

The role of culture and faith healers in the treatment of mood disorders in rural versus urban areas in United Arab Emirates

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Background

Culture plays a major role in healthcare delivery. The majority of mentally ill patients prefer to attend nonmedical practitioners such as traditional healers. Practical clinical application of the research in cultural competency can enable physicians to decide whether folk traditional healing practices are harmful or benign. Like other cultures, the Arab culture transmits a number of beliefs, which are locally shared, although considered unlikely or even objectively disprovable by others outside the culture.

Aim

In this paper, we examine the view of mood disorders as seen by the patients and the role of faith healers in the treatment of such disorders with regard to urban versus rural areas.

Patients and methods

We assessed 416 United Arab Emirates national patients with Bipolar Affective Disorder (BAD) (279 urban and 137 rural) after confirmation of diagnosis with *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revised. These patients underwent Mini International Neuropsychiatric Interview, Help-Seeking Pattern, and Experience Questionnaire, which stressed on the attitude of the patient toward psychiatric illness, belief in healer management, line and result of traditional management, and the frequency of seeking traditional healers.

Results

The current study showed that about 60% of patients of both populations had visited faith healers before seeking medical services. Rural population usually shows no commitment to treatment and resorts to traditional therapy more often compared with the urban population (24 vs. 17.5% and 33.7 vs. 19%, respectively). Rural patients were more credulous toward faith management compared with urban patients (35.1 and 18.4%, respectively), whereas a merge of the two beliefs, psychiatric and faith management, was more common in the urban population than in the rural population (31.6% compared with 9.6%, respectively). An overall 39.5% of the families of urban cases and 9.6% of the families of rural cases considered mental illness a real disease as any other organic disease. In faith healing, different diagnoses, which included touch, evil eye, witchcraft, and jinn possession, were evenly distributed among patients with varying percentages among rural and urban populations.

Conclusion

This study shows that the majority of patients suffering from mental illness, especially in rural populations, prefer to approach faith healers first, which may delay entry to psychiatric care and thereby negatively impact the prognosis of BAD. Therefore, we should improve the orientation of the general practitioners (GPs) and broaden the destigmatization program about psychiatric disorders, especially mood disorders. This highlights the importance of mental health education, developing a positive collaborative relationship with traditional healers, and highlighting the role of cultural beliefs in both the evaluation and the management of mental disorders.

Keywords:

BAD, cultural beliefs, faith healer, rural versus urban

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Introduction

Culture plays a critical role in healthcare delivery, as people bring into the healthcare field different modes and ways of communication, religious beliefs and commonly held standards, family structures, and health beliefs and practices that affect how they behave and interact with regard to the medical sector.

Culture has been described as an ‘inherited lens through which individuals and communities perceive and

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understand the world that they inhabit, and learn how to live within' (Kleinman, 1997). Physicians may lack the knowledge of health beliefs, attitudes, and practices of diverse populations. Consequently, medical histories, medications and treatment methods, symptoms, and therapeutic interventions may be miscommunicated or misinterpreted as a result of linguistic and cultural barriers. The encounter between the physician and the patient in its basic form can be seen as an interface involving different explanatory models. Failure to bridge the gap between the patient and the physician can result in improper diagnosis, unnecessary testing, misunderstanding of consent, options, and prognosis, and problems with adherence, satisfaction, follow-up, and even the outcomes of such disorders (El-Rufai, 2006). The majority of mentally ill patients prefer to attend nonmedical practitioners such as traditional healers because of the trust in the system, affordability, and ease of the service. This may cause hindrance in asking for psychiatric services and has a prognostic effect (Assad *et al.*, 2015).

Evidence from around the world suggests that a traditional or complementary system of medicine is commonly used by a large number of people with mental illness. Practitioners of traditional medicine in low-income and middle-income countries fill a major gap in mental health service delivery. Treatments used by providers of traditional and complementary systems of medicine, especially traditional and faith healers in low-income and middle-income countries, might sometimes fail to meet widespread understandings of human rights and humane care (Gureg *et al.*, 2015).

Complementary and alternative medicine relates to a broad set of healthcare practices that are not a fundamental component of a country's own convention and not incorporated into the main healthcare system (WHO, 2013). It is hard to generalize the prevalence of the use of traditional and complementary medicine. The difficulty originates partly from the fact that traditional and alternative medicines are popular in different societies and because of the range of practices inherent in every society (Posadzki *et al.*, 2013). Folk illness or culture-bound syndromes can be defined as 'illness treated within the specific context of a particular culture but not thought to fit common modern medical definitions and diagnostic categories'. Although folk illnesses are recognized as authentic syndromes or diagnostic categories by specific ethnic or cultural groups, they are often in stark conflict with mainstream western biomedical models. A physician's challenge lies in trying to learn and understand their

patients' belief models to more effectively diagnose and treat their illness (Torres and Matrullo, 1994).

Practical clinical application of the research in cultural competency can enable physicians to decide whether folk traditional healing practices are harmful or benign. A thorough cultural history and a basic knowledge of different cultural healing practices can be key players for healthcare providers and become essential as they diagnose and treat potential complications of selected traditional practices (Torres and Matrullo, 1994).

The history of faith healing is brimming with examples of miraculous or near-miraculous cures, brought about by a variety of extraordinary people and procedures. Most but by no means all of these phenomena are recorded in terms of physical healing. Physical contact, however, has often been seen as a prominent component of mental healing as well. Because a number of contemporary nonprofessional psychotherapies do involve physical contact of numerous kinds, some discussions of the healing touch may be relevant (Maple, 1968).

Time before the Islamic era was characterized by being bereft of scientific spirit, and the information on that area in the field of medical and social sciences was derived from poetry and public literature (Krawietz, 2002). Similarly, Albright (1940) argues that the belief in jinn and similar concepts stems from people in the pre-Islamic period. They possess their magical beliefs and social traditions, and believe in polytheism and abnormal forces. This had its effect on their belief about psychiatric disorders and its treatment; they believed that psychiatric illnesses were caused by superpowers, jinn, and evil spirits. They used amulets, charms, some herbages, cautery, and venesection in the treatment of different diseases (Hussien, 1991).

The Arabic traditional medicine, before Islam, was not transmitted as such totally to the early Islamic era. Many important amendments were applied depending on logic and rationality rather than on experience and experimentation. The surgical treatment included cautery, puncture, and venesection, the first two being for emergencies, either curative or prophylactic. Instruments used in cautery and puncture were made of metals, vegetables, or animal matters. The principles of cautery were not randomized or unaccepted except in emergency cases. The skill of healers depends on their wisdom and depth of understanding, besides experience, intuition, and comparison between cases, and necessitates special locations and particular dressings, certain visits, and follow-ups (El Hameedan, 1986).

Ebn El-Kaim (1982) once said that diseases are of two types: diseases of hearts and diseases of bodies. Diseases of hearts are of two types: suspicious disease and instinctual-seductive disease. Both are mentioned in the Koraan.

Islam is centered around one central goal idea, which is monotheism: 'No God but Allah'. This main doctrine, as such, represents the whole ideology of the religion. It is the basis of Islamic culture. It is not at all practicing religion as a weekend catharsis or purification. All other ideas, deeds, devotion, and even sins are related to and judged by this main principle at all times (Rakhawy, 1994).

The attribution of psychiatric symptoms to jinn appears to be fairly common among Islamic patients and to have a noticeable effect on the diagnosis, treatment, and course of what biomedical practitioners consider psychiatric disorders, most notably in the case of psychotic disorders (Lim *et al.*, 2015).

In our culture, we normally submit to forces and influences, explaining all thoughts and decisions to come from God or some supernatural sources. This could reach some extreme degree without being considered abnormal in our culture. Unless this has its religious interpretation and is not handicapping, it should not be taken as normal. Another dominant external influence on thoughts and actions is related to the influence of Iblees (the devil). This cultural trend should be considered while evaluating passivity. Obsessive thoughts are sometimes interpreted as coming from external influences despite the insight of its absurdity (Rakhawy, 1994).

The cultural background to the mental health of Arabs has been recently reviewed, to understand certain features of the mental life and practices of Arabs that would otherwise be incomprehensible to the West (Brown and Hartzkowitz, 1977). Like other cultures, the Arab culture transmits a number of beliefs, which are locally shared, although considered unlikely, or even objectively disprovable, by others outside the culture. Such beliefs have been termed delusional cultural beliefs (Murphy, 1972). They relate to supernatural agents (e.g. the devil, jinn, sorcery, or the evil eye) to which certain activities or events are attributed. The extent to which Arabs adhere to these beliefs and base their behavior on them varies a great deal from one Arab community to another.

Onto the devil may be projected unacceptable wishes, feelings, or acts. Rumination involving aggressive or

unacceptable sexual impulses are also often attributed to the devil. Individuals disown and distrust them without feeling guilty because they are believed not to be theirs: they are the devil's. The Arabic word 'Wiswas' stands for both the devil and excessively worrying thoughts (El-Islam, 1978). Possession is thought to be the act of the manipulation of man by the supernatural agents called jinn. It results in unreasonable and unpredictable behavior, of which the affected person claims unawareness and for which the others do not hold him responsible. This covers a lot of bizarre behavior, which would otherwise be considered psychotic or dissociative. Dispossession calls for rituals (e.g. Zar) (Okasha, 1966) by traditional healers, involving the submission of the client to a supernatural father figure (Murphy *et al.*, 1967). Sorcery, however, is the employment of evil spirits through witchcraft against a particular person by those who hate him – for example, a divorced wife may use sorcery to instill disharmony between her ex-husband and his new wife or to make him impotent.

For many Arabs, another person's success calls for envy of his precedence, as he may lose his better position. Similar situations would call for competition rather than envy among achievement-motivated western individuals (El-Islam, 1978). Antienvy charms such as blue beads or figures involving the number 5 (e.g. hand symbols with five fingers) are implemented to combat the envying evil eyes. Rituals endowed with antisorcery and antienvy functions include the use of amulets containing verses of the Koraan (Moslem holy book), fumigation of incense, ritual visits to tombs of religious sheikhs, and purification rituals (Mahaya) that involve drinking or bathing in water that is washed off Koraanic verses written on a plate (Sanua, 1977).

Patients and methods

Study design

Place and time of the study

This study was carried out during the period from June 2013 to December 2013. We assessed 416 United Arab Emirates (UAE) national patients with BAD recruited from the psychiatric clinic at Al Rashid Hospital, Dubai (279 and 137 patients from urban and rural areas, respectively).

The sample was not designed to represent the whole UAE population.

Methodology and sample size

First, permission to perform this study was obtained from Al Rashid Hospital Ethical Committee.

Data collection

Data were collected after taking informed consent from chosen people after discussing with them the aim of the study.

A survey study was conducted using the Arabic version of Mini International Neuropsychiatric Interview (Othman and El Rady, 1992).

All patients who were diagnosed with mood disorder according to *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revised criteria (as concluded from the results of Mini International Neuropsychiatric Interview) and fulfilled the following inclusion and exclusion criteria were included in the study.

Inclusion criteria

- (1) Age above 18 years.
- (2) Both sexes.

Exclusion criteria

- (1) Mental subnormality.
- (2) Dementia, delirium, and other cognitive disorders.
- (3) Mood disorder due to general medical condition.
- (4) Mood disorder due to substance use.

All patients were subjected to the following assessments:

- (1) Complete physical and neurological examination to exclude organic causes.
- (2) The usage of other modalities of treatment (folk therapy, primary care, physician, and psychiatrist).
- (3) The prevalence of patients who seek faith healing in an attempt to explore the social and cultural background (help-seeking pattern and experience) (El-Sheshtawy *et al.*, 1996).

Questionnaire was administered for patients to assess the healer's help-seeking pattern and experience (especially designed for the present study, modified from El-Sheshtawy *et al.*, 1996).

The slang language questionnaire presented comprises a set of questions for which the patient's answer gives information on the healer's experience.

The questionnaire assessed the attitude of the patient toward the following:

- (1) The belief in supernatural forces.
- (2) Healer's management.
- (3) The psychiatric illness, its meaning, nature, and origin.
 - (a) A question on whether the patient visited a faith healer before, during, or after psychiatric consultation.
 - (b) A question about the traditional diagnosis. Multiple choices, which included no diagnosis, evil eye, jinn possession, witchcraft, touch, or other diagnoses, and from which they could only pick one, were given to the sample patients.
 - (c) A question inquiring about whether the patient visited a healer alone or accompanied. If accompanied, the patient is asked to identify their companion, be it a family member or another person such as a friend or neighbor.
 - (d) A question determining the number of healers visited, whether one or more.
 - (e) A question on line of traditional management prescribed, in which multiple lines would be presented to the patient from which he or she can choose the correct one. These lines include treating with the Qur'an, fumigation (incense), solving of witchcraft, amulets, drinking water in which a paper was soaked, beating, or other multiple lines.
 - (f) A question evaluating the result of traditional management, whether there was full improvement, partial improvement (i.e. return of the illness again), or no improvement at all.

Result

Table 1 shows the types of treatment in rural and urban areas. Folk therapy was significantly higher in rural (33.7%) than in urban (19%) populations, but physician

Table 1 Types of treatment modalities in rural versus urban population

	Residence [N (%)]			χ^2 -Test of each treatment	
	Rural (n=279)	Urban (n=137)	Total (n=416)	χ^2	P
None	67 (24.0)	24 (17.5)	91 (21.9)	2.27	0.13
Folk therapy	94 (33.7)	26 (19)	120 (28.8)	9.56	<0.001
Primary HC	49 (17.9)	22 (16.1)	71 (16.5)	0.15	0.76
Physician	43 (15.4)	37 (27)	80 (18.6)	7.95	0.04
Psychiatrist	26 (9.3)	28 (20.4)	54 (11.5)	11.51	<0.001

HC, healthcare.

treatment was significantly higher in urban (27%) than in rural (15.4%) populations. Psychiatrist treatment seeking was significantly higher in urban (20.4%) than in rural (9.3%) populations.

Table 2 shows belief in faith management in rural and urban areas. No significant difference exists as regards skepticism in rural and urban populations. Belief was significantly higher in rural (35.1%) than in urban (18.4%) populations; belief in both was significantly higher in urban (31.6%) than in rural (9.6%) populations.

Table 3 shows knowledge about mental illness in rural and urban populations. The incidence of knowledge about mental illness in the rural population (19%) was significantly higher compared with the urban counterpart (2.6%); about 39.5% of the urban population stated that psychiatric disorders are real

diseases, compared with only 9.6% of the rural population. No significant differences were detected between rural and urban views as regards God's will and spirit touch.

From Table 4, it can be observed that about 62.8% of rural cases and 60.5% of urban cases had visited faith healers before seeking medical help; 24.5 and 26.3% of rural versus urban population visited faith healers in combination with the psychiatric line of management. An overall 12.8 and 13.2% of rural versus urban cases were visiting faith healers after seeking medical help.

About 23.4% of rural cases and 18.4% of urban cases had visited healers by themselves, whereas the majority of cases were visiting healers accompanied by family members. An overall 57.4 and 57.9% of rural versus urban population were accompanied by family members, and 19.1 and 23.7% of rural versus urban

Table 2 Belief in faith management in rural versus urban population (in folk therapy group)

	Residence [N (%)]			χ^2 -Test of each believe	
	Rural (n=94)	Urban (n=26)	Total (n=120)	χ^2	P
Unbeliever	16 (17.0)	4 (15.8)	20 (16.7)	0.03	0.8634
Doubtful	36 (38.3)	9 (34.2)	45 (37.5)	0.194	0.6598
Believer	33 (35.1)	5 (18.4)	38 (31.7)	3.66	0.047
Believer in both	9 (9.6)	8 (31.6)	17 (14.1)	9.77	<0.001

Table 3 General knowledge about psychiatric illness in rural versus urban population (in the folk therapy group)

	Residence [N (%)]			χ^2 -Test of each knowledge	
	Rural (n=94)	Urban (n=26)	Total (n=120)	χ^2	P
Not disease	18 (19.1)	1 (2.6)	19 (15.8)	5.99	0.014
God's will	28 (29.8)	6 (23.7)	34 (28.4)	0.5	0.4796
Spirit touch	39 (41.5)	9 (34.2)	48 (40)	0.60	0.43
Real disease	9 (9.6)	10 (39.5)	19 (15.8)	16.26	<0.001

Table 4 The patterns of help seeking in rural versus urban population (in the folk therapy group)

	Residence [N (%)]			χ^2 -Test	
	Rural (n=94)	Urban (n=26)	Total (n=120)	χ^2	P
Time of healer visit					
Before	59 (62.8)	15 (60.5)	74 (61.7)	0.058	0.8101
During	23 (24.5)	7 (26.3)	30 (25.0)	0.049	0.8243
After	12 (12.8)	4 (13.2)	16 (13.3)	0.004	0.9514
Accompanying					
Alone	22 (23.4)	5 (18.4)	27 (22.5)	0.392	0.5312
Family member	54 (57.4)	15 (57.9)	69 (57.5)	0.002	0.9623
Others	18 (19.1)	6 (23.7)	24 (20)	0.342	0.5586
Number of healers					
One healer	33 (35.1)	9 (34.2)	42 (35)	0.01	0.9220
> One healer	61 (64.9)	17 (65.8)	78 (65)	0.01	0.9220
Response to traditional treatment					
No improvement	46 (48.9)	15 (57.9)	61 (50.9)	0.87	0.3510
Partial improvement	35 (37.2)	7 (26.3)	42 (35)	1.436	0.2308
Improvement	13 (13.8)	4 (15.8)	17 (14.1)	0.084	0.7715

population was accompanied by other members (friends, neighbors, etc.).

As regards the number of healers visited, about 64.9% of rural cases and 65.8% of urban cases had visited more than one healer. However, about 35.1% of rural cases and 34.2% of urban cases had visited only one healer.

On reviewing the effectiveness of faith healer's management, no response was given by 48.9 and 57.9%, respectively, of rural and urban populations. Partial response was given by 37.2 and 26.3%, respectively, of rural and urban population. About 13.8 and 15.8% showed improvement in rural and urban population with no statistical significance.

It was found that the diagnoses were evenly distributed among rural and urban populations (Table 5). About 23.4% of rural cases and 34.2% urban cases were diagnosed as being possessed, 17% of rural cases and 26.3% of urban cases were diagnosed with witchcraft, 22.3 and 15.8% of rural versus urban populations were diagnosed with touch, and a good percentage of cases received no diagnosis (11.7% of rural and 10.5% of urban population). An overall 19.1% of rural and 13.2% of urban populations were diagnosed with evil eye. In addition, 6.4% of rural cases received multiple diagnoses.

Table 6 shows treatment methods given by healer according to residence; it was observed that the lines of treatment were evenly distributed among rural and urban cases. The largest percentage of cases were treated

with Qur'an in both populations (36.2 and 39.5% in rural vs. urban), followed by other semireligious methods such as papers (21.3% in rural and 21.1% in urban population) fumigation (13.8 and 13.2%), and amulets (16% in rural and 7.9% in urban population). A good percentage of the cases received multiple combinations of different lines of management (12.8% in rural and 18.4% in urban population).

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

Discussion

Types of treatment modalities

Traditional and religious healers play a key role in primary psychiatric care in Egyptian communities. They deal with minor neurotic, psychosomatic, and transitory psychotic states using religious suggestion and devices such as amulets and incantations (Rakhawy, 1994).

Historical experiences, the influence of trauma, strongly held religious beliefs, and stigma toward mental illness shaped both the perceived causes of mental illness and views on searching for treatment (Pratt *et al.*, 2016). Islamic belief systems include beliefs in the adversity and influences of certain supernatural agents – for example, the devil, the jinn, or the envying evil 'eyes' of some human beings. The devil is believed to endeavor to tempt humans, especially those with weak faith, to forget their religious observances, to have antireligious

Table 5 Diagnosis given by faith healers in rural versus urban population (in the folk therapy group)

	Residence [N (%)]			χ^2 -Test of each diagnosis		χ^2 -Test of diagnosis	
	Rural (n=94)	Urban (n=26)	Total (n=120)	χ^2	P	χ^2	P
No diagnosis	11 (11.7)	2 (10.5)	13 (10.9)	0.037	0.8471	5.962	0.31
Evil eye	18 (19.1)	3 (13.2)	22 (18.3)	0.675	0.4112		
Possession	22 (23.4)	9 (34.2)	31 (25.9)	1.622	0.2028		
Witchcraft	16 (17.0)	7 (26.3)	23 (19.2)	1.478	0.2240		
Touch	21 (22.3)	5 (15.8)	26 (21.7)	0.714	0.3982		
Other	6 (6.4)	0 (0)	6 (5)	2.541	0.1109		

Table 6 Treatment given by faith healers in rural versus urban population (in the folk therapy group)

	Residence [N (%)]			χ^2 -Test of each treatment		χ^2 -Test of all treatments	
	Rural (n=94)	Urban (n=26)	Total (n=120)	χ^2	P	χ^2	P
Qur'an	34 (36.2)	10 (39.5)	44 (36.7)	0.127	0.7220	1.98	0.739
Fumigation	13 (13.8)	3 (13.2)	16 (13.3)	0.01	0.9188		
Amulets	15 (16.0)	2 (7.9)	17 (14.1)	1.494	0.2216		
Papers	20 (21.3)	5 (21.1)	25 (20.9)	0.001	0.9772		
Others/multiple	12 (12.8)	6 (18.4)	18 (15)	0.702	0.4020		

thoughts (or religious doubts), or to diverge from the Islamic code of conduct (Al Ansari *et al.*, 1989). The jinn are believed to be supernatural beings that could either be spontaneously harmful to human or could be employed by some humans (sorcery and witchcraft) to harm others.

The current study found that the rural population usually shows no commitment to treatment and resorts to traditional therapy more often compared with the urban population (24 vs. 17.5% and 33.7 vs. 19%, respectively), which is consistent with the findings of Mbwayo *et al.* (2013).

However, El-Sheshtawy *et al.* (1996) reported an incidence of 86.97% in Mansoura University clinics, and Okasha (1966) found that 60% of patients at the university clinic in Cairo had been visited by traditional healers before coming to the psychiatrist. This difference was due to the difference in the selection of studied sample.

This could be explained by different factors:

(1) Easy and convenient way for management

As the rural population has a lower socioeconomic level (education, occupation, social class, etc.) compared with the urban population, some beliefs can be imprinted into it, such as belief in supernatural forces (jinn possession, touch, witchcraft, and evil eye), and should be solved by faith healers and not doctors.

The rural population is considered to be a closed community with high interpersonal relations and communications. Thus, when one uses the faith healers' line of therapy with accidental cure, the credit goes to the healer, thus increasing his popularity.

Moreover, a part of cultural norms is visiting the tombs of religious dead sheikhs for bringing blessing (barka), Elzikr gathering, and El-zar ceremonies. Individuals born in such a culture (closed rural area) mostly follow such behavior and rituals without doubting them, and, when these methods fail, they try other methods of treatment. But patients with reactive psychosis, mania, or depression recover spontaneously and neurotics improved with suggestion and support and, therefore, increase the popularity of the traditional healer, leading to the proliferation and magnification of such traditions and healing cultures (El-Islam, 1998).

(2) Unavailable psychiatric services

Patients belonging to such classes usually try to seek easy methods for management, conventional

methods of treatment, or home remedies without utilizing health services, which are expensive. They also have their own beliefs transmitted from older grandparents, which are difficult for correction as they grow with these beliefs and rituals that became a part of their routine life.

(3) If they visit a psychiatrist, the patient would be described as being mad

People generally find it easier to blame evil spirits for the illness than to accept the biopsychosocial causes of the illness. The patient, who is considered to be the victim of evil spirits is offered symptoms and is not held responsible for the accompanying symptoms or behavior; thus, mentally ill people often seek shelter with these lines of therapy.

A user of healer's management in urban population indicates that utilizing this line of management is largely dependent on the transmitted beliefs rather than social class. This demonstrates that no cultural level was immune against the belief of supernatural forces and its benefit in therapy, regardless of their classes.

Another factor is that our sample from the urban area is characterized by a low standard of living compared with another location in Dubai city.

Thus, UAE, as most parts of the Arab world do, continues to practice traditional healing. Natives in different parts of the Arab world still hold belief in the intervention of supernatural beings and sorcery. The role of the psychiatrist in these communities requires a fair understanding of the prevailing traditional ideologies. The belief in traditional healing is strongly held and is transmitted through generations. In the majority of cases, patients and their families choose traditional healing before visiting the mental health services (El-Islam, 1981).

Aminy and Hamdi (1995) reported that 44% of the whole sample admitted in an acute psychiatric ward in UAE visited a faith healer Muttawa before the presentation of treatment.

Primary healthcare services

The percentage of cases utilizing primary healthcare was 17.9 and 13.9% in rural versus urban areas, respectively.

However, treatments by physicians and psychiatrists are more common in urban population rather than in rural population due to the facility of medical health services and its messages (27.8 vs. 18.2% and 18.2 vs. 8.2%, respectively).

Uses of mental health services in UAE are still facing some obstacles.

- (1) Expansion of mental health and community services in UAE rural areas is not as good as in urban areas; this point can be also strengthened by the findings of Mbwayo *et al.* (2013), who emphasized that traditional medicine is more familiar with low-income and middle-income countries than with high-income ones. Conversely, complementary and alternative medicine seems to be less culture specific and more extensively used in high-income countries.
- (2) The number of personnel involved in mental health services is small in rural compared with urban areas.

Thus, the increased awareness of primary care physicians with respect to psychiatry is compulsory. It is estimated that 80% of all mental patients seek their help either from the GP or traditional healers. Many studies have shown that depression is under-recognized, underdiagnosed, and undertreated by GPs all over the world. The promotion of mental health services, especially in developing countries where human resources are limited, is not through increasing psychiatric beds, or number of psychiatrists, psychologists, and psychiatric nurses, but by better education and continuous medical education to our primary care physicians (El-Rufaie, 2006).

Finally, we believe that such information will be necessary for planning health programs and for lessening the costs of health services. We should increase the awareness of GPs about psychiatric disorders. They should discover these disorders earlier instead of carrying out many investigations and giving many medical drugs, which are expensive, and spare time; this harms the state economy and progress.

Belief in healer's management

In the present study, it was demonstrated that only 17% of rural patients and 15.8% of urban patients were disbelieving, describing that they utilized line of therapy through advice from relatives or neighbors in accordance with social and cultural norms, whereas 38.3% of rural patients and 34.2% of urban patients were doubtful about using it (God only ever knows).

Rural patients were more credulous of faith management compared with urban patients (35.1 vs. 18.4%), whereas believing in both faith management

and psychiatry was more common in urban population than in rural population (31.6 vs. 9.6%).

They believe that both lines of management should be sought to complete effectiveness.

Thus, we demonstrated that rural population shows more query and belief in faith, whereas belief in psychiatrist is more common in urban population.

General knowledge about psychiatric illness

In this study, about 19.1% of the families of cases of the rural population and 2.6% of the families of cases of the urban population did not know the meaning of psychiatric illness and did not consider it a disease. However, 29.8 and 23.7% of families of rural versus urban patients considered it to be as God's will and could not define what illness had occurred to their patients. A high percentage of cases (41.5% of rural and 34.2% of urban population) explained the illness to be caused by a spirit, touch, evil eye, witchcraft, or possession. However, 39.5% families of urban cases and 9.6% families of rural cases considered it a real disease as any other somatic disease.

This demonstrates that rural families of cases believe in spirit touch and God's will more than families of urban cases. These demonstrations would increase our attention toward the importance of spreading the meaning and concept of psychiatric illness to different areas, especially the rural areas, for better results.

Healer's help-seeking patterns and experience

The current study showed that about 60% of patients of both populations had visited faith healers before seeking medical services. This result was lower than that reported by El-Shishtawy (1996), who reported that about 71% of cases had visited faith healers before psychiatric examination. This discrepancy with our study can be attributed to the fact that her studied samples were selected only from out-patient clinics. Moreover, the sample included patients with different psychiatric disorders. In addition, Assad *et al.* (2015) found that 40.8% sought traditional healers, with 34.9% seeking more than four times. Of them, 62.2% sought traditional healers before seeking psychiatric services and 37.8% sought after seeking psychiatric services. Lower educational level, less impairment of functioning, and presence of hallucinations were significant correlates.

This would reflect the importance of paraprofessional therapy as a line affecting management and prognosis of

psychiatric patients, which is consistent with the declarations of Assad *et al.* (2015), who noted that most of the patients suffering from mental illness prefer to seek faith healers first, which may adjourn entry to professional psychiatric care and thereby negatively affect the prognosis of BAD. This highlights the importance of mental health education and developing a positive collaborative relationship with traditional healers. Consequently, our attention should be directed to different levels (urban and rural), widening the concept of mental illness and clearing the shadow and fearful halos around the meaning of psychiatric illness.

In this study, 24.5% of rural cases and 26.3% of urban cases were visiting faith healers in concomitant with psychiatric treatment, whereas 12.8% of rural cases and 13.2% of urban cases were visiting faith healers after psychiatric treatment. This could be attributed to the patient's and family's trust in faith healers in their role in curing evil eye, jinn possession, witchcraft, touch, and other supernatural forces, which were originally thought to cause the illness.

About 35% of both populations seemed to have visited only one healer, whereas 65% of both populations seemed to have visited multiple healers.

This could be attributed to the fact that people in distress would seek help, especially from healers, even if predictions and suggestions did not yield good results. The healers are not blamed. Instead, people blame their own fate and go to other more powerful healers.

Failures are not highlighted; thus, despite many failures, these healers thrive on occasional successes and maintain their reputations through active propaganda.

Response to traditional treatment

With regard to the response to traditional treatment, about 50% of both population cases reported failure of healer's management with no improvement, whereas 37.2% of rural cases and 26.3% of urban cases showed partial improvement. In this case, the illness was cured, but then it recurred. An overall 13.8% of rural cases and 15.8% of urban cases reported improvement. The ratio of partial improvement could be explained by the natural tendency of psychiatric diseases to recover spontaneously (remission and exacerbation).

These results differ partially from those obtained by Elshishtway (1996), who reported that 4% showed improvement, whereas 20% showed partial improvement; a high percentage of cases (76%) showed no improvement.

This may be explained by the differences in the degree of severity of illnesses among these patients.

Faith healer's diagnoses and management

Different diagnoses, which included touch, evil eye, witchcraft, and jinn possession, were evenly distributed among patients. These are widely accepted in our area in Egypt based on religious foundation. A high percentage of cases were diagnosed with jinn possession (34.2% in urban vs. 23.4% in rural cases), witchcraft (26.3 and 17% in urban vs. rural), touch (22.3 and 15.8% in rural vs. urban cases), followed by evil eye (19.1% in rural cases and 13.2% in urban cases); 11.7% of rural cases and 10.5% of urban cases received no diagnosis, and 6.4% of rural cases received other diagnoses.

The traditional management includes reading Qur'an on the patient in about 36.2% of rural cases and 39.5% of urban cases, drinking water with papers soaked was found in 21% of both populations (21.3 and 21.1%), wearing amulets in 16% of rural cases and 7.9% urban cases, and fumigation 13.8 and 13.2% in rural versus urban cases. Other forms of management include beating, painting with oils and ointment, and cautery. These diagnoses and forms of management were nearly similar to those given by El-Shishtawy *et al.* (1996) and Eldam (2004), who stated that Islamic scholars often advise healers to restrict themselves to methods sanctioned by the Qur'an such as 'ruqyah' (i.e. reciting Qur'anic verses while touching the patient's head), applying or drinking concoctions of honey and herbs, and giving advice about ways to avoid perilous situations. Conventional Sufi healing methods include 'azima' (blowing one's breath while one hand rests on the patient's head), 'mihaya' (written Qur'an texts are submerged in water and either ingested by the patient or used for lavages), and 'bahkara' (the writing of Qur'an texts on a piece of paper which is then burned). Moreover, Hoffer (2000) and Barker (2008) stressed on the same point by noting that, often relying on pre-Islamic beliefs and ideas such as 'sihr' (black magic) and the evil eye ('al-'ayn'), traditional folk healing methods include the recitation of prayers, amulets, incantations, and Zar ceremonies (i.e. public healing performances). Typical physical healing methods include the infliction of pain (in an attempt to oust the jinn) and confinement.

El-Islam *et al.* (1988) reported that the practice of reading verses from the Qur'an or placing them in amulets that are carried by the person is still prevalent.

Amulets have psychological meaning and impact of the feeling of protection and security on the believer; other traditional healing methods include treatment using

cautery, ritual sacrifices, and sorcery undoing. It has been customary for psychiatrists practicing in the Arab world to take a disinterested attitude if not outright antagonistic position to these religious forms of treatment. This might be receding at present when their comforting effects have been recognized. The problem with accepting or maintaining a neutral stance with these treatment methods is that they reinforce the belief of the patient and his/her family that the illness is the outcome of external uncontrollable forces independent of the person's willed action and circumstances.

UAE populations, as an Arab community, tend to hide their psychological problems as they are considered a stigma, a psychological symptom (e.g. low spirits, excessive worrying, or morbid fear are commonly attributed by lay Arabs to weakness of faith, and individuals who display them are held responsible for their failures and should be ashamed of them and help themselves).

Motor behavioral symptoms (e.g. excitement or socially embarrassing behavior) is attributed by many Arabs to jinn adversity and therefore call for traditional or religious handling rather than medical or psychiatric attention.

Conclusion

- (1) Most of both populations denied treatment and visited Folk therapy, primary care, and physicians before psychiatrist. The percentage of patients utilizing the faith healing line of management was higher in rural population.
- (2) A good percentage of cases were utilizing faith healing before going to psychiatrist; moreover, a high percentage of cases utilized both lines of therapy.
- (3) The pattern of dealing and management with patients by the faith healers was always the same despite the diagnostic differences in these disorders.

Recommendations

- (1) We should improve the orientation of the GPs, and improve public awareness about psychiatric disorders, especially mood disorders. They should be trained for early detection and interference for those cases.
- (2) Psychiatric clinics should be present in general hospitals, especially those who are near to the rural areas.

- (3) Faith healers should be included in health services, especially in mental health, as supported by Limet *et al.* (2015), who reported that maintaining constant alliances between biomedically trained mental health professionals and religious counselors may be the key for improved care for mental patients.
- (4) Highlighting the role of cultural beliefs in both the evaluation and management of mental disorders is of utmost importance, as noted by Urizaret *et al.* (2015); it may be essential for mental health staff members to consider beliefs about the disorder, especially in ethnic minorities, before applying a standard model of treatment.

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References

- Al Ansari EA, Emara MM, Mirza IA, El Islam MF (1989). Schizophrenia in ICD-10: a field trial of suggested diagnostic guidelines. *Compr Psychiatry* 30:416–419.
- Amin Y, Hamdi E (1995). Gender differences in psychiatric admissions: the influence of culture and social structure. *Arab J Psychiatry* 6:553–554.
- Assad T, Okasha T, Ramy H, Goueli T, El-Shinnawy H, Nasr M, *et al.* (2015). Role of traditional healers in the pathway to care of patients with bipolar disorder in Egypt. *Int J Soc Psychiatry* 61:583–590.
- Barker K (2008). Afghanistan's mentally ill left to superstition. *Chicago Tribune*. Available at: http://www.chicagotribune.com/news/chi-afghanistan2_barkerdec26,0,40482.story. [Last accessed 2008 Dec 26].
- Brown LC, Hartzkowitz N editors. (1977). *Psychological dimensions of near eastern studies*. Princeton, NJ: The Darwin Press.
- Ebn El-Kaim (1982). *Zad El-Sa'ad in Huda Khayr Al-Ibad (Happiness Provisions in the Guidance of the Best Subjects) - the Message Foundation - (Part IV)*.
- Eldam AG (2004). *Tendency of patients towards medical treatment and traditional healing in Sudan [unpublished doctoral thesis]*. Oldenburg, Germany: University of Oldenburg.
- El Hameedan Y (1986). *A Brief History of Arab Medicine: Saudi Arabian Library- Saudi Arabian Society for Culture and the Arts series*.
- El-Islam MF (1978). Transcultural of psychiatric patients in Qatar. *Comp Med East West* 6:33–36.
- El-Islam MF (1981). Epidemiological research on depressive I disorders. In: Ban TA editor. *Prevention and treatment of depression*. WHO Publication. (in press).
- El-Islam MF, Moussa M, Malasi TH, Suleiman MA, Mirza IA (1988). Assessment of depression in Kuwait by principal component analysis. *J Affect Disord* 14:109–114.
- El-Rufaie E (2006). Primary care psychiatry: pertinent Arabian perspectives. *East Mediterr Health J* 11:446–458.
- Gurege O, Nortje G, Makanjuola V, Oladeji BD, Seedat S, Jenkins R (2015). The role of global traditional and complementary systems of medicine in the treatment of mental health disorders. *Lancet Psychiatry*. 2: 168–177.
- Hoffer M (2000). *Folk belief and religious healing methods among Muslims in the Netherlands: a historico-sociological analysis of religious-medical thinking and acting [thela thesis]*. Amsterdam, the Netherlands.
- Hussien F (1991). A study of the role of unorthodox treatments of psychiatric illnesses. *Arab J Psychiatry* 2:170–184.
- Kleinman A (1997). Neurasthenia and depression: a study of somatization and culture in China. *Cult Med Psychiatry* 6:117–190.
- Krawietz B (2002). Islamic conceptions of the evil eye. *Med Law* 21:339–355.

- Lim A, Hoek H, Blom J (2015). The attribution of psychotic symptoms to jinn in Islamic patients. *Transcult Psychiatry* 52:18–32.
- Maple E (1968). *Magic, medicine and quackery*. Hale, London: Robert Hale.
- Mbwayo AW, Ndeti DM, Mutiso V, Khasakhala LI (2013). Traditional healers and provision of mental health services in cosmopolitan informal settlements in Nairobi, Kenya. *Afr J Psychiatry (Johannesbg)* 16:134–140.
- Othman AT, El-Rady EO (1992). Arabic version of Mini International Neuropsychiatric Interview. Macon, GA: Department of Psychiatry, Faculty of Medicine, Mercer University.
- Murphy HBM (1972). Cultural aspects of the delusion. *Stud Gen (Berl)* 20: 684–692.
- Murphy HBM, Wittkower ED, Chance N (1967). Crosscultural inquiry into the symptomatology of depression: a preliminary report. *Int J Psychiatry* 3:6–22.
- Okasha A (1966). A cultural psychiatric study of El Zar cult in U.A.R. *Br J Psychiatry* 112:1217–1221.
- Posadzki P, Watson LK, Alotaibi A, Ernst E (2013). Prevalence of use of complementary and alternative medicine (CAM) by patients/consumers in the UK: systematic review of surveys. *Clin Med* 13:126–131.
- Pratt R, Fadumo A, Hang M, Osman S, Raymond N (2016). Perceptions of mental illness in the Somali community in Minnesota. *Int J Migration Health Social Care* 12:16–25.
- Rakhawy YT (1994). Disorders of cognition. Thought disorder. In *Portrait of the psychiatric patient*. Cairo: Evolutionary Psychiatric Association Publications.
- Torres C, Matrullo CM (1994). A culture and psychopathology among Puerto Rican women in Mainland. New Brunswick, NJ: NJ Rutgers University Department of Psychology.
- Urizar A, Breslau J, Gilman S (2015). Beliefs about the causes of schizophrenia among Aymara and non-Aymara patients and their primary caregivers in the Central-Southern Andes. *Int J Soc Psychiatry* 61:82–91.
- WHO (2013) *WHO traditional medicine strategy 2014–2023*. Geneva: World Health Organization.

