Research Report

ROLE OF CULTURAL BELIEFS AND USE OF FAITH HEALING IN MANAGEMENT OF MENTAL DISORDERS: A DESCRIPTIVE SURVEY

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ABSTRACT

Background: From ancient times, cultures across the world accept faith healing practices as an intervention for mental illness. In India, cultural norms and beliefs have been shown to play an important role in the way people perceive mental illness and use the available resources to treat them.
Aims: To identify cultural beliefs and faith healing practices related to management of mental disorders among caregivers of mentally ill and to assess the reasons for following such practices.
Methods: Data were collected from 200 caregivers of mentally ill attending District Mental Health Programme (DMHP) clinics of Kannur District of Kerala. A descriptive survey design was used. A demographic data sheet and semi-structured interview schedule were used as tools.
Results: 69% were currently following faith healing practices along with psychiatric treatment. 78% had sought faith healing at the first appearance of the illness, while 92% had sought them at some point. 85.5% regarded destiny, and 50% regarded traditional rituals and practices, as a cause of mental illness. 92% felt people may not be seeking psychiatric care for management of mental illness due to fear of side effects. 83% felt people seek faith feeling practices for management of mental illness due to religious beliefs, customs and norms.
Conclusion: The study reveals various cultural beliefs and practices regarding management of mental illness. Attention of various stake holders is needed on the issues resulting from these beliefs and practices, as they can adversely affect mental health care.

Keywords: cultural beliefs, faith healing practices, mental illness.

INTRODUCTION

Background

Mental disorders account for 13 percent of the burden of diseases.[1] One in five people in India live with a mental illness.[2] For the prevention and treatment of mental illness, people seek different approaches, mainly shaped by the culture of a particular society. Culture is defined as a complex whole which includes knowledge, learned behavior, beliefs, values, customs and norms, deeply rooted in a society and acquired by men as a member of that society.[3] Phenomena like possession by spirits, deeds of malicious spirits or ancestral spirits, curses from enemies, causing displeasure to ancestors, or

Please cite this article as: Rajan B, Cherupushpam SD, Saleem TK, Jithu VP. Role of cultural beliefs and use of faith healing in management of mental disorders: A descriptive survey. Kerala Journal of Psychiatry 2016; 29(1):12-8.

being cursed are widely regarded by many cultures as causes of mental illness.[4]

The importance of spirituality in mental health is now widely accepted.[5] Faith healing has been practiced by many cultures for many years, and is an accepted mode of treatment in different cultures. People who conduct these practices are called faith healers. Most communities have a traditional healer or faith healer who treats mental illness through various healing interventions which support their cultural beliefs. Prevalence of seeking faith healing practices — like treatment offered by astrologers, priests, black magicians and so forth — is high among psychiatric patients, even with easy accessibility and availability of psychiatrists and hospitals, and this can lead to delay in seeking psychiatric care.[4,6] Recent studies have also shown that religious beliefs and practices help to cope with stresses of life and hence are beneficial to mental health.[7]

The role of cultural factors in management of mental disorders needs adequate attention from mental health professionals. Culture uniquely influences mental health of people living in a given society, and it is important to consider cultural, traditional and folk methods for conceptualizing and managing mental illnesses.[8,9] As beliefs about mental illness can affect patients' willingness to seek and adhere to treatment, understanding individual and cultural beliefs about mental illness is essential for effective implementation of mental health care approaches.

Aims

The purpose of the study was to identify the cultural beliefs and faith healing practices related to the management of mental disorders among caregivers of mentally ill. The study also assessed their reasons for following such practices.

Operational Definitions

In this study, "cultural beliefs and faith healing practices" refer to beliefs and practices related to causes and management of mental disorders. The cultural beliefs we assessed include beliefs about the existence of possession by powers such as spirit, belief that mental illness could be result of 'Karma' (deeds in past lives) or 'Kaivisham' (poisoning by others), and belief that entities like 'Jinnu' (demon), 'Malak' (angel), 'Ibilize' (devil), 'Durmoorthi' (bad power), 'Gandharvas' (heavenly beings) and destiny can cause mental illness.

The following were considered to be faith healing practices: prayer healing, 'Poojas' (a prayer ritual with flowers), 'Nivedya' (offering of food for an idol), black magic (use of supernatural powers or magic for evil and selfish purposes), offerings, witch-craft, 'Uchadanam' (driving out evil spirits), and wearing 'Thakidu' (flat piece of metal with inscriptions). These were identified using a semi-structured interview schedule.

In this study, **"**mental disorders" refer to serious mental disorders including schizophrenia spectrum disorders, mood disorders, and depressive disorders as per ICD-10 Classification for Mental and Behavioural Disorders.[10] Although faith healing practices are more commonly used for dissociative disorders, this study is restricted to population with serious mental disorders.

"Caregivers" refer to father, mother, husband, wife, children, brother, sister, in-laws, and friends who are responsible for caring and meeting the needs of the person with mental illness for at least past one year.

METHODS AND MATERIALS

The conceptual framework of this study is based and designed on the concepts of Klienman's Explanatory Model of illness, which underscores the concept that illness is a socially constructed experience and not solely the result of purely biological factors.[11]

The study used non-experimental descriptive design. The sample comprised of 200 caregivers selected by convenient sampling based on the inclusion criteria. Primary caregivers who can follow English or the regional language Malayalam

were included. Exclusion criteria were presence of any psychiatric disorders or mental retardation.

The study was conducted in 21 community mental health clinics under District Mental Health Programme (DMHP) in Kannur district of Kerala. These clinics function as part of National Mental Health Programme, on a monthly basis, at Government hospitals or Health Centres in different parts of Kannur district which has a population of about 24 lakhs. The programme covers an average 1300 patients every month through its 21 clinics.

Tools and technique

The first author (BR) developed the tools, based on review of relevant literature and discussion with experts in the field of mental health care. The first tool was a sociodemographic data sheet. It included profile of the caregiver and his/her relationship to the patient. The second tool was a semi-structured interview schedule, developed based on review of literature about the topic. It had two parts: The first part covered cultural beliefs about mental illness and details of faith healing practices, if any, engaged for management of mental illness. The second part asked about the caregivers' perception on (i) why people do not seek psychiatric help for treatment of mental disorders and (ii) why people seek faith healing practices for the same.

Content validity of the instruments were established by sending them to experts in the fields of psychiatry and mental health care. Language validity was established by translation and back-translation procedure.

A pilot study was conducted, to assess the feasibility, in a sample of 20, and necessary modifications were made. Data collection period was six weeks during February to March 2014. After getting approval from Institutional Ethics Committee, and administrative sanction from Nodal Officer of District Mental Health Programme, Kannur, data were collected from a sample of 200 participants. As the study was done as part of an academic project, the first author (BR) recruited the participants, who were caregivers of mentally ill patients undergoing treatment for any serious psychiatric disorders such as schizophrenia spectrum disorders, mood disorders, or depressive disorders at the DMHP clinics, in consultation with the treating psychiatrist. The first author visited each clinic on the assigned date in rotation, and data were collected from 200 participants. The purpose of the study was explained, and privacy and confidentiality were ensured. After obtaining written informed consent, the caregiver was interviewed in detail using the interview schedule. Data collection took 20 to 30 minutes for each participant. About 10 caregivers refused to participate, citing shortage of time.

SPSS software package (Version 16 for Windows) was used for analysis. Descriptive statistics was used.

RESULTS

Of the 200 participants, 24% belonged to the age group of below 30 years, 22.5% to the group of 30-39 years, 29.5% to that of 40-49 years and 23% to that of 50 years and above. 65.5% of participants were female. 49.5% of participants belonged to Hindu religion, 45% to Islam, and 5.5% to Christianity. 28% of the participants had high school education and 23% had graduation or professional education. Majority of the participants (75%) were unemployed. 77.5% belonged to BPL (Below Poverty Line) status, a socioeconomic status index set by the Government of Kerala. 87.5% lived in a rural area. There was equal number of participants from nuclear and joint families. 42.5% of participants were related to the patients as parents, and 22.5% as life partners.

92% (n=185) had sought faith healing practices at some point of time for management of the mental illness. 78% (n=151) had sought faith healing at the first appearance of the illness, while 11% (n=22) had consulted a psychiatrist, 5% (n=10) had consulted other practitioners and 6% (n=12) had kept their patient at home without giving treatment. Majority (91.5%, n=183) of participants were not aware of the patient's diagnosis.

More than half (69%, n=138) of participants have been following both psychiatric treatments and faith healing as the present treatment modality, 28% (n=56) were using psychiatric treatments alone, and 3% (n=6) were using psychiatric treatments along with other treatments.

Responses to the question on which factor they believed had caused the mental illness are summarized in Table 1. The most common responses were destiny (85.5%, n=171) and traditional rituals and practices (50%, n=100).

Multiple faith healing practices were found as being followed as treatment of mental illness. Of those who had followed faith healing practices at least once (n=185), 72% (n=134) had practiced 'poojas' and offerings, 76% (n=140) had tried wearing some kind of 'thakidu' or threads as a protective and curative measure against mental illness, and 64% (n=119) had engaged in prayers suggested by religious leaders. 41% (n=76) had practiced some or other kind of spirit removal methods, including 'uchadanam' (3%, n=5). Animal sacrifice was practiced by 19% (n=36).

Considering which religion's faith healing practices were tried, of the 167 participants who responded to the question, 40% (n=67) were following Hindu faith healing practices, 31% (n=52) were following Islamic religious practices, and 4% (n=7) were following Christian faith healing practices. 15% (n=25) had tried healing practices of more than one religion.

Reasons for following the faith healing practices

Table 2 summarizes responses to the question, "Why you think people do not seek psychiatric care for management of mental illness?". The most common responses were fear of side effects of psychiatric medicines (92%, n=185) and economic burden (57%, n=114). Most common responses to the question "Why you think people seek faith

Table 1. *Beliefs regarding cause of mental illness (n=200)*

Characteristics	n	%
Physical and chemical disturbances of brain	47	23.5
Consumption of Herbs and poisons	25	12.5
Traditional rituals and practices	100	50
Destiny	171	85.5
Killing snakes and animals	89	45.5
Physical illness	68	34
'Manthravadam'	8	4
Spirit possession	25	12.5
Divine wrath	45	22.5
Result of 'Karma' (result of one deeds in past)	60	30
Curse by dead relatives	15	7.5

Table 2. *Distribution of participants based on reason for following other practices (n=200)*

Characteristics	n *	%
Reasons for not using psychiatric care		
Fear of side effects	184	92
Long duration of hospital stay	39	19.5
Fear of dependence on medicines	102	51
Difficulty in travelling	41	20.5
Economic burden	114	57
Reasons for following the faith healing practices		
Religious beliefs, customs and norms	166	83
Others' compulsion and opinion	158	79
Belief in magical cure	116	58
Social stigma to see a psychiatrist	114	57
Faith healing practices are less expensive	103	51.5
Easy availability of faith healers	47	23.5

*Most participants provided multiple responses.

healing interventions for management of mental illness?" were religious beliefs, customs and norms (83%, n=166) and others' compulsion and opinion (79%, n=158) (Table 2).

DISCUSSION

Socio-personal variables presented in this study are similar to the findings of other related studies.[12,13] A large majority of participants (92%) of the present study followed faith healing practices for managing mental disorders at some point of time. Similarly, only 11% consulted a psychiatrist for treatment during the first appearance of the illness, whereas 78% followed faith healing practices. It reflects the influence of culture and belief on health-seeking behaviours of people in this part of the country — an influence that leads to delays in obtaining medical help. Similar findings have been reported by an earlier Indian study on patients' health-seeking behavior.[13]

Majority (91.5%) of participants were not aware of their patients' diagnosis. Another study reported that caregivers present their patient's illness as there was something wrong with their relative, rather than citing a diagnosis as in the case of physical illness, due to fear of stigma. Addressing such issues through psychoeducation would help in dealing with caregivers' hesitation to engage with psychiatric care.[14]

Traditional healers play a significant role in the management of mental illness in developing countries.[15] Present study identified that 69% of the sample were still following faith healing along with psychiatric treatment. This finding is supported by another study, which assessed the help-seeking behaviours of caregivers of patients with schizophrenia or psychosis in two Indian cities, and found that 16% and 32% of the participants in the two cities intended to continue with faith healing practices alongside the psychiatric care.[16]

Our study highlights the cultural differences among caregivers in their belief about cause of mental illness and preferences for its treatment. This study shows that majority participants reported multiple factors as the cause of mental illness. Among the multiple responses, 23.5% considered physical and chemical disturbances of brain as the cause of mental illness. In contrast, 72.5% of sample believed in supernatural causation of mental illness. Belief in supernatural power, spirit possession and divine wrath as the cause of mental illness has been consistently reported in several studies conducted in India and other countries.[17-20] In some cultures, the traditional model of illness causation emphasizes social and spiritual dysfunction as a cause of illness, with supernatural intervention is regarded as the main cause of serious illness.[21] These findings imply that current concept of causation of mental illness as a complex interaction among biological, psychological, social, and cultural factors should be imparted to people through mental health education.[22]

'Pooja' and offerings, as well as wearing 'thakidu', were practiced by majority of the participants. Similar findings have been made by other researchers too. An Indian study which intended to find out the belief and utilization of faith healing, its implications, and associated sociocultural factors in psychiatric inpatients of Orissa discovered that 75% of patients attempted faith healing prior to presenting themselves to mental health services.[23]

Mental health care follows the bio-psychosocial model, and religion is considered one of the most important psycho-social factors in human life.[24] In our study, help seeking behaviours were seen to traverse boundaries of religion — It was found that about 15% of participants used combined practices from more than one religion. These findings are supported by another study that explored religious healing in psychiatric patients attending a hospital in Tamil Nadu, South India, which found that 66% followed faith healing and that the religion of the healer or place of worship is of less significance.[12] Hence, it is important to recognize the role played by religious beliefs in the treatment and prevention of mental disorders.[25,26]

It is also important to assess the reasons for seeking other practices and not following modern treatment, as it may help in modifying management plans to suit the needs of the specific patient. The present study found that 92% of participants felt that fear of side effects of psychiatric medications could be preventing people from seeking psychiatric treatment, and 51.5% and 57% respectively felt economic burden and stigma could be the deterrent.

A similar study on influence of sociocultural factors on help seeking behaviour reported that trust, easy availability and accessibility, recommendations by significant others and belief in supernatural causation of illness were the important reasons for choosing a particular facility.[27] These findings are also supported by another study among caregivers of patients suffering from schizophrenia and psychosis.[16]

A major limitation of the study is social desirability bias by the respondents when enquired about belief system and cultural practices, which is difficult to control in a quantitative survey. Another limitation was recruitment of the subjects through convenient sampling. A mixed qualitative-quantitative approach would help to widen the understanding of this topic.

CONCLUSION

Many age-old beliefs influence health-seeking behaviours of those affected by mental illness. Mental health care should be developed with due consideration for cultural beliefs and practices. Findings of the present study should call the attention of policy makers, planners and higher authorities, at the state as well as local level, to various issues that might result from these practices, as they may delay seeking medical help and thereby adversely affect the illness prognosis.

REFERENCES

1. Saxena S, Funk M, Chisholm D. World Health Assembly adopts Comprehensive Mental Health Action Plan 2013-2020. Lancet 2013;8;381(9882):1970-1.
2. Gururaj G, Girish N, Issac MK. Mental, neurological and substance abuse disorders: Strategies towards a systems approach. In: Burden of disease in India. National Commission on Macroeconomics and Health. New Delhi: Government of India; 2005.
3. Subramanian N. Cultural beliefs and faith healing- their influence on psycho pathology and management of mental and behavioral disorders. Kerala Journal of Psychiatry 2009; 24:46-58.
4. Sethi BB, Trivedi JK, Sithole P. Traditional healing practices in psychiatry. Indian J Psychiatry 1977;19(4):9-13.
5. Verghese A. Spirituality and mental health. Indian J Psychiatry 2008; 50(4):233–7.
6. Boral GB, Bagcht R, Nandi ND. An opinion survey about the causes and treatment of mental illness and the social acceptance of the mentally ill patients. Indian J Psychiatry 1999; 22:235-38.
7. Nguyen A. Cultural and social attitudes towards mental illness in Ho Chi Minh City, Vietnam. Stanford University Research Journal 2003;2(1):27-31.
8. Gautam S, Jain N. Indian culture and psychiatry. Indian J Psychiatry 2010; 52,S3:309-13.
9. Viswanath B, Chaturvedi SK. Cultural aspects of major mental disorders: a critical review from an Indian perspective. Indian J Psychol Med 2012; 34:306-12.
10. World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research. Geneva: World Health Organization;1993.
11. Lewis-Fernández R, Kleinman A. Cultural psychiatry. Theoretical, clinical, and research issues. Psychiatr Clin North Am. 1995; 18(3):433-48.
12. Campion J, Bhugra D. Experiences of religious healing in psychiatric patients in south India. Soc Psychiatry Psychiatr Epidemiol 1997; 32(4):215-21.
13. Worthington RP, Gogne A. Cultural aspects of primary healthcare in India: A case- based analysis. Asia Pac Fam Med 2011; 16:10-8.
14. Olasoji M, Maude P, McCauley K. A journey of discovery: experiences of carers of people with mental illness seeking diagnosis and treatment for their relative. Issues Ment Health Nurs 2016; 37(4):219-28.
15. Latypov A. Healers and psychiatrists: the transformation of mental health care in Tajikistan. Transcult Psychiatry 2010; 47(3):419-51.
16. Naik SK, Pattanayak S, Gupta CS, Pattanayak RD. Help-seeking behaviors among caregivers of schizophrenia and other psychotic patients: A hospital-based study in two geographically and culturally distinct Indian cities. Indian J Psychol Med 2012; 34(4):338-45.
17. Srinivasan TN, Thara R. Beliefs about causation of schizophrenia: do Indian families believe in supernatural causes? Soc Psychiatry Psychiatr Epidemiol 2001; 36(3):134-40.

18. Adebowale TO, Ogunlesi AO. Beliefs and knowledge about aetiology of mental illness among Nigerian psychiatric patients and their relatives. Afr J Med Med Sci 1999; 28(1-2):35-41.
19. Kurihara T, Kato M, Reverger R, Tirta IG. Beliefs about causes of schizophrenia among family members: a community-based survey in Bali. Psychiatr Serv 2006;57(12):1795-9.
20. Gureje O, Lasebikan VO, Ephraim-Oluwanuga O, Olley BO, Kola L. Community study of knowledge of and attitude to mental illness in Nigeria. Br J Psychiatry 2005; 186:436-41.
21. Maher P. A review of 'traditional' aboriginal health beliefs. Aust J Rural Health 1999; 7(4):229-36.
22. U.S. Department of Health and Human Services. Mental health: culture, race, and ethnicity—a supplement to mental health: a report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; 2001.
23. Kar N. Resort to faith-healing practices in the pathway to care for mental illness: a study on psychiatric inpatients in Orissa. Ment Health Relig Cult 2008; 11(7):720-740.
24. Sabry WM, Vohra A. Role of Islam in the management of Psychiatric disorders. Indian J Psychiatry 2013; 55:205-14.
25. Agara AJ, Makanjuola AB, Morakinyo O. Management of perceived mental health problems by spiritual healers: A Nigerian study. Afr J Psychiatry (Johannesbg) 2008; 11(2):113-8.
26. Kurihara T, Kato M, Reverger R, Tirta IG. Beliefs about causes of schizophrenia among family members: a community-based survey in Bali. Psychiatr Serv 2006; 57(12):1795-9.
27. Chadda RK, Agarwal V, Singh MC, Raheja D. Help seeking behaviour of psychiatric patients before seeking care at a mental hospital. Int J Soc Psychiatry 2001; 47(4):71-8.

Source of support: None
Conflict of interest: None declared
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First submitted: 4th April 2016
Published online: 7th October 2016