



A comparative study on the quality of life of psychiatric patients and their caregivers visiting faith healers, and those not visiting faith healers

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ABSTRACT

Aim: To assess and compare the Quality of Life among Patients and Caregivers visiting faith healers and those not visiting faith healers in psychotic as well as neurotic patients.

Materials & Methods: Total 100 pairs (patient and their respective caregiver) were enrolled in the study. The pattern of presentation and the quality of life of patients and caregivers was assessed. The enrolled subjects and their caregivers as per the criteria, were divided into 2 groups- Group 1 consisting of those who visited faith healers and Group 2 consisting of those who didn't visit faith healers. All subjects then were subjected independently to the Supernatural Attitude Questionnaire and WHOQoL-BREF Punjabi scale.

Results: We found that QoL scores across the different domains followed a pattern with respect to the Group 1 and Group 2 patients such as Group 2 patients having higher QoL scores in Domain 4. Similarly, the same pattern was followed in the QoL scores of the caregivers of Group 1 and Group 2 patients with caregivers of Group 2 patients having a higher QoL as compared to caregivers of Group 1 patients.

Conclusion: The study showed that Quality of life of patients and their caregivers who believed in faith healers and those who didn't could be compared and the insights from them used to improve adherence among various psychiatric patients.

Keywords: Faith healers; Quality of life; caregivers;

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INTRODUCTION

According to the World Health Organization (WHO), mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and

is able to make a contribution to his or her community (1). Previously, it was underestimated and undervalued in terms of healthcare. But with the passage of time, it has gained importance. Mental illnesses place a significant burden on the individual, family



and community due to their associated difficulty, social dysfunction along with poor adherence to treatment. These burdens can comprise of emotional burden such as fear, sadness, guilt, anger, loss, stigma which sometimes also arise due to medical costs. There are various types of mental disorders which as per some of the cultures are believed to be due to some supernatural invisible forces (2). There are several potential reasons as to why despite increase in occurrence of mental illnesses, there is still significantly less participation in engagement of treatment. Amongst the most probable explanations, one is that patients with mental illness or those who are substance abusers are disabled and paralyzed, and are hence unable to seek the required services. Another reason considered is stigma which acts as a key barrier to successful treatment engagement leading to significant mortality and disability (3).

When it comes to the prevention and treatment of mental illness, people seek that approach which is appropriate to their society and culture. Many cultures believed mental illnesses to be widely caused by supernatural forces such as spiritual or evil possession and therefore faith healing by various traditional health practitioners started being practiced as a way of curing these diseases. Sometimes it was also found to be effective and beneficial to the patients visiting them. Faith healing is a concept in which it is considered that some religious rituals or prayers as performed in religions can bring about healing, because according to the beliefs these can bring forth a divine presence and power towards correcting that disease or disability. It is characterized by physical extraction of disease objects, through charms and amulets, counter magic, talisman, prayers, witchcraft and temple healing (4). Therefore, when some people face a serious debilitating illness for which they are unable to find a cure, they may consider supernatural healing or faith healing as the only way to get rid of their illness and improve their health.

For many people who are troubled with emotional distress or common mental problems going to the faith healer might hold an importance distinct to which the healing

which is based on medicines can provide (5). There are various cultural beliefs and reasons regarding management of mental illness by faith healing and for these, various issues have to be addressed. Assessment of quality of life of patients and caregivers is considered to observe differences in Quality of Life, if any, between those who go to the faith-healers and those who do not. Quality of life is a concept which stresses the psychosocial aspects of diseases. We can use it in various ways such as for assessing of health needs of populations or for allocating health resources and is a helpful tool in measuring the disease outcome and well-being of the patient (6). Understanding the factors that are related to Quality of life in various mentally disabled patients is crucial for the development of public health policies which can ultimately improve overall health outcomes.

Thus the present study was conducted to assess and compare the Quality of Life among patients and caregivers visiting faith healers and those not visiting faith healers. A sub-categorization of the patients based on their diagnosis as either psychotic and neurotic was also done and thus the Quality of Life assessed was also used to note any significant differences in the QOL based on the diagnosis.

MATERIALS AND METHODS

The current study was a cross-sectional study. The subjects registering as outdoor/indoor patients and their respective primary caregivers reporting to the department of psychiatry, GGSMCH, Faridkot, were enrolled for the study. A total of 100 patients and their respective caregivers who fulfilled the inclusion and exclusion criteria were enrolled in a period of 1 year. A detailed written informed consent was taken from the patient and caregiver.

A thorough assessment was done including the history and mental status examination (MSE) of the patient. The diagnosis was independently confirmed by the consultant of the department as per the ICD-10 criteria. All the information pertaining to socio-demographic profile, illness related variables like history of illness and mental status examination (MSE) was documented in the



pre- validated structured Psychiatric Evaluation Proforma.

Routine investigations were done as per the need for inclusion and exclusion criteria, including opinion from other specialities. The enrolled Subjects and their caregivers, after fulfilling the inclusion criteria, were divided into 2 groups-

Group 1, being those enrolled subjects and their caregivers who visited faith-healers and Group 2, being those enrolled subjects and their caregivers who did not visit faith-healers. The groups were each subdivided into 2 subgroups 'a' and 'b', with 'a' subgroup denoting Neurotic subjects and 'b' subgroup denoting Psychotic subjects. All subjects were subjected to the WHOQoL-BREF Punjabi scale to assess the quality of life of the patients and caregivers in both the groups. They were also given the Supernatural Attitude questionnaire in order to gauge their beliefs on the supernatural and faith-healing. The assessment and comparison of pattern of presentation of the two groups with comparison of Quality of lives in the two groups, along with the Quality of Life among patients of Psychotic and Neurotic disorders was conducted using appropriate statistical analysis.

INCLUSION CRITERIA FOR PATIENTS

For all patients, inclusion criteria were:

Psychiatric OPD/IPD patients having any of the following psychiatric disorders:

- Psychotic Disorders (F20-29)
- Mood Disorders (F30-39)
- Neurotic, Stress-related and Somatoform disorders (F40-48)
- Patients belonging to the age group 18-60 years.
- Patients providing a written informed consent for participation in the study.

EXCLUSION CRITERIA FOR PATIENTS

For all patients, exclusion criteria were:

- Patients belonging to ages below 18 years or above 60 years.
- Current or previous history of neurological illness like Parkinson's

disease, brain tumours and SOLs, stroke, etc.

- Organic brain syndrome like dementia, meningitis, encephalitis, encephalopathy, frontal lobe lesions, etc.
- Severe medical ailment like cardiac, respiratory, renal and other medical illnesses that may interfere with the evaluation.
- Head Injury.
- Mental Retardation.

INCLUSION CRITERIA FOR CAREGIVERS

- For all caregivers, inclusion criteria were:
- For the purpose of the study, primary caregivers staying with the patient for a minimum duration of 6 months were included.
- Primary caregiver taking care of patient's daily needs and demands, supervising medication and coordinating with the treating team.
- Primary caregiver belonging to the age group 18-60 years.
- Primary caregiver providing a written informed consent for participation in the study.

EXCLUSION CRITERIA FOR CAREGIVERS

For all caregivers, exclusion criteria were:

- Caregivers belonging to ages below 18 years or above 60 years.
- Caregivers having an active psychiatric illness.
- Current or previous history of neurological illness like Parkinson's disease, brain tumours and SOLs, stroke, etc.
- Organic brain syndrome like dementia, meningitis, encephalitis, encephalopathy, frontal lobe lesions, etc.
- Severe medical ailment like cardiac, respiratory, renal and other medical illnesses that may interfere with the evaluation.
- Head Injury.
- Intellectual Disability.

The data pertaining to clinical details was entered in form of data matrix in Microsoft



Excel software and analyzed using IBM SPSS software version 21.0.

RESULTS

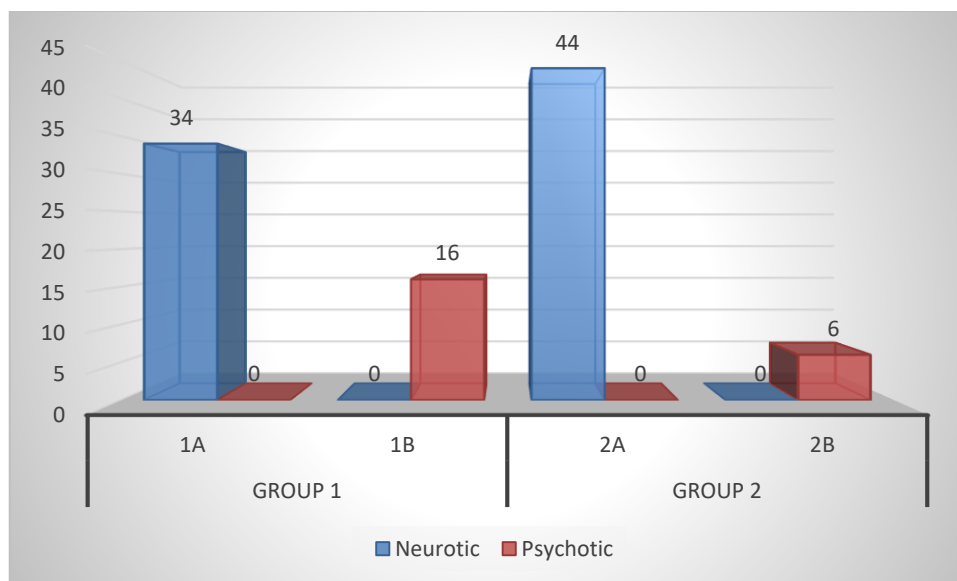


Figure 1: Distribution of study population on the basis of diagnosis

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Table 1: Mean values of various domains assessed by WHOQoL-BREF in patients and caregivers

WHOQOL – PATIENT		group 1		group 2		T	Sig. (2-tailed)	
		Mean	Std. Deviation	Mean	Std. Deviation			
Patients	WHOQOL_D1 (physical)	56	11.466	55.62	11.407	-0.638	0.525	NS
	WHOQOL_D2 (psychological)	54.8	13.479	56.56	11.048	-0.726	0.47	NS
	WHOQOL_D3 (social relationships)	54.56	9.072	55.3	11.372	-0.36	0.72	NS
	WHOQOL_D4 (environmental)	72.18	9.187	76	9.109	-2.088	0.039	S
Caregivers	WHOQOL_D1 (physical)	62.3	7.215	63.54	10.547	-0.686	0.494	NS
	WHOQOL_D2 (psychological)	60.94	8.634	65.02	9.222	-2.284	0.025	S
	WHOQOL_D3 (social relationships)	57.56	7.9	58.74	11.255	-0.607	0.545	NS
	WHOQOL_D4 (environmental)	72.5	11.564	77.32	7.97	-2.427	0.017	S

The results showed that there was no statistically significant difference in the mean value of domain 1, 2 and 3 of Group 1 and Group 2. On statistical analysis ($p= 0.039$), a statistically significant difference was found in the mean value of domain 4 of Group 1 and Group 2.

The mean values for various domains assessed by WHOQOL in the caregivers in group 1 and Group 2 and their subgroups 1a,1b,2a, and 2b was assessed by WHOQOL – BREF. The results showed that a statistically significant difference was found in the mean value of domain 4 of Group 1 and Group 2.



Table 2: Comparison of mean values of various domains assessed by WHOQOL-BREF in Group 1 of patients with subgroup 1a and 1b.

		Sub Group 1a	Sub Group 1b	Mean difference	P value
Patients	D1	54.91+12.02	58.31+10.13	-3.4	0.763
	D2	53.21+13.51	58.19+13.18	-4.98	0.545
	D3	53.24+5.54	57.38+13.74	-4.14	0.547
	D4	74.29+8.27	67.69+9.67	6.6	0.066
Caregivers	D1	61.94+7.36	63.06+7.06	-1.12	0.975
	D2	59.62+8.00	63.75+9.49	-4.132	0.405
	D3	58.21+7.90	56.19+7.96	2.018	0.904
	D4	72.00+12.06	73.56+10.71	-1.56	0.955

The results showed that the mean difference values of various domains assessed by WHOQoL-BREF in Subgroup 1a of patients when compared to subgroup 1b in domain 1,2,3 and 4 was non-significant. The mean difference values of various domains assessed by WHOQoL-BREF in Subgroup 1a of caregivers when compared to subgroup 1b in domain 1,2,3 and 4 was non-significant. (Table,Figure 10)

DISCUSSION

The present study was carried out in a tertiary care hospital, Guru Gobind Singh Medical College and Hospital, Faridkot to assess the Quality of life of Psychiatric patients and caregivers visiting faith-healers and those not visiting faith-healers and further comparing the quality of life of neurotic and psychotic patients.

From the results of the supernatural questionnaire, most of the Group 1 and Group 2 patients didn't believe that their mental illness was due to witchcraft or influenced by evil spirits with Group 2 patients being more disbelieving. Most of the patients from group 1 also believed that their mental illness was caused by wrong deeds done in previous births as compared to patients from Group 2. In the present study, it was observed that on an average, psychotic patients believed more in supernatural occurrences, ghosts, witchcraft, faith-healing, exorcism and prayers. These observations are corroborated from the findings from the study by Razali SM et al (7), where it was found that supernatural explanations such as witchcraft/black magic

were most commonly present in psychotic illness.

In the present study, WHOQoL-BREF mean score for Group 1 patients in Domain 1 (physical health) was 56.00 ± 11.466 , WHOQoL-BREF mean score for Group 1 patients in Domain 2 (psychological health) was 54.80 ± 13.47 , in Domain 3 (social relationships) 54.56 ± 9.072 and in Domain 4 (environmental domain) WHOQoL mean score was 72.18 ± 9.187 . The WHOQoL-BREF mean score of Group 2 patients in Domains 1,2,3 and 4 was 55.62 ± 11.407 , 56.56 ± 11.048 , 55.30 ± 11.372 and 76.00 ± 9.109 respectively.

Though there are studies conducted where QoL assessment is done for various mental illnesses but for the purposes of the present study, subjects and their caregivers were focused according to their visit to FH (Table1). In the study carried out by Akvardar Y et al(8), healthier subjects were taken as a control and it was found that QoL of psychiatric patients was lower than healthy subjects. In the study by Grover S et al (9), OCD (neurotic) patients were taken as per ICD-10 diagnosis and their QoL scores were Domain 1 (61.16 ± 14.63), Domain 2(57.94 ± 16.58), Domain 3(58.86 ± 19.01) and in Domain 4(55.6 ± 16.06), caregivers in this study had lower QoL score.

In the present study, QoL scores across the different domains followed a pattern with respect to the Group 1 and Group 2 patients with Group 2 patients having higher QoL scores as compared to the Group 1 patients which was most prominent in scores in Domain 4. Similarly, the same pattern was followed in the QoL scores of the caregivers of



Group 1 and Group 2 patients with Caregivers of Group 2 patients having a higher QoL as compared to Caregivers of Group 1 patients (Table 1).

Thus, it can be summarised that the Quality of Life of those patients and their caregivers who don't go to the faith-healers is generally higher than their counterparts who go to the faith-healers.

Furthermore, It was observed that the Quality of Life of the caregivers was higher than the patients in their care. In the study conducted by Ndikuno C et al (10), it was found that 57.3% of the caregivers had a poor QoL. Each domain had a score found for physical health 52.20 ± 15.90 , Psychological 55.97 ± 15.94 , Social relationship 51.64 ± 21.08 and Environmental 50.9 ± 17.35 . This poor QoL might be due to the task of caregiving which can be because of caregiving hours, their environment and attention.

WHOQoL-BREF for the patients visiting FH from subgroup 1a in Domain 1(physical) mean score was 54.91 ± 12.029 and subgroup 1b had 58.31 ± 10.137 (Table2). The study by Costa R et al (11), showed that total minutes of physical activity was a significant predictor of physical domain of QoL ($p=0.004$)

For the Group 1a patients in Domain 2(psychological), mean score was 53.21 ± 13.510 and for Group 1b patients it was 58.19 ± 13.187 (Table 2). In the study by Akvardar Y et al(8), mean domain score of Domain 2 for Schizophrenia patients was $(12.22 \pm 3.16)/20$ and for BPAD patients had $(13.95 \pm 1.67)/20$. The results in this study shows that BPAD patients had significantly higher scores than schizophrenia group.

The domain 3 score (social relationship) in the Group 1a patient 53.24 ± 5.54 an Group 1b patients have 57.38 ± 13.740 . In the study by Akvardar Y et al(8), the patients with Schizophrenia showed significantly lower scores in social relationship domain.

For environmental domain (Domain 4) the mean domain score of subgroup 1a and subgroup 1b is 74.29 ± 8.27 and 67.69 ± 9.67 respectively. In the study by Akvardar Y et al (8), the psychotic patients had WHOQoL-BREF mean domain score as $12.72 \pm 3.77/20$ wherein

the schizophrenia patients had the lowest score.

In the present study, in patients going to the faith-healers, the QoL of psychotic patients was significantly higher in all the domains except Domain 4 (Environmental) where it was significantly lower. Thus, it can be inferred that psychotic patients believe that their Quality of Life is improved after visiting faith-healers. This could be because of the general tendency of psychotic patients of coming from less secure financial environments and being more prone to violence and self-harm thus resulting in impaired personal safety.

In the present study, in caregivers of the patients going to the faith-healers, the QoL of the caregivers didn't follow a general trend while differentiating between the caregivers on the basis of the diagnosis of the patients in their care (neurotic or psychotic) and thus no conclusion could be derived from the QoL of the caregivers. This could be because of less intensity in the shared beliefs between the caregivers and their patients.

CONCLUSION

As per the responses to the Supernatural Attitude Questionnaire, majority of the patients visiting faith-healers believed in witchcraft/black magic, Supernatural shadow influence, evil spirits, wrong deeds done in previous births when compared with the responses of the patients not visiting faith-healers. Patients from psychotic group were more prone to have supernatural beliefs as compared with patients from neurotic group. Introducing the WHOQoL-BREF scores, there was a general trend that quality of life of patients as well as their caregivers who were not visiting faith-healers was better than their counterparts who were visiting faith-healers which could be mainly because of early treatment adherence, more compliance as well as stronger belief that their health could be improved by treatment.

The QoL scores of psychotic patients who were visiting faith-healers was significantly better than the neurotic patients visiting faith-healers in all domains except Domain 4 (Environmental Domain) where it was

significantly worse. This could be because of the general tendency of psychotic patients of coming from less secure financial environments and being more prone to violence and self-harm thus resulting in impaired personal safety.

LIMITATIONS OF STUDY

If the number of patients in each group been larger, the data could have been generalized. Convenience sampling was done to choose the subjects. The study was hospital-based and it was conducted in a single centre in a treatment seeking population hence, the findings may be underestimations of magico-religious beliefs and practices in the community. Moreover, follow up of patients and caregivers could have been done in order to gauge how or if their beliefs were influenced. The assessment was cross sectional and change in magico-religious beliefs was not assessed longitudinally.

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