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Facts and Fiction about Faith Healing as Psychotherapeutic Intervention: The Indian Scenario

KEY WORDS: faith healing, psychiatry patients, yoga, mindfulness, Mehendipur-Balaji, trance, culture- bound syndrome.

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ABSTRACT

Faith healing practices in the management of psychiatric patients are not unfamiliar in Indian scenario. The present paper review researches on faith healing and psychotherapy in Indian context. Brief history of faith healing as a psychotherapeutic method, link between faith healing and psychotherapy and different patterns of faith healing has been briefly reviewed. Perspectives on faith healing as part of supportive psychotherapy has also been considered. Some of the issues with respect to faith healing as a part of supportive psychotherapy in India will be made clear in the future, based on doctoral research undertaken by one of the authors.

INTRODUCTION

The magical chants of the faith healer are loud enough to ward off the spirits, even when the legal aspects of mental health have set its crucial milestones. The temple and the Dargah are still swamped with the requests to "bless and cure", the mentally sick. Even when the scientific community has explained the quackery of faith healing via the language of "statistical efficacy", the Indian psyche still expresses its preference for the healer. The deities are believed to avenge the evil spirit and restore goodness.

For many, faith healing becomes an alternative course of treatment (Raguram, 2002). The mere presence at a temple can often result into the alleviation of "disturbances". At the same time, prayers and chants also create a significant impact on the management of symptoms via the strategies of "autosuggestion", "ritualistic trance "and allied (Satija, Singh, Nathawat and Sharma, 1981). Faith healing centers in India act as cultural clinics that are beyond a biomedical model of symptom relief. More than anyone else, Sudhir Kakkar has initiated such studies on Mehendipur Balaji temple as early as 1982.

Faith healing complicates the scenario of mental health treatment in India (Siddiqui, Lacroix and Dhar, 2014). The societal and economic factors like illiteracy, aversion towards psychiatry and expensive "mainstream" services often project the faith healer as a reliable option (Sethi and Trivedi, 1980). Psychiatric conditions are perceived to be mysterious by the Indian mass and the etiology is often assigned to negative spirits and other malevolent powers. In this situation, the faith healer is expected to be the medium of communication with the "divine". His venture would be the "rescue" of the affected. Their services function as "cultural first aids" for different mental health conditions (Bathla, Chandhna, Bathla and Kaloiya, 2011).

We now need to acquaint with the practice of psychiatry in the management of mental patients in our country in the remote past. The contributions made by religion and spirituality in practicing psychotherapy in India are inevitable. The age old healing methods, prior to the Brish Empire focused on the indigenous wisdom. They had a unique pattern of treatment. The social harmony allowed the family and the community to assist the healer. Psychiatry had a great deal of difficulty in establishing the fundamentals of psychotherapy in a land that solely believed in traditional modalities of treatment. Even when, these "reformative movements" had "reformed" the Indian society from some practices that were detrimental to the mentally ill, it also rated "traditional healing methods" to be an absolute quackery.

The premier lunatic asylums were constructed in the regions of Bombay, Calcutta and Madras (Somasundaram, 1984 (Sébastia, 2009). The colonial culture tried to create a superficial harmony within the Indian society via the introduction of asylums. The lunatics were perceived to be no different from the criminals or street wanderers as they were all put under the same roof. The role of family and community was restricted, disrupting the harmonious social system. Asylums maintained the policy of keeping the mentally ill away from a normal society. These establishments did not focus on their betterment in alliance with the cultural climate. The asylums initiated the silent death of an age old healing habitat. The British reign henceforth initiated the very first movement of psychiatry in India.

However, psychiatry gradually understood its flaws in practice in terms of psychotherapy, conceptual clarity and diagnosis. Psychotherapy being a western idea had to be connected with the Indian constructs. This venture was initiated by scholars like Girindra Shekar Bose. Bose was the first to look at psychoanalysis from an Indian cultural point of opinion. The "Freudian couch" was metaphorically replaced by the "Indian Deck Chair". He likewise got to the extent of criticizing Freud for taking a generic psychoanalytical treatment perspective. According to him, patients had their differences in every single cultural context. Bose, in his attempts of Indianisation of psychoanalysis, spoke around the influence of maternal deities in the Indian culture. Freud propagated the concept of penis envy based on his observations of upper-class Viennese women who envied their fathers, husbands and other important men in their life for being able to utilize their educational status and enjoyment of social freedom. Bose on the other hand, spoke around his upper class westernized Bengali men, who held the "wish to be female", such that feminity in India at certain levels were linked with powerful goddesses, who accepted a significant social position (Sinha, 1966, (Hartnack, 2003). He is also credited for involving principles from Bagvath Gita, as a portion of western psychotherapy.

Yoga and the principles of mindfulness slowly attained their role in western psychotherapy. The connection of Yoga and psychotherapy came up with their similar base of mythology and philosophical system. The techniques of autosuggestion and hypnosis are ingrained in the "yogic" approaches of cure. Yet the research literature on the efficacy, indications and Contra - indications dications of the therapeutic outcome on a relative basis are missing (Sauermann,1979). The acceptance of mindfulness into the mainstream psychotherapeutic practice becomes quite bright in terms acknowledging and utilizing indigenous healing traditions, however, it may not get any modification in the "adjunctive" status of indigenous healing traditions.

The concept of culture bound syndromes was indianized by theorists like Wig. The role of culture in creating contextual meanings to psychopathology is definitely important in the therapeutic formulation of the condition. Certain syndromes are caused by the specific cultural practices and Wig highlighted this in the Indian setting. He endorsed the construct of "hanuman complex". Via this concept, Wig was speaking simultaneously about the Indian client and the therapist. Here, the Client and the

therapist in the Indian therapeutic chamber are compared to the characters in the tale of lord "Hanuman". The inability of the client to believe in his self and the skill of the therapist to intervene were beautifully explained using this therapeutic metaphor. With such a contribution, Wig reminded the clinical world about the rich heritage of the Indian folklore via the story of a deity who lost the knowledge about his flying powers due to a childhood curse and later on reminded by Jambavan during a crucial mission in search of mother Sita (Wig, 2004). The stories of victory, loss, jealously, pain and allied are extremely important when the therapist addresses the "Indian super ego". J.S Neki, S. Dube and B.B Sethi were other pioneers who added a great deal of work in realizing the aspects like "Indian guilt". These were the culturally sensitive components in implementing psychotherapy in India.

Medical plurality is promoted by world health organization. This explains the need of standardizing indigenous healing traditions in developing countries, as a potential back up to the mainstream medical services. Psychotherapeutic services in India need to make a relation with the faith healing practice, so as to promote its strategies and also receive an acceptance towards a trickling down process. The existence and quality of psychotherapy are still a matter of "awe" for a significant part of the population. There is a huge call for competent mental health professionals due to the domination of blind faith in the destiny of India's mentally ill. On a parallel level, the issue of integration becomes a matter of concern for many mental health professionals as well the healers due to the apprehension, that their individual practice might lose its face in the society. This is due to the fact that, certain indigenous practices have contraindications to the existing pathological conditions and certain psychotherapeutic practices may not acknowledge the aspects of prayer and rituals. For example, practices like "Yoga" when have proven efficacy with the neurotic spectrum, via the components of mindfulness and allied, the application of the same with the psychotic spectrum may carry detrimental effects to the client (Bhaskaran, 1991, (Sébastia, 2009). Also faith healing and indigenous practices on an independent level may not complete the therapeutic package without involving components like supportive therapy or psycho education considering the issue of relapse, even when faith healing testimonials, may or may not acknowledge, the same (Weiss et al, 2001, (Sébastia, 2009).

The endorsement of faith healing tradition is to be done after considering certain preliminary explorations. In the process of Indianisation of psychotherapy, the temple and the clinic may equally become involved in the management of psychiatric conditions. The medicalization of faith healing would let the gates of healing open to the psychotherapeutic practitioner as well. The alterations should be done while considering the existing family structure, social hierarchy and cultural sanctity of mental health treatment creating a safe link between the faith healer and the psychotherapist for the effective practice of psychotherapy in the Indian context (Sébastia, 2009).

We now focus on the relationship between faith healing and so called psychotherapy. Accommodating, faith healing practices with modern psychiatry is a huge concern for many mental health professionals. Every single culture promotes rituals, rites and devotion under the singular umbrella of faith. The priest is adored as the medium of communication with the almighty. The continuum of faith healing extends from spirituality to that of a curing, "religious therapy". People pray on a regular basis, give their offerings and get involved in religious chants. This has become a part of their spiritual / mental health regime. They pray so as to get protected from negative forces and attract positive energy. When they are haunted by experiences that are beyond the rationality of ordinary mind, they go to their faith healer, exorcist or astrologer. When individuals laugh to themselves or get frightened, a mental health professional nowhere comes into the picture, for help seeking. Whether the field of psychiatry prefers it or not, the idea to collaborate with the community resources has become the need of the hour, both in terms of research and practice.

The step towards "accommodation" primarily begins with the best possible outcome to the client. Here ethical consideration takes a good share of decision making regarding accommodation more than the attitude of the mental health professional. The client and the family possess the power of autonomy. They have the right to express their desire to approach a faith healer. However, in certain instances, the invisible factors of pressure like social norms, superstition, etc. could become reasons for involving coercion in many forms of faith healing practice (Sarkar, 2014). Coming to beneficence and non-maleficence aspect of faith healing, many patients were benefited from the personal attention given by the healer. However, there have been instances where the patient has been put into fasting for a long time and beaten with iron rods, etc. that have ended up being harmful to him or her Sarkar and Seshadri, 2014). Faith healing traditions cannot be restricted or accepted from the fewer cases of failure or success. A generalization based on isolated events would be stereotypy.

There are multiple faith healing requests in the medical chamber. Such requests are often put forward by the family of the patient. The clinician on the first hand could reject these requests. Those who are trained in evidence based therapies may not find faith healing practices appealing due to its involvement with superstitions and mythological beliefs. Some practitioners have indeed found the requests for faith healing traditions to be professionally offensive. The outright rejection of an interest in faith healing tradition without justification would be against the acknowledgement of autonomy of the client. Another approach would be giving a midway answer which includes neither acceptance nor rejection of the faith healing tradition. Since, medical professionals of a particular modality may not be familiar with the healing principles of another domain; the tendency to become judgmental would be unprofessional. However a pinch of caution would still be acceptable. Some professionals may endorse faith healing practices. This would be applicable to clinicians who believe in the independent functioning of faith healing. These clinicians act as ambassadors of faith healing practices. The reason for endorsing could be based on the assumption that, faith healing tradition works on "placebo effect". The issue of non-maleficence comes up when the clinician, endorse a potentially harmful faith healing practice. A very different perspective from all of this would be the inquiry of beliefs about a particular faith healing method, which the patient and their relatives hold. This helps the clinician to explore a variety of promises and pitfalls hidden. Here the autonomy of the client and the clinician is maintained (Sarkar, 2014).

There is no right or wrong approach to be taken by the clinician. It is indeed necessary to have knowledge on a variety of faith healing traditions. Many provide relief, many may serve as a placebo and many may be potentially dangerous. In whatsoever conditions, the health care provider should always remind the patient about the harmful effects of faith healing tradition, if at all any. Clinical decision making is indeed a tiring task.

COMMENTS

The present paper summarizes major trends in faith healing practices as a supportive psychotherapeutic device for psychiatric patients in our country. The accommodation of faith healing tradition would be unique to the socio cultural milieu and pathology manifested. A worm's eye view will be necessary for the clinician to understand true rules of accommodation of faith healing tradition. The second author has undertaken a doctoral research on this theme under the supervision of the first author (Nathawat), who has extensive experience on this topic while working with psychiatric patients attending Mehendipur Balaji (Satija et al., 1981; 82; 84)

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