Collaborating with Traditional and Faith Healers in Mental Health: A Public Health Approach

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Abstract

There is an increasing interest in collaboration between biomedical services and traditional and faith healers for mental health care. In this article, we briefly outline recent research in this area and discuss some of the challenges to collaboration, particularly in relation to the care of people living with serious mental illness (SMI). Several approaches to collaborative mental health care have been attempted primarily in Africa, but also in Asia. Challenges to these collaborations include mutual distrust, power differentials, conceptual and methodological problems, and a lack of organizational support and resources. Importantly, the perspectives of people with lived experiences of mental illness are seldom considered. Research suggests that "bottom-up" approaches using community engagement, dialogue, and mutual learning may enable more effective and sustainable collaboration. We identify a need for greater involvement of people with lived experience of mental illness and their families and consider the potential of a public mental health approach in which collaborations are embedded within communities and existing support structures and accompanied by policies and interventions to address social as well as spiritual and medical needs.

Keywords: *Collaboration, help-seeking, low- and middle-income countries, mental health, traditional and faith healing*

Introduction

There is an increasing interest in collaboration between biomedical services and traditional and faith healers (TFHs) for mental health care.[1] It is well-known that help-seeking for mental illness is pluralistic, and TFHs are viewed by many as a valued community resource, which may help fill the "treatment gap" in low- and middle-income countries (LMICs).[2] While TFH may help address psychosocial, cultural, and spiritual needs, concerns regarding harmful practices, such as chaining and enforced fasting, have also led to calls for regulation and oversight.[3,4] The World Health Organization advocates for consideration of the role of TFH in the development of community mental health, "capitalizing on the positive aspects of the care and support they provide while at the same time working to stop the use of coercive practices"[5] (p191). In this article, we briefly outline the research to date, focusing on recent studies, and discuss some of the challenges to collaboration, particularly in relation to the care of people living with SMI. To address these, we draw out lessons for collaboration between TFH and formal mental health services which take a dialogic "bottom-up" approach,[6] involving people with lived experience, families, communities, and healers, as well as health workers.

Collaboration with Traditional and Faith Healers in Mental Health

In many settings, psychiatric services are scarce or unaffordable. It is estimated that approximately three-quarters of people living with schizophrenic disorders in LMIC do not receive medical treatment.[7] Nonetheless, even as formal mental health services have expanded in some contexts, patients and families are likely to continue seeking traditional and faith healing.[4,8] Reasons proposed for the enduring popularity of TFH include their ability to engage with and address shared spiritual and cultural beliefs, their relative accessibility and affordability, and the availability of social, emotional, and

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psychological support.[9] In light of this, many people have called for greater collaboration with TFH.[4,9,10]

Several approaches to collaborative care have been attempted primarily in Africa, but also in Asia,[1] with many involving provisions of biomedical treatment within healing facilities. For example, in the COSIMPO trial in Ghana and Nigeria, one of the few trials conducted in this area, community health workers (CHWs), conducted visits to TFH to provide assessment and medication and monitor harmful practices.[11] In Gujarat, India, biomedical treatment was provided at an Islamic shrine (*dargah*).[12] In Ghana, collaboration with healers has received official support within mental health policy. Coupled with an expansion of community mental health services, this has increased visits to traditional and faith-based healing sites by mental health workers.[13] In Indonesia, there are various pioneering practitioners combining practices and rituals from Islam, Hinduism, and Catholicism into mental health care.[14] In most of these endeavors, the aim is to provide holistic care and prevent human rights abuses.

Challenges to Collaboration

Despite the promise suggested by these collaborations, studies have repeatedly identified several challenges. Predominant among these is a lack of trust between biomedical practitioners and TFH.[15] In many contexts, this distrust has roots in colonial histories where traditional practitioners were dismissed as "witch doctors" and their expertise devalued and, in some cases, criminalized.[16] Health workers often have limited first-hand knowledge of healers' practices and may view them as "backward" and superstitious, particularly healers whose practices do not align with religious orthodoxy.[17] In most interventions, training is unidirectional from medical "experts" to healers, rather than a mutual learning process. Indeed, studies have shown that training alone is insufficient to change practices, particularly in the long term.[18] Given that biomedical services receive state backing and institutional support, healers are acutely aware of power differentials and can fear the loss of their livelihood and authority.[19]

Efforts at developing interventions with TFH can also suffer from conceptual and methodological problems, including a lack of clarity regarding what exactly is meant by "traditional" or "faith" healing and misleading assumptions regarding their use. Numerous dynamic and diverse practices globally are subsumed into the rubric of "traditional and faith healing."[20] A failure to recognize and engage with this diversity and the rich variety of cosmologies, meanings, and healing practices within and between countries risks de-contextualizing and erasing the very sociocultural realities that such interventions aim to consider.[20] There are also concerns that in some settings, collaborations may reinforce normative morality and associated harmful practices among healers, which may further disadvantage groups such as women.[21]

Lack of wider organizational support and resources within health facilities such as staff time, transport, and reliable supplies of medication, as well as supervision and support, can also make collaborations difficult to sustain. Furthermore, even where drugs are available and free of charge, user dissatisfaction with psychotropic medication in both high- and low-income countries leads to nonadherence among a significant proportion of patients.[22,23] In addition, the quality of care in many psychiatric institutions is often very poor, with few specialists and limited services to address psychosocial needs.[4,24] Coercion and abuse are also widespread within these institutions.[3]

Most importantly, many interventions do not sufficiently engage with the perspectives of people with lived experiences of mental illness, who have most to suffer from harmful or negligent practices. It is primarily family caregivers who make choices about where and how to seek help which may not align with the preferences of the individual affected.[25] Stigma and misconceptions about the ability of people living with mental health conditions to make choices may also mean that their viewpoints are ignored.

Previous Research and Lessons Learned

Despite these complexities, studies suggest several approaches to address these. First, the mental health knowledge gap between healers and mental health workers may be less than assumed.[26] A study by Abbo in Uganda[27] revealed that signs and symptoms described by traditional healers were very similar to those used by psychiatrists to diagnose psychosis, suggesting the potential areas of convergence.[2] Furthermore, many healers share a desire to improve the health and well-being of their patients and welcome additional support, for example, to manage difficult symptoms such as agitation, restlessness, and aggression, as well as to prevent harm to their patients, families, and others using their services.[13,28]

Second, the conceptualization of what is considered a successful outcome may differ between mental health practitioners and people with lived experience. For example, research outcomes are primarily measured using standardized scales such as the Positive and Negative Syndrome Scale, providing a narrow clinical view of recovery. However, for people using TFH, the benefits of treatment and what is considered recovery may be experienced from a more holistic perspective, in which the process of healing as well as the outcome is important.[29] This includes varied social, psychological, and phenomenological aspects, such as social support within religious communities, sensory and embodied effects of healing practices and rituals, the resolution of spiritual problems, for example, through confession and forgiveness, and the opportunity to engage in valued spiritual practices, such as prayer, dance, trance, and meditation.[29-31] Religious and spiritual beliefs and rituals can also bring meaning, hope and comfort for many.

Given this, studies have proposed a bottom-up approach to collaboration characterized by dialogue and mutual learning. Veling *et al*. report on a study in KwaZulu-Natal, South Africa, which set out to establish a collaboration with healers to increase access to psychiatric treatment for people with possible psychosis. They developed a four-pronged strategy which consisted of engaging with community leadership; establishing a community advisory board; developing a mutual understanding of concepts of mental illness with traditional health practitioners (THPs); and developing a method for screening and referral by THPs of people with suspected psychosis. THPs were asked to refer clients who they perceived as "disturbed" to the research team. The "disturbed" terminology was chosen during preparatory discussions as it translated an isiZulu term used by THPs to describe a syndrome that resembled the clinical construct of psychotic disorder. They found that not only were THPs willing to engage in their study but they were also able to reliably identify potential "caseness" in more than half of their clients.[26] The authors conclude that the key to the success of the collaboration was building trust through acknowledging local authorities, mutual respect for health constructs, taking time to find common ground, and adapting procedures to sociocultural norms.[26]

A similar approach was adopted in Ethiopia with Orthodox Christian practitioners. The research team instituted a series of consultative workshops with priests, holy water attendants, and mental health practitioners using a participatory "transformative learning" approach to encourage mutual learning and critical reflection. Facilitators intentionally used techniques to reduce power hierarchies between the participants during these dialogues. Topics discussed included a comparison of explanatory models, the use of restraints, stigma, and segregation, and possible approaches to address this. The participants together decided on a collaborative approach, in which a clinic was established close to two churches to provide psychiatric consultation and free biomedical treatment, while patients also continued to receive treatment with holy water.[32,33] The Transform study, led by the authors of this article, brings together TFH and CHWs to develop a collaborative care pathway to improve access to biomedical treatment for SMI. The intervention is grounded in engagement with key stakeholders in deprived urban communities in Bangladesh and Nigeria and ethnographic research to understand stakeholder knowledge, experience, and values and build trust and mutual learning. Training is being codeveloped with healers and health workers.[34]

While these bottom-up approaches have led to promising results, what is still missing is the active participation of people with lived experience of mental illness, as well as consideration of their broader social and economic needs. Globally, people living with SMI face significant social, structural, and economic disadvantages, which impact on their recovery whatever the source of treatment.[24] As acknowledged within social psychiatry,[35] addressing stigma and discrimination and improving access to supportive, meaningful relationships, safe secure housing, and livelihoods are vital to recovery, as much as relief of symptoms. This will require a public health "whole systems" approach which goes beyond formal and informal health sectors and a focus on treating the individual, to taking action to address poverty and inequality and the social and structural determinants of mental ill-health.[36,37]

Recommendations

Help-seeking for mental illness is dynamic and diverse with common concurrent or sequential use of various forms of treatment in the search for a cure. How collaborations will work in practice will, thus, vary according to the uniqueness of each setting; yet, common factors supporting successful collaborations can be identified. Respectful dialogue and mutual learning not only between healers and health workers, but also caregivers and people with lived experience, can identify shared understandings, as well as opportunities for questioning, discovery, and transformative change.[33,38] Yet, efforts to establish collaborations to improve access to biomedical mental health care may have limited success if they fail to address entrenched power hierarchies and health system challenges as well as engage with the values and needs of people with lived experience and their families. This calls for a public mental health approach, in which such collaborations are embedded within communities and supported by policies and interventions to address social as well as spiritual and medical needs.[37]

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Conflicts of interest

There are no conflicts of interest.

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