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The prevalence, classification and treatment of mental disorders among attenders of native faith healers in rural Pakistan

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Abstract Background: Although native faith healers are found in all parts of Pakistan, where they practice in harmony with the cultural value system, their practice is poorly understood. This study investigated the prevalence, classification and treatment of mental disorders among attenders at faith healers. Method: The work of faith healers with 139 attenders was observed and recorded. The mental status of attenders was assessed using a two-stage design: screening using the General Health Questionnaire followed by diagnostic interview using the Psychiatric Assessment Schedule. Results: The classification used by faith healers is based on the mystic cause of disorders: saya (27%), jinn possession (16%) or churail (14%). Fifty-one percent of attenders were given a research diagnosis of mental disorder: major depressive episode (24%), generalized anxiety disorder (15%) or epilepsy (9%). There was little agreement between the faith healers’ classification and DSM-III-R diagnosis. Faith healers use powerful techniques of suggestion and cultural psychotherapeutic procedures. Conclusions: Faith healers are a major source of care for people with mental health problems in Pakistan, particularly for women and those with little education. Further research should assess methods of collaboration that will permit people with mental health problems to access effective and culturally appropriate treatment.

Introduction

Traditional forms of mental health care contain important elements that have not been adequately studied or understood. Several common principles have been identified in traditional treatments [1]. These include:

1. The familiarity of the local cultural values to the healer
2. A holistic approach that brings together physical, psychological, social and spiritual methods
3. The charisma of the healer and the confidence he inspires in the local community
4. The use of suggestion and altered states of consciousness to mobilize the healing process
5. The involvement of family and other community members in the healing process
6. A ceremonial format, and
7. The use of clear and compelling instructions to engineer change in the attenders’ social environment

In Pakistan, traditional beliefs and religion play an important role in the socio-cultural and political life of the people. In Islamic cultures, the family and community hold a central position in the life of the individual, and they can make a tremendous contribution to the therapeutic process. Native faith healers are found in all parts of Pakistan, where they practise from shrines. They are held in high regard and are either descendants of the great sufis or their khalifas. They are considered to be spiritual or moral guides, and they are consulted for a range of ailments including physical illness, emotional problems, congenital defects or other disappointments in love, family or business. The WHO studies of pathways to care showed native faith healers to be an important source of care for people who ultimately attend psychiatric services [2].

The traditional milieu may be therapeutic, but there may be negative effects; for example, there have been reports from some centres (though not Rawalpindi) that access to psychiatric care is delayed after seeing a native
or religious healer [2]. Akerele recommended closer collaboration between mental health systems and traditional medicine, incorporating the mutual development of practical guidelines for care, the exchange of information, and the referral of appropriate patients between traditional and medical services [3].

There is a marked difference in the availability of health and other civic facilities between rural and urban areas of Pakistan. Throughout Pakistan, there is one doctor per 10,000 of the population, of whom most work in the cities. Literacy rates among the people of rural areas are as low as 25% of men and 7% of women. Many faith healers practise in areas where people carry a strong heritage of traditional beliefs; health facilities are not easily available and access to modern concepts of mental health problems and their treatment is poor. In many rural areas where health facilities are not available, faith healers are the only source of care, but even where health facilities are available, the faith healer is often preferred and considered to be better at dealing with emotional problems.

In order to understand the prevailing practices of treating mental health problems in the community, it is important to understand the role and function of faith healers in relation to these problems. Although no such studies have been carried out in Pakistan, the work of faith healers has been investigated elsewhere. Carstairs and Kapur investigated psychiatric needs and consultation in the south-Indian coastal village of Kota [4]. The village was served by several different sources of care including primary care physicians applying Western medicine, Ayurvedic practitioners using traditional Indian medicine, Mantarwardis who apply holy verse and astrology, and Patris who act as the medium for healing spirits. Despite the apparently contradictory approaches of these different schools of healing, the validity of each was accepted within the community. Similar observations of a pluralistic understanding of psychiatric disorder have been made elsewhere in India [5, 6], though faith healers are more frequently consulted and are considered specialists in mental health problems [6]. Indian traditional healers were highly respected and crucially provided their clients with an explanation of the cause of their distress. However, the situation has been changing as the effects of general and health education along with the apparent benefits of Western medicine challenge indigenous approaches, such that, in Kota, the Western-trained doctor had become the preferred source of consultation [4]. In the early 1930s, Field observed the medical customs of the Gâ people of southern Ghana [7]. She emphasised the conscientious and systematic approach of the medicine men to diagnosis and identifying the cause of illness before treatment. She also drew a clear distinction between the scientific approach of Western medicine and the ‘fundamental set of supernatural concepts’ on which native Gâ understanding of illness was based. Field later published a series of case descriptions of mental illness among rural Gâ seen at shrines [8]. She described the cases under a psychiatric classification, and preferred this to an ethnological classification, because the latter would have been ‘hopelessly heterogeneous’; for example, ‘witchcraft cases’ would have included a mixture of depression, physical illness, childhood fears, epilepsy and migraine.

This study aimed to investigate the prevalence of mental disorders among attenders at five faith healers in the rural area of Gujarkhan near Rawalpindi, and to elicit the classifications and interventions used by the faith healers. Such a study has not been carried out before, and an additional aim was to explore the feasibility of carrying out research in collaboration with faith healers. Therefore, it was important for the research to be planned and carried out in a manner that respected the faith healers and the people who sought care and advice from them.

**Subjects and methods**

The faith healers practising in Gujarkhan, a small market town and sub-district headquarters, were identified from the lists kept by the Department of Religious Affairs. This list includes the number of disciples of each healer and the daily attendance, which are used to determine the amount of government aid given to each facility. Hence, the list is kept up to date. Nine faith healers were selected who were available throughout the week at one fixed facility, and who had large followings, having been there for two or three generations. These were approached and the purposes of the study were explained. Five agreed to participate in the study.

All of the faith healers were practising in rural areas within 30 km of Gujarkhan. Most are descendants of renowned saints of the area, and claim to have inherited special powers from their ancestors. They have undergone a rigorous apprenticeship and religious education from an early age under the tutelage of their guide and mentor to hone their natural gifts. They claim to be linked to at least one of the major sub lineages, all of whom trace their bloodlines back to MUHAMMAD (peace be upon him). One faith healer was a favoured disciple of a saint, who had been blessed with healing powers after many years of service, training and penance directed by his mentor. People consulting the faith healers consider the healer to be their spiritual guide and consider it an honour to follow his or his family’s wishes. The personal endorsement given to the study by the collaborating faith healers was the most important reason for the high rate of co-operation. The main reason given by the faith healers who did not agree to take part was that their disciples/clients came from distant places and were not able to stay for the additional 60 min required for the study.

The work of the faith healer with each attender was observed and a record made of the healer’s description of the problems and linked to at least one of the demographic information about the attender (age, gender, marital status, education, occupation and religion). After the consultation, attenders were approached and asked to take part in the study. The research was explained to them, and they were asked to give informed consent.

The research diagnostic procedure followed a two-stage design: initial screening using the 12-item version of the General Health Questionnaire (GHQ) [9], followed by a diagnostic interview of a stratified sample using the Psychiatric Assessment Schedule (PAS) [10]. The PAS does not include items to identify epilepsy or psychosis, and therefore these disorders were detected on the basis of the history and mental state examination. The GHQ has established validity and reliability in many cultures. The 12-item version was chosen because it is brief and can be read out to illiterate respondents. It was chosen above other mental health screens (such as the World Health Organisation’s Symptom Reporting