International Journal of Community Medicine and Public Health
Kudi SR et al. Int J Community Med Public Health. 2023 Dec;10(12):4774-4780
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20233778

Original Research Article

Role of faith healers in the treatment of severe mental illness in India

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Received: 18 September 2023
Accepted: 04 November 2023

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ABSTRACT

Background: The cultural diversity has influenced the beliefs of people regarding health and illness. An aim of the study was to assess the role of faith healers in the treatment of severe mental illness.
Methods: It is a retrospective cross-sectional study with convenience sampling technique was used, on 123 caregivers of patients with severe mental illnesses using standardized tools like MINI, BPRS, and YMRS.
Results: 41.5% participants firstly contacted faith healer while 86% visited faith healer anytime during the course of illness. 47.2% took treatment from faith healer for <6 months, 21.1% took 6-12 months and 17.9% more than 13 months. 22.8% circulated between faith healer to faith healer, 18.7% from psychiatrist to faith healer and 27.6% from medical professional to faith healer.
Conclusions: There is an immense need to create awareness regarding mental illness and treatment options available.

Keywords: Faith healer, Severe mental Illness, Traditional healer, Psychiatric care

INTRODUCTION

The World Health Organization (WHO) has defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". Mental health nowadays becoming a serious problem for all age groups and cultures. In India, very few patients with mental illness visit health care facilities to receive the treatment for mental illness at the first onset of symptoms. They visit health care facilities with the deterioration of disease.[1]

India is a country with cultural diversity. The cultural diversity has influenced the beliefs of people regarding health and illness. Based on their believes people choose health care delivery system.[2] Patient with mental illness or their primary caregivers prefer to visit traditional healers or faith healers to treat the mental illness. The decision to select care provider as first help for the psychiatric illness is also influenced by affordability, ease of the services and trust of careseekers on the careproviders, awareness regarding illness and social stigma associated with mental illness in their community.[3] Belief systems of society has been found to have a major impact on delay in treatment.[4] Instead of visiting psychiatrists, community people visit traditional healers or faith healers on the onset of the mental illness.[5]

Ancient Hindu literature suggested psychiatric disorders are the reflection of the metaphysical entities, sorcery or with craft and supernatural powers. Unlikely Ayurveda concluded that illness occurs due to the imbalance among three types of bodily fluids caused by the intake of the inappropriate diet, disrespect to elders, teachers or the gods, excessive joy or fear, results in mental shock or faulty activity of body.[6] Based on the etiological reasons treatments were suggested in the form of prayers, charms, herbs, and moral persuasion.[7]

In India, people believes that symptoms of the mental illness are caused by the spirit possession, invisible entities, or supernatural powers.[8] Various studies conducted in India concluded that majority of patients do not approach mental health care providers 1st time to treat mental illness. Mostly they visit faith healer at first time and some of them continue to visit faith healer along with treatment they receive from mental health care provider. Faith healing has become a prominent way of treating mentally ill patients due to lack of awareness about mental illness.[9]

Although mental health services are limited in many countries of the world, especially in developing countries like India, or even those places where mental health services are easily available people don't like to go to avail benefits of the services. Mentally ill patients avail benefits of psychiatric services after receiving various kinds of non-psychiatric care services, such as faith healer services.[10]

Family members lack of awareness regarding mental illness and poor knowledge regarding management of the sign and symptoms of mental illness insist them to approach faith healer as they are easily available to them.[11,12] Socio-economic and demographic factors and the availability of professional mental health care also influence help-seeking behaviour, as availability of low-cost treatment was an important reason for seeking help from hospitals and faith physicians.[13] The stigma associated with mental illness in society also made people hesitate in seeking psychiatric help at first time.[14] Many Indian studies reported that people have negative pessimistic opinion about mental illness. Compared to women, there were more men who received more professional health care.[15]

Above findings shows that care of mental illness is highly influenced by the belief system and cultural practices of people. Based on their belief people chose faith healers over psychiatrist. In this paper, we examined the role of faith healers in the treatment of mental illness.

Objectives of the study were to understand the socio demographic factors of caregivers which lead the patients to the faith healers, and to assess the switching over behaviour to faith healers from medical professionals among mentally ill patients.

METHODS

A retrospective research design was adopted for this study. Based on the previous study prevalence rate and considering 95% confidence interval and 5% precision 114 sample size was calculated. Researcher taken data from newly registered 123 patients with severe mental illness visited psychiatric outpatient clinic AIIMS, New Delhi from July to December 2019 were recruited using convenient sampling technique. Data was collected from their primary caregivers who was either patient parent or spouse or spend more than 12 hours a day with patient during the course of illness. The patients aged between18 and 60 years and meeting diagnostic criteria of schizophrenia (F20), other psychosis, mania and bipolar mood disorder as per ICD-10 and willing to participate in study were included in the study. The patient whose caregiver diagnosed with severe mental disorder based on the ICD-10 criteria were excluded from the study.

Measuring tools

Tool I: Self-developed structured demographic data sheet and clinical profile sheet.

Tool II a: Screening Instrument: M.I.N.I screening. V7.02 (for patients).

Tool II b: Screening Instrument: M.I.N.I screening. V7.02 (for caregivers).

Tool III: Severity of symptoms in patients: BPRS/YMRS.

Tool IV: WHO pathway encounter form.

Tool V: Self-developed checklist to find the reasons for choosing faith healers over psychiatrist and treatment received from the faith healer.

Self-developed structured demographic data sheet and clinical profile sheet include variables such as age, sex, marital status, education, occupation, religion, type of family, and income. Similar details were included for the caregivers. In addition, clinical details like total duration of illness, duration since onset of illness, course of illness, medications received (with dosage), past history of psychiatric illness and family history of psychiatric illness were recorded.

The mini-international neuropsychiatric interview (M.I.N.I. 7.02) is a short, structured diagnostic interview. With an administration time of approximately 15 minutes, the M.I.N.I. 7.02 is the structured psychiatric interview of choice for psychiatric evaluation and outcome tracking in clinical psychopharmacology trials and epidemiological studies. Rating is done to the right of each question by circling either yes or no.

BPRS is used for assessing symptom severity and assesses 24 symptom constructs such as hostility, suspiciousness, hallucinations, and grandiosity. It is particularly useful in gauging the efficacy of treatment in patients who have moderate to severe psychoses. The time necessary to complete the interview and scoring is 20-30 minutes**.**

YMRS is a checklist that provides an evaluation of the severity of mania to monitor treatment response or detect relapse. It consists of a checklist of 11 items rated either from 0 to 4 (seven items) or from 0 to 8 (four items).

WHO pathway encounter form describes the pathways in which patients with mental illness follow for the treatment

of mental illness. It also includes information about the onset of illness, time taken to reach treatment centers and decision-makers of treatment.

Content validity has been obtained for the self-developed structured demographic data sheet and clinical profile sheet and self-developed checklist to find the reasons for choosing faith healers over psychiatrist and treatment received from the faith healer. Intra-rater reliability done to measure reliability of self-developed checklist to find the reasons for choosing faith healers over psychiatrist and treatment received from the faith healer (r=0.71).

Data collection procedure

Ethical permission has been obtained from the ethical committee of the institute (reference no. IECPG-135/28.02.2019). The patient, with their accompanying family member, were explained about the purpose of the study and written informed consent was taken. Information was collected regarding demographic characteristics of patients as well as caregiver, duration of illness, presenting symptoms and their duration, diagnosis according to ICD-10 (diagnosed by psychiatrist), and duration of treatment. After that researcher himself introduced the mini-international neuropsychiatric interview (M.l.N.l. 7.02), Brief psychiatric rating scale (BPRS) and young's mania rating scale (YMRS), to diagnose severity of mental illness. WHO Encounter Pathways introduced after that. Information has taken from patient primary care giver in single meeting only. It took approximate 45 minutes to collect data from each participant. At the end of data collection queries of each participants have been answered.

Data analysis

Data entered daily on excel sheet, recorded and scores were allocated for each item. The entries were checked for any errors. Data taken from all selected participants (123) analysed.

Data were analyzed using statistical package for the social sciences (SPSS) version 20. Descriptive statistics such as frequencies, percentages, is calculated. In inferential statistics, Pearson Chi^2, used. For statistical significance, p value of <0.05 was considered.

RESULTS

Sample characteristics

The mean age of the patient was 31.46±9.39 years, among them 65.9% were males, and 34.1% were females. 49.6% were single, 44.7% were married. The mean age of caregivers was 42.30±10.9 years, 52.0% were male and 48.0% female. 79.7% of caregivers were married, and 15.4% of caregivers were single while 4.9% of caregivers widows. 31.7% of caregivers were graduates while 19.5% of caregivers secondary education and illiterate each, and 4.1% were professional. 37.4% of caregiver was employed that is skilled worker and shop and market sales, workers, skilled agricultural and fishery workers, plant and machine operators, craft worker, while 17.0% caregiver was technician, legislators, senior officials, and manager, and 33.3% of caregivers were unemployed, 12.2% of caregiver was clerk.

The majority of 58.5% of caregivers had monthly family income ranging from rupees 6327-18949/ month. 32.8% of caregivers belonged to lower-middle socioeconomic status while 22.0% of caregivers belongs to upper-middle socioeconomic status, and 5.7% of belonged to upper socioeconomic status. Out of the 123, 65.9% were from a rural area and while 34.1% belonged to an urban area.

Table 1 shows demographic characteristics and frequency of visiting faith healer with respect to various demographic characteristics of patients. Majority of patients contacted faith healer as their first contact to treat mental illness from 18-38 years. 7 patients >48 years visited faith healer after approaching psychiatrist. Majority of male and female patients approached faith-healer at first to treat mental illness. Majority of the patients were single and they firstly contacted faith healer after the onset of the mental illness. 55 participants were married and out of married participants majority visited faith healer at first.

Table 1: Frequency of the visiting faith healer with respect to demographic characteristics of patients (n=123).

Demographical characteristics	Total	Never visited faith healer	Psychiatrist to faith healer	First contacted faith healer
Age in years				
18-28	59	9	6	44
29-38	39	4	6	29
39-48	13	2	3	8
>48	12	2	7	3
Gender				
Male	81	11	11	59
Female	42	6	11	25
Marital status				
Single	61	6	7	48

Continued.

Demographical characteristics	Total	Never visited faith healer	Psychiatrist to faith healer	First contacted faith healer
Married	55	10	12	33
Widow	4	0	2	2
Divorced	3	1	1	1
Education status				
Illiterate	9	1	2	6
Primary	4	1	1	2
8th	14	1	1	12
10th	57	6	12	39
12th	7	0	1	6
Graduate	29	8	5	16
Professional	3	0	0	3
Occupation				
Students	25	3	3	19
Unemployed	38	6	12	20
Elementary	2	1	0	1
Skilled workers and shop and market sales, workers, skilled agricultural and fishery workers, plant and machine operators	39	4	5	30
Craft worker	10	0	1	9
Technician, legislators, senior officials and managers	9	3	1	5
Occupation status				
Working	55	7	9	39
Not working	68	10	13	45
Monthly family income (Rs)				
<6,323	4	1	1	2
6,327-18949	72	8	10	54
18,953-31589	26	2	7	17
31,591-47,262	15	4	3	8
47,266-63,178	1	1	0	0
63,182-126,356	1	0	1	0
>126,360	1	1	0	0
Socio-economic status				
Upper	8	2	5	1
Upper middle	26	6	2	18
Upper lower	38	4	7	27
Lower middle	36	4	3	29
Lower	15	1	5	9
Residence				
Urban	42	7	7	28
Rural	81	10	15	56
Diagnosis				
Schizophrenia	69	7	15	47
BPAD	22	4	5	13
Mania	21	5	0	16
BPAD with psychosis	4	0	1	3
Mania with psychosis	7	1	1	5

Majority of participants visited faith healer who have education till 10th standard. 30 participants who were skill workers visited faith healers at first contact. 20 unemployed visited faith healers at first and 12 visited after taking treatment from psychiatrist. Majority 45 participants who were not currently working approach faith healer firstly to seek treatment for mental illness. Majority 54 participants had monthly income 6,327-18949 visited faith healer at onset of the symptoms. Majority 56 participants from rural area visited faith healer at first and 15 visited after approaching psychiatrist. Majority of

participants had schizophrenia and 56 approached faith healers firstly to cure symptoms.

Table 2 shows frequency and percentage distribution of type of Faith healers approached for the treatment of mental illness. 58.53% approached Priest, 68.29% participants approached Muslim leader, 9.75% to Christian leader and 50.40% to tantric/ojjha. Individual participants had visited more than 1 faith healer.

Table 2: Frequency and percentage distribution of type of faith healers approached for the treatment of mental illness (n=123).

Faith healer	f	%
Priest	72	58.53
Muslim leader	84	68.29
Christian leader	12	9.75
Tantric/Ojjha	62	50.40

Table 3 shows frequency and percentage distribution of duration of contact with faith healers. 47.2% participants visited faithhealer for <6 months, 21.1% visited faith healers for 6-12 months and 17.9% visited faith-healer beyond 1 year.

Table 4 shows frequency and percentage distribution of pattern of switchover of patients to faith healers. 30% revisited faith healers. 18% participants approached faith healer after visiting psychiatrist. 29.2% participants approached faith healer after approacher practitioner other than psychiatrist.

Table 3: Frequency and percentage distribution of duration of contact with faith healers (n=123).

Duration of contact with faith healers	1-6 months	6 months-12 months	>12 months
Number of patients	58 (47.2%)	26 (21.1%)	22 (17.9%)

Out of 123, 17 never visited faith healer, means 106 participants visited faith healer. Out of 106, 11 participants not visited faith healer once approaching psychiatrist (Table 4).

Table 4: Frequency and percentage distribution of pattern of switchover of patients to faith healers (N=123).

Switch over to faith healer	From faith healer to faith healer	From psychiatrist to faith healer	From others to faith healer
Number of patients	37 (30%)	22 (18%)	36 (29.2%)

Others: general practitioner, AYUSH, community health nurse

From Table 5, it can be observed that about 27 of urban cases and 56 of rural cases had visited faith healers before seeking medical help and overall; 8 and 15 of urban versus rural cases were visiting faith healers after seeking medical help. While 7 and 10 urban versus rural cases not visited healers during course of treatment.

Table 5: The patterns of help seeking in rural versus urban population (in the folk therapy group) (n=123).

Parameters	Urban	Rural	Chi square	P value
Time of healer visit				
Before approaching psychiatrist	27	56	0.49	0.7
After approaching psychiatrist	8	15		
Never visited	7	10		
Frequency of visit				
Never visited	7	10	0.47	0.7
Visited once	27	56		
More than one	8	15		
Visited with				
Self	0	7	4.63	0.2
Family	35	63		
Others	7	11		

As regards the number of healers visited, about 56 of rural cases and 27 of urban cases had visited only one healer. However, about 8 of rural cases and 15 of urban cases had visited more than one healer.

About 7 of rural cases had visited healers by themselves, whereas the majority of cases were visiting healers accompanied by family members. An overall 63 and 35 of rural versus urban population were accompanied by family members, and 1 of rural population was accompanied by other members (friends and neighbors).

No significant difference was detected as regards treatment given by healer according to residence.

DISCUSSION

India is a low middle-income country where two-thirds of the population dwell in rural areas, with limited psychiatric services concentrated in metropolitan and urban areas. Generally, faith healers, local practitioners and general medical physicians within the community act as first healthcare providers (HCPs) to most of the patients. Centuries-old beliefs regarding spiritual and superstitious causation of psychotic disorders further promote help-seeking from these faith healers/local practitioners, where a lot of crucial time is lost.[16]

In developing countries, people with mental illness would like to go to faith healers as they are the 1st choice of carer

for their patients followed by the general practitioner and psychiatrist. In developing countries, it is very important to involve traditional healers to bridge the gap between mental health needs and available services, as they are easily available, accessible, and acceptable to the individuals of the community.[17]

In our study 41.5% of patients firstly approached faith healers, 43.9% other medical professionals, general practitioner and community health office and 14.6% only approached psychiatry. Jilani et al found that 64.3% contacted faith healers followed by contacts with local practitioners 23.5% and general medical practitioners (12.2%) and psychiatrist (6.3%).[18] Naik et al, faith-healers was the initial contact persons for a majority of patients in study center I (56%) and study center II (64%).[17] Jeyagurunathan et al also reported that majority of participants had their first contact with general practitioner 36.0%, psychiatric care 21.8%, and rest taken religious/traditional treatment.[19] The difference in findings can be due to cultural beliefs and differences in the attitude of people.

To treat mental illness partients visit various faith healers. In our study 58.53% approached priest, 68.29% participants approached muslim leader, 9.75% to Christian leader and 50.40% to tantric/ojjha. Sharma et al reported that people visited to Hanumanji, dasha mata, Allah, and Chichagad maharaj, Bhathiji maharaj, Ramdev Pir to treat mental illness.[10] Kishore et al reported that in India 25% people believe that mental illness could be removed by Tantric/Ojha/Samana/Priest.[20] Salve et al found that 12% patient preferred treatment from tantric/Ojha for treatment of mental illness.[21]

This study found that 47.2% participants visited faith healer for <6 months, 21.1% visited faith healers for 6-12 months and 17.9% visited faith-healer beyond 1 year. In present study in regards to switchover to treatment 30% revisited faith healers. 18% participants approached faith healer after visiting psychiatrist. 29.2% participants approached faith healer after approacher practitioner other than psychiatrist. Amin et al found that 80% participants visited faith healers. Out of them 56% visited before approaching psychiatrist, 36% took treatment from faith healer along with psychiatric treatment and 8% visited faith healer after approaching psychiatrist.[22] Jalal et al found that 57% prefer to continue with the psychiatrist, and 34% would visit both, and only 5% would prefer faith healer.[23] Upadhaya et al found 47% patients firstly approach faith healer to seek treatment for mental illness, 20% approached faith healers after seeking treatment from general medical practitioner.[24]

Limitations

The data in this kind of study were only be collected retrospectively and, therefore, rely largely on recall precision. These findings on pathways to care and duration of untreated psychosis is predominantly based on patients' self-report. Apart from recall errors, also selective reporting can be a problem.

CONCLUSION

The first care provider plays a significant role in the direction of the path taken by the patient to reach a mental health professional. Understanding the pathway to mental health care provides information about health services use among patients and helps to determine the care delay in psychiatry. As in many sub-Indian areas, a large proportion of the Indian population went to see traditional healers in the first place for their mental health problems. The main reason for delayed consultation among the studied patients was lack of awareness about signs and symptoms of severe mental illness, as well as social beliefs about the origins of mental illness calling for a strengthening of public awareness and education.

Recommendations

Similar studies can be considered in different demographic and geographical areas to yield area-specific findings to plan further development of mental health services.

To develop modules for the education of community health professionals and also for the public and test their efficacy through research.

This finding can be used in planning mental health care services.

ACKNOWLEDGEMENTS

Authors would like to thank Ms. Denny Marrium, Dr. Snehil, Dr. Jaswant, Mr. Sanjay, and Murali Narayanamurthy.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Kudi SR, Khakha DC, Ajesh KTK, Deb KS, Lata K, Kumar H. Role of faith healers in the treatment of severe mental illness in India. Int J Community Med Public Health 2023;10:4774-80.