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Psychiatric Disorders and Folk Theories among the Tribal Communities in Northeast India

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Abstract
Background*: Folk theories are the popular lay beliefs about an object or a phenomenon, based upon known facts, hearsay, or personal experiences. Folk beliefs about mental illness are indispensable to social psychiatry because they undergird the norms and values of health promotion and shape the experiences and expressions of various illnesses. In the realm of mental health, they play a pivotal role in health seeking behavior, causal attributions, treatment adherence, etc.*
Materials and method*: A qualitative design using semi-structured interviews was used to explore the folk beliefs about mental illnesses among the lesser known tribal communities in the rural and remote areas of Manipur. A total of thirty respondents belonging to ten different tribal groups who speak different languages were interviewed. Reflexive thematic analysis by Braun and Clarke was adopted as the analytical method.*
Results*: Findings highlight key themes such as the level of awareness and mental health literacy, causal explanations, description of morbid symptoms, beliefs about cure and prognosis, stereotypes, stigma, willingness to seek medical treatment for psychological and psychiatric illness.*
Conclusion: *The study provides actionable insights for mental health service providers such as psychologists, psychiatrists, physicians, psychiatric social workers and psychiatric nurses in clinical as well as community settings and more importantly, the findings highlight the need for targeted approaches to mental health literacy from policy makers in a protracted conflict area like Manipur.*
Keywords*: social psychiatry, folk theories, culture and mental health, tribal mental health.*

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I. Introduction

The phenomena of mental health and illness are varied and complex. One of the reasons is that they are intertwined closely with the socio-cultural factors in which individuals live. Although mental health and illness may be experienced at the individual level, cultural beliefs and practices mediate the phenomenology of those experiences. Therefore, how people identify, categorize, label and make sense of mental illnesses are embedded in their worldviews, or more specifically, in their folk theories. Noticeably, folk theories serve as repositories of myths, superstitions, causal attributions or etiological explanations of mental illnesses with implications for preferred treatment methods or approaches and prognostic beliefs about a variety of health problems. These beliefs not only underpin the norms and values of health promotion but also shape the experience and expression of illness (Ward & Heidrich, 2009). Therefore, lay people's informal, implicit and usually 'unscientific' beliefs and explanations serve as a window to look at the way in which a society views and responds to issues of mental health. Most importantly, lay beliefs have behavioral consequences (Furnham, 1988). It influences help-seeking behaviour and the types of treatment sought (Dalal, 2016; Schnittker et al. 2000). For instance, ethno-cultural groups who believe Schizophrenia to be associated with sinfulness do not consider psychiatric hospitals as the right place for an effective treatment (Swami, et.al, 2008). Attribution of mental illness to social and environmental etiology leads people to neglect mental health services (Narikiyok & Kameoka, 1992). Therefore, lay perspectives on mental illnesses serve as an important proxy for understanding the level of awareness and mental health literacy, stereotypes, stigma and willingness to seek medical treatment for psychological and psychiatric illnesses prevalent in a society.

Lay beliefs are culture specific because they relate to knowledge, attitudes and values (Pendleton, 1983). Since, most of the existing models of lay-people's health beliefs have been developed by social and medical psychologists based on the findings from Western cultures (Furnham, 1988, p.110), they predominantly reflect the views of the white, educated, industrialised and developed countries with western constructs of mental health (Quinn & Knifton, 2014). Although there has been some contributions from the major Asian cultures, representation of cultural knowledge and practices of the smaller cultural groups on mental health in the mainstream literature have been found to be lacking. The need for understanding lay perspectives among psychiatrists, psychologists, psychiatric social workers, psychiatric nurses and other mental health professionals

is even more keenly felt in a multi-ethnic and multicultural society like India. The present paper aims to contribute towards this felt need.

The primary objective of this paper is to address the gap in the knowledge about the theories and social representations of psychiatric disorders from the most under-represented cultural groups from the Northeastern region of India. It aims to do so by highlighting popular lay beliefs and social practices among the tribal communities in the state of Manipur who predominantly come from a rural background and lack access to modern scientific healthcare. It also explores the stigma and discrimination associated with psychiatric disorders among the tribal communities. This exposition of the knowledge, attitudes and practices of lay people on psychiatric disorders will enable counsellors and mental health professionals to act as a conduit between the traditional or folk healing practices and the evidence-based modern psychiatric treatments. In addition, it will stimulate research, provide actionable insights and pave the way towards a more proactive state policy making in the area of mental health. Before we discuss lay theories of psychiatric disorders among various ethnic groups, a brief overview of mental health resources in the state is imperative.

Overview of mental healthcare in Manipur

Manipur is a state of concern on the issue of mental health because mental health indicators are poor in the state. It is also a conflict-ridden region identified by the government of India under the 'disturbed areas' category. According to the National Mental Health Survey of India (2016), the prevalence of severe mental disorders in Manipur along with West Bengal was higher than all the other states that were surveyed. Manipur had the highest prevalence rate of neurosis and stress related disorders with 14.1 percent compared to the average of 10.6 percent among the total populations surveyed. Conspicuously, there is a higher need for physical infrastructure and mental health professionals. However, mental healthcare infrastructure and manpower are acutely inadequate. There is not even one dedicated psychiatric hospital in the state in a state with a population of about thirty two lakhs (Census, 2011). Only two departments of psychiatry, one at JNIMS and another at RIMS have been established by the government to serve the entire state with a population of about 3 billion people. Worse still, none of the hill districts (10 out of 16 total districts) do not have even a single psychiatrist posted at the District Hospitals. According to the National Mental Health Survey Report (2016) the ratio of mental health professionals to the general population was 1:2,000 in the State. Most importantly, Manipur does not have a stand-alone state mental health policy with targeted goals and specified mechanisms.

Compounding the grim scenario is the fact that 69.79 percent of the population live in rural areas (Census, 2011). There is also a disproportionately lower number of physicians and specialists from these tribal communities. As such, self-styled agents and institutions comprising quacks, faith healers, shamans, witchcrafts, etc. become the frontline mental health experts. The risks and benefits of their practices, interventions still remains largely beyond the radar of official or scientific examination or analysis. It is in this backdrop that an exploratory study has been conducted to highlight some popular beliefs and practices regarding mental illness among the major tribal communities of Manipur who inhabit the hilly (rural) districts in the state.

II. Material and Methods

Study Design: The present study is an exploratory inquiry with a qualitative design. This method is preferred because the research focuses on an empirically uncharted sphere.

Study Location: Five rural districts of Manipur- Senapati, Kangpokpi, Chandel, Ukhrul and Tamenglong

Study Duration: January 2021 to December 2021

Sample Size and Sampling Method: Purposive sampling method was used in order to obtain data from thirty key informants (N=30) who can provide a significant quantum of data. Chain referral method was used to identify the prospective participants. Informed consent was obtained individually prior to the interview. All ethical guidelines mandated by the American Psychiatric Association (APA) were adhered to throughout the research process

Procedure: Data was collected through in-depth interviews with a semi-structured interview schedule prepared in consultation with experts in the field. Thirty participants (N=30) belonging to ten different Scheduled Tribes (STs) participated in the study. The names of the tribal groups are: Thangal, Maram, Liangmai, Paite, Kuki, Kom, Tangkhul, Poumai, Zeme and Khoibu. Among them, the Marams come under the *particularly vulnerable tribal groups* (PvTGs) identified by the Government of India similar to the Koraga tribal groups of Kerala and Karnataka. The participants represent five different rural districts of Manipur. Most of these tribal groups represent the most marginalized groups with a very low socio-economic index. Majority of them survive on subsistence farming.

Data Analysis: The audio-taped data from the in-depth interviews were transcribed verbatim. Then the transcribed data was translated into English by researchers fluent in both the native language as well as English. Forward translation and back translations were done independently by different translators. Following the six

phase framework of Thematic Analysis by Braun and Clarke (2006, 2019) data was manually coded and the themes were identified. The main themes and subthemes derived from the data are discussed below.

III. Results

A total number of 30 respondents (N= 30) participated in the study. There were 18 males and 12 females in the study. The median age of the participants was 52 years. The average duration of each interview was 45 minutes**.** Audio recordings of all the interviews were done with prior consent of the participants. The recordings were transcribed verbatim into the respective languages by individuals who are native speakers of the language. Then the transcripts in the native languages were translated into English by senior researchers who are fluent with the local language as well as English.

Theme 1: Generic conception of mental disorders and intellectual disabilities

Although some of the participants indicated a distinction between mental disorders and intellectual disabilities, the distinction appears to be either hazy or superficial. A common feature among all the different tribal communities is a generic vocabulary for referring to any form of mental illness or intellectual disability. Even if there exists multiple terms in their vocabulary, they appear to be words that describe signs or symptoms and clearly non- indicative of any typology or classifications. In essence, the different words converge semantically that imply a unitary conception of mental disorders. For instance, the Liangmai tribe has terms like *Pachun tangmakbo, Pachun Tanuakbo, Papi Lumbo, Padiuwimakbo, and Tachun Masantamibo* to refer to anyone with odd, strange or unusual behaviours. As an interviewee explained, "*all these words can be roughly translated as one whose mind is not in the best or optimal condition*". Nevertheless, the consensus on the point that the deviance in thoughts or behaviours are due to an aberration in the mental faculty is evident in the responses.

Theme 2: Signs and symptoms of mental disorders

Weirdness or oddity of behaviour is the most common schema for an individual with a psychiatric disorder or intellectual disability. Laughing excessively, stealing, neglect of personal hygiene, wearing the same old or torn clothes, refusal to study or work, aloofness from friends and withdrawal from participation in social activities are the popular descriptions of signs and symptoms of mental disorders. Regular changes in the signs and symptoms synchronizing with the lunar cycle is another common perception reported by the participants from the different communities. For instance, a participant from the reported, "*their behaviour changes during the thasi (new moon) and thanou (full moon)"*. Similar belief about the influence of the *yusum (new moon) and yusan (full moon)* on the behaviour also exists among the Liangmai tribes.

Theme 3: Co-existence of superstitious and scientific etiological explanations

Non-scientific causal explanations include curse, violating a taboo, witchcraft, black magic, being possessed by an evil spirit. As a female participant from the Khoibu tribe (whose mother is suffering from Schizophrenia) says, "*another important reason is 'kacher*" (violating a social taboo). Causal explanations that align with scientific explanations include physical or psychological trauma. Physical trauma due to vehicular or other accidents and psychological trauma due to the loss of loved ones, failure in exams or love are some of the etiological explanations that lean towards a scientific explanation. However, lay conceptions about mental illnesses of the tribal communities depart from the contemporary scientific knowledge and practice (Haslam et al, 2007).

Theme 4: Negative attitude towards the mentally ill

The predominant attitude towards the mentally ill appear to be generally negative. Avoidance, ridicule, making fun of them, calling them stupid, playing pranks on them and distancing from them appear to be the common responses from the community members. They are also feared and avoided as aggressive, violent or dangerous. As a participant reported, "*they can suddenly become violent and we can't really know when that will happen".*

Theme 5: Mental disorders run in the family through blood

A common folk belief among the tribal communities is that mental disorders are passed on from the older generation to the younger ones through the medium of blood. The popularity of this belief is evident from the frequent references to "blood' and 'bloodline' by the participants. This in turn serves as a reason for the strong stigma against the mentally ill. This belief also has direct implications for marriage alliances. An important background check before consenting to a marriage alliance is to ensure that the prospective bride or the groom do not have a family member with a mental illness or a history of mental illness along the lineage.

This is evidenced from what a participant reported, "*even marriage alliances are turned down when a family comes to know that someone in the family of the suitor suffers from a mental illness*".

Theme 6: Psychiatrists as the last resort for treatment for mental illnesses

Currently, the first point of contact for mental problems are priests or pastors from the church, self-styled faith healers and shamans. These traditional healers are popular because of they have been performing these roles since historical times. Mental health professionals are consulted only when the prayers or potions prepared by the local or traditional healers do not help. This initial reluctance to seek help from doctors and trained mental health professionals by the tribal communities may primarily be due to the fact that modern systems of medicine are not compatible with the folk beliefs about the nature of mental illnesses. Psychiatric treatment sought only as the last resort. Additionally, there is also a belief that certain mental illness should never be allowed to be treated by medical doctors as they can never be cured trough modern medicine. The participants do not explain the specific types of mental illnesses but said that certain illnesses, instead of being healed, they end up getting worse or even lead to death due to the medication prescribed by the doctors. As an interviewee said, "*some types of mental disorders should never be treated by medical doctors. There is no chance of getting cured by taking medicines given by doctors at the hospital. Instead they will die when they take the medicine".*

IV. Discussion

The most glaring revelation is the generic conceptualization mental illnesses. Even the distinction between mental disorders and intellectual disabilities are superficial or hazy. The boundary or the distinction between psychiatric disorders and intellectual disabilities appear to be permeable or superficial at best. In other words, the lay understandings of mental disorders are predominantly superstitious including a belief that all mental disorders are passed down the lineage through the blood. This preponderance of unscientific beliefs and practices may be due to the lack of mental health literacy campaigns that focus on information, education and communication. The absence of any dedicated mental health infrastructure and services in the rural districts in the state can also be a factor that can explain the preponderance of traditional approaches to treatment of mental illness. This unscientific theories can result in delay or negligence in the assessment, treatment or provision of timely interventions for individuals with mental illnesses or intellectual disabilities. Additionally, stereotypes and stigma about mental illness also exists among them and stigma has been identified as the most significant barrier to seeking mental health services (Shidhaye & Kermode, 2012; Thompson-sanders et al. 2004).

Knowledge of the signs and symptoms of mental illnesses by the tribal communities often tend to reflect the stereotypes that people hold about mental disorders. This is substantiated by the fact that their vocabulary in their descriptions about mental illnesses do not reflect the subjective experiences of the mentally ill, such as mood changes, sleep disturbances, hallucinations, delusions, suicidal ideation etc. Hence, mental health professionals such as psychiatrists, psychologists and psychiatric social workers need to be patiently educate their clients or patients about the myths, misperceptions and superstitions that they might be strongly believing and provide scientific knowledge and information.

V. Conclusion

The findings of the study reveal that the lay conceptions about mental illnesses of the tribal communities in the rural places depart from the contemporary scientific knowledge and practice. The folk theories are mostly unscientific although their belief that mental disorders run in the family resonates with the heritability of most mental illnesses. Additionally, stereotypes and stigma about mental illness also exists among them. These finding have practical implications for health-seeking behaviour, patient-doctor communication and client-therapist interactions. It also adds valuable theoretical insights on the interface between cultural beliefs and science.

Limitations of the study and future directions: Although there are 33 officially recognised tribal groups, only 10 tribal groups were represented in the study. Further, there are significant variations in the languages of tribe from village to village. Therefore, the linguistic differences may also reflect differences in the terminologies used to signify different concepts. Future studies may be aimed at covering the tribal groups that have been left out. Comparisons between groups that show variations in their languages may also be drawn in order to identify and highlight any interesting features**.**

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