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Healing beyond Medicine: Cultural Perspectives in Psychiatric Illness

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Abstract

Introduction: Mental disorders constitute a wide spectrum ranging from sub-clinical states to very severe forms of disorders. Many patients are exposed to numerous types of magico-religious therapy. Superstition and religious beliefs continue to hinder individuals with behavioural issues and mental illness from obtaining psychiatric care. Religious priests and traditional faith healers are often the very first point of contact for many people in India; however, these beliefs may hinder their ability to heal.

Objective: This study aims to determine the role of cultural and faith healing practices in the treatment of psychiatric illnesses.

Methods: A cross-sectional study was conducted at a tertiary care hospital, involving 205 caregivers of mentally ill patients, who had sought prior help from faith-healers. A semi- structured questionnaire was administered to the caregivers to determine the cultural beliefs regarding the cause of mental illnesses, reasons for not using psychiatric care and the reason for following faith healing practices. Statistical analysis was performed to determine the role of cultural and faith healing practices in the treatment of psychiatric illnesses.

Results: The study showed that the most commonly cited belief (82.4%) regarding the cause of mental illness was destiny. The most prevalent reason (89.8%) for not using psychiatric care was fear of side effects. This study noted that the most common reason (81%) for resorting to the faith healing practices were religious beliefs, customs and norms. The prevalence of faith healing practices by caregivers of mentally ill patients is 64.94%.

Conclusion: The study found that many age-old beliefs influence the health- seeking behaviours of people suffering from mental illnesses. The findings of the current study should draw the attention of policymakers, planners and higher authorities, at the state and municipal levels, to numerous concerns that might come from these activities, as they might delay obtaining medical attention and so adversely affect the illness prognosis.

Keywords: Psychiatric illness • Cultural beliefs • Faith healing practices.

Introduction

Mental disorders are a spectrum rather than binary diseases, ranging from mild to life threatening disorders [1]. Mental disorders account for 13.0% of the burden of disease [2]. One in five people in India live with a mental illness [3]. People explore different solutions to prevent or treat mental illness, frequently influenced by their cultural background. Culture refers to beliefs, values and habits developed within a society. In many cultures, including India, mental illness is usually attributed to supernatural origins such as spirit possession, curses, or ancestor wrath. As a result, magico-religious therapies are frequently sought alongside or instead of medical care [4,5]. Superstitions and religious beliefs often deter individuals with mental illness from seeking psychiatric care. In India, traditional faith healers and religious priests are frequently the first point of contact [6-8]. Key reasons for seeking faith healing include family beliefs, past positive experiences, financial constraints, stigma and easy access. In serious illnesses, people often turn to supernatural or religious options for hope. Cultural beliefs significantly influence how mental illness is understood and managed, making it essential for mental health professionals to consider traditional and folk practices for effective care [9-11].

In many cultures, notably in India, mental illness is frequently blamed on supernatural forces such as possession, curses, or divine punishment. Individuals with this belief system seek aid from faith healers, religious priests, or traditional healers as the initial step in treatment. According to studies, around 75% of psychiatric patients seek out non-medical interventions before consulting with mental health experts, affected by variables such as family beliefs, stigma, accessibility and financial restrictions [12,13]. Cultural standards can accept experiences like passivity or obsessive thoughts as the result of external powers like God or the devil, which may not be judged aberrant unless functionally impaired [14]. These interpretations are critical for understanding patient behaviour and should be included during psychiatric evaluation and treatment planning.

Despite advances in psychiatric care, traditional and faith-based healing therapies are still extensively used due to their cultural acceptance and accessibility. According to research, none of the therapeutic systems, whether faith-based or medical, is totally sufficient on its own; rather, patients frequently employ them in combination or succession, depending on perceived effectiveness [15,16]. Family and community engagement has a significant impact on treatment decisions, frequently delaying psychiatric care and perhaps worsening prognosis [17,18]. The current study intends to investigate the impact of cultural beliefs and faith healing practices on treatment-seeking behaviour and outcomes in psychiatric disease, as well as to make recommendations for culturally integrated mental healthcare treatments.

Methods

Study design: Observational cross-sectional study.

Setting: Career Institute of Medical Sciences and Hospital, Lucknow.

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Participants: A Total of 205 patients and caregivers were clinically evaluated in the OPD and IPD of the Department of Psychiatry in the Career Institute of Medical Sciences and Hospital, Ghaila, Lucknow.

Inclusion criteria

- All patients presenting to the psychiatry OPD who fulfilled the ICD-10 diagnostic criteria for any psychiatric disorder and have sought prior help from faith healers, except those mentioned in the exclusion criteria.
- All participants aged between 18 and 60 years.
- Caregivers who were willing to give written informed consent.

Exclusion criteria

- Intellectual disability disorder.
- Dementia, delirium and other cognitive disorders.
- Mood disorder due to general medical conditions (e.g., tuberculosis, diabetes mellitus, hypertension, cerebrovascular attack).
- Mood disorder due to substance use.

Sampling technique

A Non-Probability Sampling technique of convenience type was used, where all participants who fulfilled the ICD-10 diagnostic criteria for any psychiatric disorder and had sought prior help from faith healers were included in the study.

Study methods: A total of 205 patients and their caregivers from the OPD and IPD of the Psychiatry Department at Career Institute of Medical Sciences and Hospital, Lucknow, were evaluated based on inclusion and exclusion criteria. Informed consent was obtained and each patient was assessed using the MINI plus scale and diagnosed per ICD-10.

Caregivers of patients who had previously sought help from faith healers were interviewed using a semi-structured questionnaire covering beliefs about mental illness, reasons for avoiding psychiatric care and preference for faith healing. The interview, conducted in the local or English language, lasted about 20 minutes. Data were collected confidentially and encoded into an Excel sheet using study variables.

Study tools

Socio-demographic profile: A semi-structured proforma was used to collect socio-demographic and clinical details, including age, gender, education, occupation, cultural background, religious affiliation, illness history and use of faith healing.

M.I.N.I. plus: The MINI is a validated, structured interview tool commonly used in research for quick and reliable psychiatric diagnosis. In this study, MINI was administered to all participants, following standardized protocols to ensure accuracy. It helped document symptoms and confirm diagnoses based on DSM-IV and ICD-10 criteria, supporting consistent clinical assessment across the sample.

Semi-structured questionnaire: A semi-structured interview was administered to caregivers of patients who had sought faith healing, focusing on three areas: beliefs about mental illness causes, reasons for not using psychiatric services and motivations for following faith healing practices. The interview consisted of yes/no questions and took about 20 minutes to complete, providing insight into cultural influences on treatment choices.

Ethical Approval

Ethical approval for the study was obtained from the Institutional Research Cell. Confidentiality and anonymity of personal information were strictly maintained throughout the study. Participants were informed about the purpose of the study, their voluntary involvement and their right to withdraw at any time without any consequences. The study protocol was approved by the institutional ethics committee prior to commencement.

Data Analysis

Data analysis was performed using SPSS version 29, Chicago. The result was analyzed using descriptive statistics and making comparisons among various groups. Categorical data were summarized as in proportions and percentage (%) while discrete as mean ± SD. A p-value of less than 0.05 was judged statistically significant.

The data was presented using graphs and Tables.

Results

The most commonly cited belief was destiny, with 169 participants attributing mental illness to this cause, constituting 82.4% of the sample. Traditional rituals and practices were cited by 100 participants, accounting for 48.8%, followed by killing snakes and animals (43.4% or 89 participants), physical and chemical disturbances of the brain (22.9% or 47 participants) and physical illness (33.2% or 68 participants). Other beliefs included the result of 'Karma' (28.8% or 59 participants), divine wrath (22.0% or 45 participants), consumption of herbs and poisons (12.2% or 25 participants), spirit possession (11.7% or 24 participants) and curse by dead relatives (7.8% or 16 participants) (Table 1) (Figure 1).

The most prevalent reason was fear, cited by 184 participants, representing 89.8% of the sample. Economic burden was another significant factor, with 126 participants indicating financial constraints (61.5%). Drug dependency was cited by 108 participants (52.7%), while difficulty in traveling and long hospital stays were reasons for 47 (22.9%) and 39 participants (19.0%) respectively (Table 2).

A total of 71 male and 134 female participants were included. The association between beliefs and gender was examined using chi-square tests. Consumption of herbs and poisons was significantly associated with gender (χ^2=4.236, df=1, P<0.05), with fewer males (5.6%, n=4) holding these beliefs

Table 1. Distribution of the studied participants based on beliefs regarding cause of mental illness.

Beliefs Regarding Cause of Mental Illness	No. of Cases (n=205)*	Percentage
Physical and chemical disturbances of brain	47	22.90%
Consumption of Herbs and poisons	25	12.20%
Traditional rituals and practices	100	48.80%
Destiny	169	82.40%
Killing snakes and animals	89	43.40%
Physical illness	68	33.20%
Spirit possession	24	11.70%
Divine wrath	45	22.00%
Result of “Karma” (result of one deed in past)	59	28.80%
Curse by dead relatives	16	7.80%

*Most of participants had multiple responses.

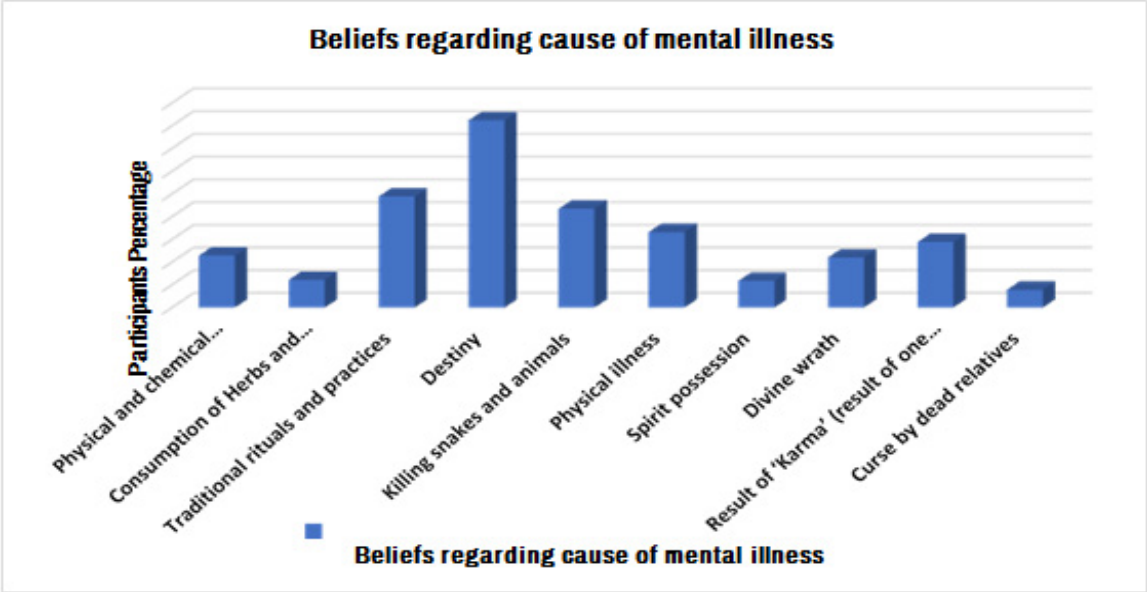

Figure 1. Distribution of the studied participants based on beliefs regarding cause of mental illness.

Table 2. Distribution of the studied participants based on reasons for not using psychiatric care.

Reasons for not using Psychiatric Care	No. of Cases (n=205)	Percentage
Fear of side effects	184	89.80%
Long duration of hospital stays	39	19.00%
Drug dependency	108	52.70%
Difficulty in travelling	47	22.90%
Economic burden	126	61.50%

Table 3. Association of beliefs regarding the cause of mental illness with the gender of subjects.

Beliefs Regarding Cause of Mental Illness	Gender		χ^2; df; P value
	Male (N=7)	Female (N=134)	
Physical and chemical disturbances of brain	14	33	0.633; 1;
	(19.7)	(24.6)	0.426
Consumption of Herbs and poisons	4	21	4.236; 1;
	(5.6)	(15.7)	0.037
Traditional rituals and practices	36	64	0.161; 1;
	(50.7)	(47.8)	0.688
Destiny	61	108	0.907; 1;
	(85.9)	(80.6)	0.341
Killing snakes and animals	33	56	0.415; 1;
	(46.5)	(41.8)	0.519
Physical illness	25	43	0.204; 1;
	(35.2)	(32.1)	0.651
Spirit possession	10	14	0.594; 1;
	(14.1)	(10.4)	0.441
Divine wrath	71	31	0.316; 1;
	(19.4)	(23.1)	0.574
Result of "Karma" (result of one deed in past)	21	38	0.034; 1;
	(29.6)	(28.4)	0.854
Curse by dead relatives	6	10	0.063; 1;
	(8.5)	(7.5)	0.802

compared to females (15.7%, n=21). No significant associations were found between gender and beliefs regarding other causes of mental illness, including physical and chemical disturbances of the brain, traditional rituals and practices, destiny, killing snakes and animals, physical illness, spirit possession, divine wrath, result of 'Karma' and curse by dead relatives (P>0.05 for all) (Table 3)

Chi-square tests were used to assess associations between gender and reasons for avoiding psychiatry care. Significant differences were found for the reason of long duration of hospital stays (χ^2 =5.896, df=1, P=0.015), with a higher proportion of females (28.2%, n=20) citing this as a deterrent compared to males (14.2%, n=19). No significant associations were observed between gender and other reasons such as fear of side effects, drug dependency, difficulty in travelling, or economic burden (P>0.05 for all) (Table 4).

Table 4. Association of reasons for not using psychiatry care with the gender of subjects.

Reasons for not using Psychiatry Care	Gender		χ^2; df; P value
	Male	Female	
Fear of side effects	117 (87.3)	67 (94.4)	2.511; 1; 0.113
Long duration of hospital stays	19 (14.2)	20 (28.2)	5.896; 1; 0.015
Drug dependency	67 (50.0)	41 (57.7)	1.117; 1; 0.291
Difficulty in travelling	33 (24.6)	14 (19.7)	0.633; 1; 0.426
Economic burden	77 (57.5)	49 (69.0)	2.614; 1; 0.106

Discussion

The present study offers an in-depth analysis of how cultural beliefs and faith healing practices impact the treatment-seeking behaviour of caregivers of individuals with psychiatric illnesses. The results underscore the deeply entrenched role of sociocultural factors in shaping perceptions and responses to mental health disorders in India.

Mental disorders contribute to 13.9% of the total disease burden in India, with nearly one in five people living with a mental illness [19,20]. Despite advancements in psychiatric services, cultural interpretations of mental illness remain dominant. These interpretations often link psychiatric symptoms to supernatural causes, such as possession by spirits, ancestral displeasure, curses, or karma [21,22]. This belief system shapes how people interpret symptoms and whom they approach for treatment.

Our findings echo earlier studies, which highlighted that faith healing is often the first recourse for mental illness in culturally conservative societies. Faith healers are trusted figures within communities, offering treatment that aligns with prevalent religious and cultural beliefs [23,24]. In the current study, a significant proportion of caregivers (82.4%) believed in destiny as a cause of mental illness, while other reasons included traditional rituals (48.8%), killing animals (43.4%) and divine wrath (22.0%).

These findings align with studies by Rajan B, et al. [4], Kauser L, et al. [18] and Sharma DB, et al. [25], who found that cultural attributions significantly influence help-seeking behaviour. Amin R, et al. [26] reported similar patterns in Kashmir, where lack of education and rural residency were major factors for seeking faith healers first.

A striking observation in our study was that nearly 90% of participants cited fear of side effects as the reason for not opting for psychiatric care. Economic burden (61.5%), drug dependency concerns (52.7%) and long hospital stays (19.0%) were other commonly reported barriers. These findings are consistent with previous literature suggesting that perceived disadvantages of psychiatric treatment often led to preference for culturally familiar alternatives [27-30].

Moreover, 81.0% of caregivers followed faith healing due to religious beliefs and customs. Peer and community influence (77.1%) also played a crucial role. Social stigma (61.0%) and lower cost (55.1%) further justified the continued use of faith healing. These observations mirror findings from Chakraborty K, et al. [31] and Rishi J [32], who noted that people preferred religious and traditional interventions due to societal pressure and stigma.

Socioeconomic and demographic variables had a notable influence. The majority of caregivers were from rural areas (85.4%) and most were illiterate (57.6%) or had only primary education. These individuals belonged predominantly to low-income groups, with 38.0% earning less than 1600 units per month. This correlates with studies by Kishore J, et al. [33] and Campion J, et al. [34], which emphasized that faith healing is more common among lower socioeconomic strata due to accessibility, cost and community integration.

Importantly, no significant associations were found between gender and beliefs related to causation or treatment of mental illness, except that more females (28.2%) than males (14.2%) cited long hospital stays as a barrier (P=0.015). This may be attributed to caregiving responsibilities and societal expectations placed on women, echoing research by Al-Krenawi A and Graham JR [35], which reported heightened stigma and treatment burden on women.

Further, the belief that faith healing is less expensive showed significant association with older age groups (P<0.05)The role of faith healing as a primary care modality in mental health can be either supportive or obstructive.

Finally, the mechanisms employed by faith healers, such as giving charms, conducting rituals, or prescribing symbolic sacrifices may fulfill a psychological or spiritual role akin to the placebo effect, providing temporary relief through culturally sanctioned avenues. These practices, however, cannot replace the need for scientifically validated psychiatric care.

Limitations

Nature of the study

This is a cross-sectional study in which causal relationships between the variables cannot be determined.

Study setting

The study's setting is a single tertiary care hospital in North India which may not represent the diversity of psychiatric patients in other geographic regions or healthcare settings, thus limiting the external validity of the findings.

Study tool

The use of a single semi structured questionnaire for evaluating cultural beliefs and faith healing practices were used, therefore all the other cultural and traditions norms could not be assessed.

Information bias

The caregivers found it difficult to recall all the past events associated with the cultural beliefs and faith healing practices.

Conclusion

Prevalence of faith healing practices in our study is 64.9%.

While destiny (82.4%) emerged as the most common cultural belief regarding the cause of mental illnesses, the fear of side effects of anti-psychotics and anti-depressants (89.8%) was one of the major reasons for not using psychiatric care.

Religious beliefs, customs and norms (81.0%) were the most common reason for following faith healing practices.

Recommendation

This study underscores the critical need for psycho-educational initiatives, especially targeting rural communities and individuals from lower socio-economic backgrounds. Increasing mental health awareness in these populations is essential.

To combat deeply rooted stereotypes and the social stigma associated with psychiatric disorders and their treatment, it is recommended that nationwide educational campaigns be developed. These programs should aim to inform and empower both patients and their caregivers, fostering a more accepting and informed approach to mental health care.

Acknowledgement

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Conflict of Interest

None.

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