Research Report

DELAY AND TREATMENT FACTORS OF PSYCHIATRIC TREATMENT AMONG PATIENTS SEEKING FAITH HEALERS

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ABSTRACT

Background: Belief in faith healers, lack of awareness and stigma of mental illness have placed obstacles in timely identification and treatment of mental illness. This study assessed the factors influencing individuals with mental illness to seek faith healers. It was also planned to study the delay caused due to faith healers in starting psychiatric treatment.

Methods: Cross-sectional study of 100 consecutive patients who had visited a faith healer at least once and attending the outpatient clinic of the department of psychiatry was done using a semi-structured questionnaire.

Results: Fear of psychiatric medication (46%), stigma of psychiatric illness (44%) and beliefs in myths (43%) were the main reasons for avoiding psychiatric treatment. There was a significant delay in psychiatric treatment initiation when comparing people who first visit faith healers to those who first visited psychiatrists (28.2 months vs 14.5 months, p=0.002). Post-visit to psychiatrist, 57% prefer to continue with the psychiatrist, and 34% would visit both, and only 5% would prefer faith healer.

Conclusions: Myths and stigma regarding psychiatric illness are prevalent, and mental health education can improve the scenario.

Keywords: Faith healer, stigma, myths, psychiatric treatment

INTRODUCTION

Patients who have mental illness tend to seek the help of faith healers as they attribute their mental illness to ghosts, evil spirits, witchcraft and other invisible and abstract elements.[1] Psychiatric patients tend to access faith healers first, and a study reports that 56% of

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psychiatric patients attribute their illness to a supernatural force.[1] Faith healing is a concept that religious belief or faith can bring about healing, either through prayers or rituals that, according to adherents, evokes a divine presence and power towards correcting disease and disability.[2]It is commonly believed that faith healers are gifted with an ability to control evil phenomenon; therefore, it is in the social and economic interest of the patients that for such ailments they report to the nearest healer.[3]

The stigma of mental illness, the paucity of the medical facility, large number of faith healers, economic problems, educational status, poor knowledge of psychiatric treatment, faith in traditional healing, and lower socioeconomic status are hypothesized to present significant social obstacles in seeking appropriate psychiatric treatment.[4,8] A survey carried out over three months to determine experiences of religious healing in a group of 198 consecutive psychiatric patients attending a hospital in Tamil Nadu, showed that 89 (45%) had sought between 1 and 15 sessions from either Hindu, Muslim or Christian healers. The number of patients visiting healers was linked significantly with their income. A considerably higher number under the age of 17 years had received such help compared with older age groups. Social support, methods of traditional healing and the implications for service delivery were discussed by this study.[4]

Prevalence of seeking faith healing practices is high among psychiatric patients, despite easy accessibility and availability of psychiatrists and hospitals, and this can lead to delay in seeking psychiatric care.[5,6] Two studies from India have indicated that only a small percentage of psychiatric patients consult a psychiatrist at the onset of symptoms.[7,8,9] A study of 200 new patients visiting a psychiatric outpatient service at a tertiary care hospital were interviewed on a semi-structured questionnaire for the various services contacted by them for their mental health problems before the current contact. Psychiatrists were the first choice in 45% of the cases followed by nonpsychiatric physicians and religious faith healers. Essential reasons for seeking help from various sources included easy accessibility, belief in the system or healer and good reputation. Mean duration of treatment varied from 2.35 months with the alternative system practitioners to 16.63 months with the psychiatrists.[8] An Indian study reported that 69% of all rural patients still visit indigenous therapists and faith healers in India.[10] This study included a total of 295 patients (203 males) were included in this study. The majority of the patients (45%) were suffering from Bipolar affective disorders (45%), followed by schizophrenia (36%). The majority, 203 (68%), were from the rural area, with 94 patients being illiterate. The mean distance travelled for treatment was 249 km. The majority of these (69%) had first contacted faith healers, and a qualified psychiatrist was the first contacted person for only 9.2% of the patients.[10]

Belief in faith healers presents unique hindrances to psychiatric treatment like lack of assimilation of psychiatric concepts, disbelief in psychiatrists, apprehension regarding the effectiveness of the medication, concerns regarding time for the illness to respond, the fear regarding long term use of medications, the dread of serious medication adverse effects and fear of worsening of the condition. All these might lead to a delay in the initiation and also the continuation of psychiatric treatment.

Therefore, it is of great importance to examine the reasons for seeking faith healers and avoiding psychiatric treatment among people in rural areas. Further, no study to date has been done on the delay in initiating psychiatric treatment caused by a visit to faith healers.

The study aims to examine the factors influencing mentally ill to seek treatment from faith healers and the factors that bring them to a psychiatrist. It aims to assess the delay in initiating proper psychiatric treatment in those patients who visit faith healers. The examines the reasons for visiting faith healers in psychiatric patients. The study examines the socio-demographic and clinical profile of such patients. The study further examines the reason for consulting psychiatrists in patients who have visited faith healers. The study also estimates the delay in psychiatric treatment initiation and the levels of compliance among patients who visit faith healers.

MATERIALS AND METHODS

A cross-sectional study of 100 consecutive patients who had visited a faith healer at least once and attending the psychiatric outpatient clinic of a tertiary care hospital was done using a semi-structured questionnaire from April to June of 2019. The study included patients between age 18-60 years clinically diagnosed to have any psychiatric disorder as per ICD 10 criteria, who had at least one visit to a faith healer during the period of illness. Patients not willing to give consent, unwilling to complete assessment or questionnaire, and patients with ICD 10 criteria mental retardation or dementia or any neurological disorder which hampers the completion of the questionnaire were excluded. A total of 167 patients were screened, 38 patients refused to give consent for the study, nine patients were excluded- had comorbid neurological conditions like epilepsy, stroke or traumatic brain injury, 8 cases had dementia and 2 cases had mental retardation. Ten patients returned incomplete questionnaires and were excluded.

A semi-structured questionnaire to elicit socio-demographic data and faith-based practices was used to collect data. Content validity of the questionnaire was established by sending them to experts five psychiatrists and five psychologists, and the content was validated based on earlier studies[1,2, 4,5,8-10] and their questionnaires and the aims and objectives of the study. Language validity was established by translation and back-translation procedure.

Consecutive patients attending psychiatric outpatient unit after written informed consent were diagnosed using the ICD 10 diagnostic criteria for research (DCR). They were then given the semi-structured questionnaire to assess the socio-demographic variables and faith-based beliefs and practices. The purpose of the study was explained, and privacy and confidentiality were ensured, and the institutional ethics committee approved all proceedings.

The data were represented as categorical and continuous variables and was analyzed using chi-square test, independent sample t-test and ANOVA. The data analysis was done using SPSS version 16 for windows.

RESULTS

The first contact of a mentally ill person was mostly with general practitioners and other medical specialists (31%) followed by faith healers (25%) and indigenous and Ayush specialists (19%). The possibility of a mentally ill person meeting a psychiatrist as the first

Table 1: Pattern of first and second consultation

	First Consultation (%)	Second consultation (%)	
		Psychiatry	Faith Healer
Psychiatrist	10	8	2
Psychologist	13	4	9
Faith/religious healer	25	8	17
Indigenous therapist/AYUSH	19	5	14
Others/ hijama /acupuncture	2	1	1
Other modern medicine speciality/general practitioners	31	8	23

person to consult was a dismal 10%, and a psychologist was 13%. Further, it was noted that 74.2% of those who went to a general practitioner or a medical specialist next visited a faith healer. This finding demonstrates a clear failure of the reference system (Table 1).

Of the100 participants, 26 as part of a pathway to care visited a psychiatrist at some point before visiting faith healers while 74 visited faith healers before consulting psychiatrist. Data were analyzed by splitting the participants into two groups those who visited psychiatrist first (n=26) and those who visited faith healer first(n=74) (Table 2 and 3).

There was a significant association of sex, occupation and education with the seeking of faith healers. More females and unskilled labourers sought faith healers, while graduates tended to seek psychiatrists. (Table2) No difference was observed between two groups in terms of socioeconomic status, residence, marital status and religion (Table 3).

The major diagnostic groups observed were mood disorders (43%), psychotic disorders including schizophrenia (29%), neurotic, stress-related and somatoform disorders (27%), and obsessive-compulsive disorder (13%). There was no significant association of diagnosis with seeking faith healers. ($\chi 2=1.72$, $p= 0.56$) Of the patients, 43 had episodic, and 57 patients had a continuous disorder. There was no association of the pattern of illness with seeking faith healers. ($\chi 2=1.33$, $p= 0.83$)

There was a significant delay in starting psychiatric treatment (pharmacotherapy or psychotherapy) among those who visited faith healers first. ($t=-2.4$; $p=0.002$) They took almost double the time to start treatment than those who went to the psychiatrist first. The time to start proper medical treatment was

Table 2: Socio-demographic data among groups

	Psychiatry (n=26)	Faith healers (n=74)	X^2 P-value
Sex			
Male	18 (69 %)	28 (38 %)	7.63 (d. f.=1) 0.006
Female	8(31 %)	46 (62 %)	
Occupation			
Student	6 (24 %)	10 (14 %)	13.61 (d. f.=6) 0.03
Unemployed	8 (31 %)	44 (60 %)	
unskilled labourer	8 (31%)	6 (8 %)	
skilled labourer	2 (7 %)	9 (12%)	
Professional	2 (7 %)	3 (4 %)	
Business	0	1 (1%)	
Retired	0	1 (1 %)	
Education			
Illiterate	0	5 (7 %)	8.083 (d. f.=3) 0.04
Primary	3 (12 %)	17 (23 %)	
Secondary	12 (46 %)	39 (53 %)	
Graduate	11 (42 %)	13 (17 %)	

significantly longer in people who went to faith healers than psychiatrists. (t= 5.45; p<0.001). Further taking psychiatric treatment significantly reduced the chances of going to faith healers (t=-4.32; p<0.001) (Table 4).

Table 3: Socio-demographic data among groups

Socioeconomic status			
Low	5 (19 %)	27 (36 %)	2.72 (d. f.=2) 0.26
Middle	18 (68 %)	39 (52 %)	
High	3 (12 %)	8 (11 %)	
Residence			
Urban	3 (12 %)	5 (7 %)	0.62 (d. f.=2) 0.74
Rural	17 (65 %)	50 (68 %)	
Semi-urban	6 (23 %)	19 (25 %)	
Marital status			
Single	11(42%)	18(24%)	9.04 (d. f.=4) 0.06
Married	15(58%)	37(50%)	
Widow	0	9(9.5%)	
Divorced	0	9(9.5%)	
Separated	0	5(7%)	
Religion			
Hindu	9(35%)	11(15%)	4.93 (d. f.=2) 0.09
Muslim	17(65%)	62(84%)	
Christian	0	1(1%)	

The most common reason for visiting a faith healer in the entire sample was the cultural perception of mental disorders (57%) followed by belief in miraculous cure (51%). The most prevalent reason for not visiting a psychiatrist was fear and misconception regarding psychiatric medication (46%) with 44% delaying treatment due to stigma and a further

Table 4: Illness and treatment pattern among groups

	Groups	N	Mean (SD)	t	p-value
Total duration of illness	psychiatry	26	58.00 (75.75)	-0.58	0.56
	faith healers	74	67.92(75.10)		
Duration of illness before going to psychiatrist	psychiatry	26	14.54(20.66)	-2.4	0.02
	faith healers	74	28.23(34.02)		
Duration of illness before going to faith healers in months	psychiatry	26	16.42(13.88)	5.45	<0.001
	faith healers	74	5.11(6.72)		
Total number of visits to faith healers	psychiatry	26	2.54(0.81)	-4.32	<0.001
	faith healers	74	3.68(1.25)		

43% not reporting to the psychiatrist due to ignorance. The lack of proper identification and referral was cited as the reason for not seeking psychiatric treatment by 39% of patients. The most common reason for discontinuing psychiatric treatment was the fear of medication dependence (62%). While 42% discontinued due to treatment duration, 35% attributed it to adverse medication effects, and 28% stopped treatment due to financial constraints. (Table 5)

The overwhelming choice for future treatment was from a psychiatrist with 57% choosing to continue with a psychiatrist and 34% preferring to visit both psychiatrist and faith healer. Only 19% preferred treatment from a psychologist in future. Only 5% chose faith healers alone as the avenue for future treatment.

The most common reasons for stopping treatment from faith healers were dissatisfaction with the faith healer (56%) and increase of symptoms while under such treatment (55%). Further, 40% changed to a psychiatrist following education by others that psychiatric illness needs proper treatment. Treatment from faith healers leads to worsening or continuation of illness in 73% while only 27% reported improvement. While psychiatric treatment led to an improvement in 78% cases with only 22 % reporting non-improvement.

The reasons for mental illness provided by faith healers were witchcraft/ poisoning/ black magic (63%), ghost/ gandharva/jinn/ malak/ibiliz (52%), curse from God/ dead people/ evil eye (34%) and results of past deeds (19%). The most common mode of treatment was chanting mantras/Quranic

verses/ poojas/ nivedyam (69%), followed by talisman/ locket (53%). Exorcism was the mode of treatment in 41%, while 29% were treated using counter-magic.

Table 5: Future treatment plan

Care pathway	Percentage
Psychiatrist	57%
Psychiatrist + faith healer	34%
Psychologist	16%
AYUSH	7%
Others	9%
Faith healer	5%

Post psychiatric treatment, 57% patients were aware that psychiatric illnesses are medical/ brain disorders and 34% were aware that it might need long term treatment, while only 25% believed it to be due to supernatural causes.

DISCUSSION

Similar studies echo the low tendency to report to a psychiatrist first. [10, 11, 12] A study on pathways to care found that 9.2% alone went to a psychiatrist first.[10] The need for proper education regarding psychiatric illness and their treatment needs to disseminate in the general population and among fellow medical professionals especially as 74.2% of those who go to a general practitioner ends up with a faith healers. The visit to faith healers is prevalent across the country, and the rate in this study is similar to that of earlier studies which show a range 30-80% chance of visiting faith healers.[1, 10, 11, 12] Further our study shows patients report earlier to a faith healers (5 months) than psychiatrists (16 months),. This is alarming as the delay has to be brought down to ensure a better prognosis. No study has however examined this important variable.

The major finding of the study was that faith healer visit doubled the time to seek psychiatric treatment. This delay may lead to more morbidity and increased chances of becoming chronic. There are, however, no studies in this area to compare the findings. Therefore, it is imperative to study the delay caused by faith healer visit in initiating psychiatric treatment across different social settings. There is also the prevention of further faith healer visits after coming to a psychiatrist according to our study. This variable also has not been examined by any previous study.

This study shows that significantly more females went to faith healers than males. This pattern is contradicted by a study from India, which showed that males and females visit equally to a faith healer. This observation needs to be studied further to establish the gender pattern among people who visit faith healers. There was a significantly higher propensity for unskilled labourers to seek faith healers. This is consistent with the observation that people with lower education and socioeconomic status seek faith healers more.[1, 10] The study shows that people with graduate education visit psychiatrists than faith healers, which is also consistent with studies that show that lower education leads to more chances of seeking faith healers. [1, 10, 12] Our study found no association of socioeconomic status with a visit to a faith healer while many other studies which had shown that people from low socioeconomic background often visit faith healers.[1, 10, 11] It may be because the present study had very few patients from the higher

socioeconomic strata. There was no significant association found between marital status, religion and visit to faith healers. An earlier Indian study had noted no significant association of marital status with faith healer visit.[14] An earlier study from Kerala also showed a similar distribution of religions and showed no preponderance among any religion to visit faith healers.[11]

There was no association of psychiatric diagnosis with seeking faith healers. This finding resembles the observation in an Indian study which found no significant association of ICD-10 diagnostic groups with seeking care from faith healer or psychiatrist.[14]

The most common reasons for visiting faith healers in the present study were cultural perception of mental disorders and belief in miraculous cure. This is almost similar to the observations made by earlier studies which have talked about cultural/religious beliefs and magical cure beliefs as reasons for faith healer visits.[1, 10, 11,12] Fear of psychiatric medication was the most prevalent reason for avoiding psychiatric care, while stigma was quoted as the second most common reason. This is, however, in contradiction to an earlier study that cites stigma (73%) as the most common reason.[10] This may be due to the higher awareness/ misconception regarding medications and increased awareness of psychiatric care decreasing stigma in Kerala. However, further studies are needed to know the pattern across different cultural settings. The fear of medication dependence (62%) was the most common reason for discontinuing psychiatric treatment followed by the long treatment duration (42%). A similar pattern was seen in an earlier study from Kerala, which psychiatric medicines.[11]

The reason for stopping faith healer care was dissatisfaction with the faith healer and non-improvement/ worsening of the illness while under their care. This was also echoed by an earlier Indian study, which showed that the major reason was non-improvement .[1] There was nearly 78% improvement with psychiatric treatment compared to 27% improvement with faith healers. This finding is also echoed across different studies. [1, 10, 14]

Following psychiatric treatment, 57% were able to accept that mental illnesses are medical/brain disorders. The pattern was also shown by a study from rural and urban India, which showed that 59.1% and 65.5% respectively were able to accept it as an imbalance of brain/ neurotransmitters.[16] This shows that understanding of illness tends to improve post-exposure to the mental health care system and psychoeducation needs to be strengthened in all patient to improve their knowledge.

The prevalence of faith healer visits necessitates new directions of thought and devising newer programmes to have a holistic and inclusive approach to the detection and treatment of mental illness. A unique project was developed over time in North Gujarat, at Mira Datar Dargah, with traditional healers of the dargah, called “Dava and Dua” project since 2008, run by the Altruist Trust and its founder Milesh Hamlai, a caregiver himself. The model takes care of preserving traditional systems but incorporating detection and treatment of mentally ill and preventing torture and cruelty toward mentally ill by advocacy and training of traditional healers. A psychiatric service is established just beside the shrine to facilitate the treatment, providing free psychiatric consultation, psychological

assessment, and therapies along with medicine. Referrals and follow-up system are established. Furthermore, there is a monitoring committee chaired by the District Magistrate/District Judge, with the District Health Officer, a local police officer, a local medical officer, two representatives from the local community, a representative from the religious place, and a mental professional as other members.[17] Such innovative and inclusive projects can be implemented to better care for the mentally ill in our state also.

Our study was limited by the rural and low socioeconomic population background of participants. There is a possibility of information bias as the information elicited was based on recall about the onset, duration of illness, and reasons for choosing different treatment facilities many moths back.zed. Further, as this is a tertiary care centre, it does not reflect the true picture of the community. A more inclusive urban-rural split community study will throw more light on the problem.

CONCLUSION

The study brings to light the delay in starting proper psychiatric treatment in people who visit faith healers. It demonstrates that psychiatric care not only produces a significant improvement of symptoms but also helps in preventing further faith healer visits, improving the knowledge regarding psychiatric illness, enhancing the perception of psychiatric treatment among patients, and ensuring better treatment compliance. More comprehensive educational efforts and innovative programmes need to be formulated to dispel the myths regarding the cause of mental illness, the effects of psychiatric medication and to decrease the stigma associated with mental illnesses.

Conflict of Interest

None

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Nil

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