which type of treatment would you recommend to him?

Would you like to say any other things?

Appendix 2

The dimension of the patient's questionnaire "according to the Schwarzer's model"

These questions were constructed according to the Schwarzer's model in Self-efficacy and Health Behaviors (1992), to study the tendencies of the patients towards the medical and traditional treatment in Sudan.

1) Risk Perception:

***What does the patient think about his/her illness?**

***How the patient looks to the symptoms in his/her behavior?**

1) Please try to describe your illness (symptoms)?
2) What do you call your illness/what name does it has?
3) What do you think has caused your illness?
4) Some people think that, the sickness comes as a result of a weakness in the body. What do you say about this?
5) Some people think, the sickness is a part of their fate. What do you say about this?
6) Some people think that, their illness is hereditary. What about your illness?

2) Out Come Expectancies:

***What is the patient brought about the effect of his/her illness?**

***How he thinks about the severity of his illness (development of the symptoms)?**

1) To what extend that your illness affect your social surrounding?
2) Do you think your illness can be treated and you will become totally healthy again?
3) What does it mean for you to become healthy?
4) What do you believe, how long would be needed to become healthy?
5) Do you believe there could be any obstacles in becoming healthy again/to recover from your illness?

3) Perceived Self-efficacy:

***What the patient prepared for performed specific plan or (intended behaviour) to be healthy?**

*What are the reactions and the direct effects of the outcome expectancies on the self-beliefs efficacy (preparation stage) of patient?

1) To what extend the expectation about your illness affected you personally?
2) Did you believe that you could positively influence your recover from illness?
3) Perhaps you have been ill for several times and you developed the strong conviction that you are a person that is becoming healthy in any case. Did you have this experience and this feeling that you will become healthy this time, too?
4) What did you feel after your first meeting with El-Sheikh/doctor and now?
5) Do you think your illness can be treated and you will become totally healthy again?
6) If yes: what kind of treatment do you think you should receive?

4) Action Plan:

***What are the subordinate intentions of the patient towards health and treatment?**

***Which kind of treatment that the patient chooses to recover from his/her illness?**

*How the patient performs (the desired action) to become healthy?

1) What tendency do you have towards the traditional healing?
2) Where did you start your treatment?
3) Whom did you consult?
4) Please try to describe your feelings as you entered the last place of treatment for the first time?
5) What were the reasons of changing the last treatment?
6) What do you say, if you know some people saying; the traditional treatment is more efficient and successful than others?
7) Which type of treatment, the medical or the traditional do you think is faster?
8) Which type of treatment, the medical or the traditional do you think is cheapest?

9) Some people think that, El-Sheikh is the one who can diagnose and treat the illness. What do you say about this?
10) We just assume that; one of your relatives will become ill and ask you for advice, which type of treatment would you recommend to him/her?

5) Action Control:

***How the patient survives the critical situation in his/her illness, and how he /she can protect and control the action from being interrupted?**

*What is the high-risk situations that the patient can imagine it from his/her illness, and how he /she can avoid this stage?

1) Since how long have you been here?
2) What do you feel when you think about your illness?
3) What do you say, if El-Sheikh/doctor said; it is not easy to solve your problem?
4) If somebody would advice you to practice the tow types of treatment at the same time, to avoid the critical situation in your illness, would you agree?

6) Goal Intentions:

***What are the subordinate intentions (global intentions) for the patient to recover from his/her illness?**

***Where the patient can allocate the available resources for health?**

*What are the sub goals that can help to increase the difficulty level of patient's situations, until he/she can resist under all possible circumstances?

1). Now you are here after having some experiences, what has changed in your pervious idea about illness and treatment?

What would you say, when you know some people saying that?

2) These kinds of traditional treatment, which are practiced nowadays is founded in Islam religion.

3) The traditional treatment is a part of your culture.

7). Health Action:

*How the patient evaluates his experience with illness and treatment?

***Does the patient still have strong power to make decision for new action/plan to recover from his illness?**

1) How did you know this place?
2) Which things let you to feel dissatisfaction from the last treatment?
3) What did you learn from your experience?
4) What is your plan to recover fast (totally) from your illness?
5) What about your feelings from the first time you met the doctor/El-Sheikh and now?
6) To which group of patient do you have a pleasant feeling?

8) External Barriers and Resources:

***Which kind of environmental supports that can help the patient in his/her situation?**

*What are the opportunities that have to be considered?

***What are the external factors that function as important determinants of change?**

***Which things from the inner of the patient (internal) that can protect him/her in a difficult situation?**

1). Who supported your decision to come here for the treatment?
2) What are the most important things from your inside, that, you believe could help or support you to recover and become healthy again?
3) Which kind of social environmental supports that can help you to make control for treatment progress?
4). How did you protect your self in a difficult situations?

Appendix 3

Practitioners' questionnaire

Name:

Age:

Level of education:

Occupation:

Place of work:

1. How did you learn this job (treating ill people)?
2. How long have you spend in this field/practiced this work?
3. How many patients did you see in a day?
4. How did you meet your patient (individual, with the family or group of patients)?
5. For how long did you use to meet your patient?
6. Can you tell us about the concept (a etiology) of mental disorders?
7. How did you classify the mental disorders?
8. What are the causes of mental disorders?
9. How did you diagnose these types of illness?
10. What are the methods would you prefer to use in the treatment?
11. Which is the most disorders response to these methods of treatment?
12. Did you use to make follow up for the patients after the treatment?
13. Did the patient after the treatment comes back for check?
14. Is the recovery after practicing the treatment will be completely?
15. What do you think about the patients who are started their treatment with medical doctors/traditional healers and left it to the other one?

16. What do you think about the patients who used to deal with the medical and traditional treatment at the same time?
17. What tendency do you have towards the other types of treatment?
18. Is it possible to have integration or collaboration between medical and traditional treatment?
19. If yes, how it could be?

Appendix 4

Tables

Table 5.2.1.d: Patient's ability to make health plan decision for the previous treatment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Patient	11	22.0	22.0	22.0
	Family/relatives	22	44.0	44.0	66.0
	Friend	9	18.0	18.0	84.0
	Sheikh "healer"	3	6.0	6.0	90.0
	Myself	5	10.0	10.0	100.0
	Total	50	100.0	100.0	

Table 5.2.1.e: Influence of external barriers and resources on patient's health decision

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Family/relatives	36	72.0	72.0	72.0
	Friend	9	18.0	18.0	90.0
	No one	5	10.0	10.0	100.0
	Total	50	100.0	100.0	

Table 5.2.2.e: Effects of patient belief on the origin of illness “is it hereditary” on indicators of tendency towards traditional healing

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Perception on the cause of illness."Is it hereditary"	Yes, hereditary	Count	11	1	12
		Expected Count	9.4	2.6	12.0
		% within Perception on the cause of illness."It is hereditary"	91.7%	8.3%	100.0%
		% within Tendency towards traditional healing.	28.2%	9.1%	24.0%
		% of Total	22.0%	2.0%	24.0%
	No, psychosocial problems	Count	12	4	16
		Expected Count	12.5	3.5	16.0
		% within Perception on the cause of illness."It is hereditary"	75.0%	25.0%	100.0%
		% within Tendency towards traditional healing.	30.8%	36.4%	32.0%
		% of Total	24.0%	8.0%	32.0%
	No, fate & misfortune	Count	12	5	17
		Expected Count	13.3	3.7	17.0
		% within Perception on the cause of illness."It is hereditary"	70.6%	29.4%	100.0%
		% within Tendency towards traditional healing.	30.8%	45.5%	34.0%
		% of Total	24.0%	10.0%	34.0%
	Don't know	Count	4	1	5
		Expected Count	3.9	1.1	5.0
		% within Perception on the cause of illness."It is hereditary"	80.0%	20.0%	100.0%
		% within Tendency towards traditional healing.	10.3%	9.1%	10.0%
		% of Total	8.0%	2.0%	10.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Perception on the cause of illness."It is hereditary"	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 1.946$, df = 3, $p < 0.05$, n.s.

Table 5.2.2.f: Effects of patient belief on the origin of illness “is it a result of general weakness in the body” on indicators of tendency towards traditional healing

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Perception on the cause of illness. "Is it a result of a general weakness in the body?"	Agree	Count	18	6	24
		Expected Count	18.7	5.3	24.0
		% within Perception on the cause of illness. "It comes as aresult of a weakness in the body"	75.0%	25.0%	100.0%
		% within Tendency towards traditional healing.	46.2%	54.5%	48.0%
		% of Total	36.0%	12.0%	48.0%
	Don't agree	Count	13	1	14
		Expected Count	10.9	3.1	14.0
		% within Perception on the cause of illness. "It comes as aresult of a weakness in the body"	92.9%	7.1%	100.0%
		% within Tendency towards traditional healing.	33.3%	9.1%	28.0%
		% of Total	26.0%	2.0%	28.0%
	Don't know	Count	8	4	12
		Expected Count	9.4	2.6	12.0
		% within Perception on the cause of illness. "It comes as aresult of a weakness in the body"	66.7%	33.3%	100.0%
		% within Tendency towards traditional healing.	20.5%	36.4%	24.0%
		% of Total	16.0%	8.0%	24.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Perception on the cause of illness. "It comes as aresult of a weakness in the body"	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 2.825$, df = 2, $p < 0.05$, n.s

Table 5.2.2.g: Effects of patient belief on the origin of illness “is it a part of fate” on indicators of tendency towards traditional healing

			Tendency towards traditional healing.		
			positive	negative & hesitate	Total
Perception on the cause of illness. "Is it part of the fate?"	Agree	Count	28	6	34
		Expected Count	26.5	7.5	34.0
		% within Perception on the cause of illness. "It is a part of fate"	82.4%	17.6%	100.0%
		% within Tendency towards traditional healing.	71.8%	54.5%	68.0%
		% of Total	56.0%	12.0%	68.0%
	Don't agree	Count	6	3	9
		Expected Count	7.0	2.0	9.0
		% within Perception on the cause of illness. "It is a part of fate"	66.7%	33.3%	100.0%
		% within Tendency towards traditional healing.	15.4%	27.3%	18.0%
		% of Total	12.0%	6.0%	18.0%
	Don't know	Count	5	2	7
		Expected Count	5.5	1.5	7.0
		% within Perception on the cause of illness. "It is a part of fate"	71.4%	28.6%	100.0%
		% within Tendency towards traditional healing.	12.8%	18.2%	14.0%
		% of Total	10.0%	4.0%	14.0%
Total		Count	39	11	50
		Expected Count	39.0	11.0	50.0
		% within Perception on the cause of illness. "It is a part of fate"	78.0%	22.0%	100.0%
		% within Tendency towards traditional healing.	100.0%	100.0%	100.0%
		% of Total	78.0%	22.0%	100.0%

$X^2 = 1.225$, df = 2, $p < 0.05$, n.s.

Declaration

Herewith, I declare that this submitted work is original and that I have used only the references cited in the text and included in the reference list.

_____

Signature