Social Psychiatry and Psychiatric Epidemiology
https://doi.org/10.1007/s00127-018-1519-9

REVIEW

The perceived effectiveness of traditional and faith healing in the treatment of mental illness: a systematic review of qualitative studies

A. S. J. van der Watt[1] · T. van de Water[1] · G. Nortje[1] · B. D. Oladeji[2] · S. Seedat[1] · O. Gureje[2] · Partnership for Mental Health Development in Sub-Saharan Africa (PaM-D) Research Team

Received: 25 October 2017 / Accepted: 13 April 2018

Abstract

Purpose This work complements a quantitative review by Nortje et al. (Lancet Psychiatry 3(2):154–170, 2016) by exploring the qualitative literature in regard to the perceived effectiveness of traditional and faith healing of mental disorders.

Method Qualitative studies focusing specifically on traditional and/or faith healing practices for mental illness were retrieved from eight databases. Data were extracted into basic coding sheets to facilitate the assessment of the quality of eligible papers using the COREQ.

Results Sixteen articles met the inclusion criteria. Despite methodological limitations, there was evidence from the papers that stakeholders perceived traditional and/or faith healing to be effective in treating mental illness, especially when used in combination with biomedical treatment.

Conclusion Patients will continue to seek treatment from traditional and/or faith healers for mental illness if they *perceive* it to be effective regardless of alternative biomedical evidence. This provides opportunities for collaboration to address resource scarcity in low to middle income countries.

Keywords Traditional healing · Faith healing · Mental illness · Perceived effectiveness · Qualitative · Review

Introduction

> "Medicine born of necessity was at first magic, then a prayer, finally an art, and only recently a science." (Bromberg, W., 1937, *The mind of man*. New York: Harper.)

Traditional and faith healers (TAFH) constitute a key part of the mental health care system [1–3]. This is especially true in low and middle income countries [4] where patients with severe mental illness either do not receive formal psychiatric treatment [5] or receive sub-optimal care due to the failings of medical and psychiatric care systems [3]. The World Health Organization (WHO) estimates that around 80% of the population in developing countries depend on TAFH for their health care needs [1].

Due to scarcity and the uneven distribution of formal health care resources, with fewer health personnel in rural than in urban areas [6], TAFH often serve as the first [7] or alternative point of contact for large sections of the population [3]. TAFH are perceived by the community as more

Electronic supplementary material The online version of this article (https://doi.org/10.1007/s00127-018-1519-9) contains supplementary material, which is available to authorized users.

✉ A. S. J. van der Watt
bertevdwatt@sun.ac.za

T. van de Water
tanya.clinpsych@gmail.com

G. Nortje
g.nortje@gmail.com

B. D. Oladeji
bibideji@yahoo.com

S. Seedat
sseedat@sun.ac.za

O. Gureje
oye_gureje@yahoo.com

[1] Department of Psychiatry, Stellenbosch University, Francie van Zijl Drive, Tygerberg, South Africa

[2] Department of Psychiatry, University of Ibadan, Ibadan 900001, Oyo State, Nigeria

Published online: 25 April 2018

accessible and affordable than formal health care providers [2, 4]. Further, TAFH are sometimes consulted subsequent to patients going to hospital [8], because they provide patients with culturally relevant explanations of the cause of illness [9]. TAFH share the cultural belief systems of the communities where they are located [1]. These belief systems influence the diagnosis and treatment practices [10] and provide explanatory causes of illness to patients and their caregivers [1], and possibly their perceptions of the appropriateness and effectiveness of treatments.

Whilst TAFH are able to recognize common psychiatric illnesses [11]—with psychosis being the most easily identified—this recognition remains limited [12]. For example, the biomedical concept of *depression* is only partially understood [13], with the condition often labelled as *thinking too much* or *being stressed* [1]. Culturally specific understandings of mental illness notwithstanding [14], there is evidence showing that biomedically-defined psychiatric disorders are not only present but are also recognizable in cultures that do not subscribe to biomedical paradigms [15]. When such disorders are diagnosed and treated by TAFH, they may use alternative culturally relevant labels for such conditions. In a systematic review focused on evidence from quantitative studies, Nortje et al. [2] found that there is some benefit for patients with a limited range of mental health conditions attending TAFH. The authors highlight the inadequacy of relying only on quantitative evidence to assess the effectiveness of TAFH approaches. In particular, due to the exclusion of anecdotes and case reports, many insightful papers were not reported on. For this reason, *perceived* effectiveness—which influences preference of treatment modality [3]—of TAFH could not be adequately explored in the review [2]. In this paper, we seek to complement the review by Nortje et al. [2] by providing evidence derived from qualitative and ethnographic studies of the perceived effectiveness of TAFH approaches for mental disorders. We hypothesized that traditional and faith healing interventions for mental illness would be perceived as effective, with the type of intervention sought strongly dependent on both contextual and cultural beliefs relating to illness causation.

Methods

Search strategy, definitions, and selection criteria

This review aimed to include publications that address, directly or indirectly, the effectiveness of TAFH for mental disorders. The following broad keywords were used in the literature search to maximize the scope of the search: traditional healing, traditional healers, complementary medicine, alternative medicine, spiritual healing, spiritual healers, faith healing, faith healers, mental health, mental illness, treatment, counselling, effectiveness, efficiency, and usefulness. Eight widely used databases were searched including EBSCOhost, Cochrane Library, PubMed, PsychOnline, PsychLit, CINAHL, Social Science Citation Index, and African Journals On-line. Reference lists of included articles were consulted for additional papers; however, this did not yield additional papers. RefWorks was used to coordinate the search. The review protocol is registered on Prospero (CRD42016048954).

Traditional and faith healing

For the purpose of this review, which serves as a complementary paper to Nortje et al. [2], the operational definition of traditional and faith healers as provided by Nortje et al. [2] was used: "healers who explicitly appeal to the spiritual, magical, or religious explanations for disease and distress" (p. 155). As indicated by Nortje et al. [2], this definition includes those healers who typically use sacred rituals, ceremonies, talismans, divination, and prayer to treat mental illness. TAFH who use physical treatments, such as herbs or bone-setting to complement spiritual treatments, were also included. For the current review to be in synchrony with that of Nortje et al., we excluded healers who use mainly physical, humoral, or quasi-mechanical treatments for mental illness (for example, acupuncture, chiropractic, herbalism, homeopathy, traditional Chinese medicine, Ayurveda, Qi-gong, Reiki, sweat lodges, and Western medicine) [2].

Mental illness

Only studies in which TAFH practices (as defined above) were used to treat mental illness were included in the current review. In this review, we regard as "mental illness" any condition that would have been so classified in either the Diagnostic and Statistical Manual (DSM) [16] or the International Classification of Diseases (ICD). Thus, studies which specifically indicated a DSM or ICD disorder, or where the symptomatology described met the definition of a "mental illness" as per the DSM or ICD, were included.

Additional selection criteria

Only peer reviewed studies published in English before July 2016 were included in the review. No starting period was specified so as to be as inclusive as possible. The current review included qualitative studies that employed focus groups, individual interviews, case studies, and observations which provided insight into the perceived effectiveness of TAFH in the treatment of mental illness. The perspectives of healers, patients, patient care givers, and other treatment staff were included so as to generate data on diverse views and experiences. Effectiveness/efficacy was defined

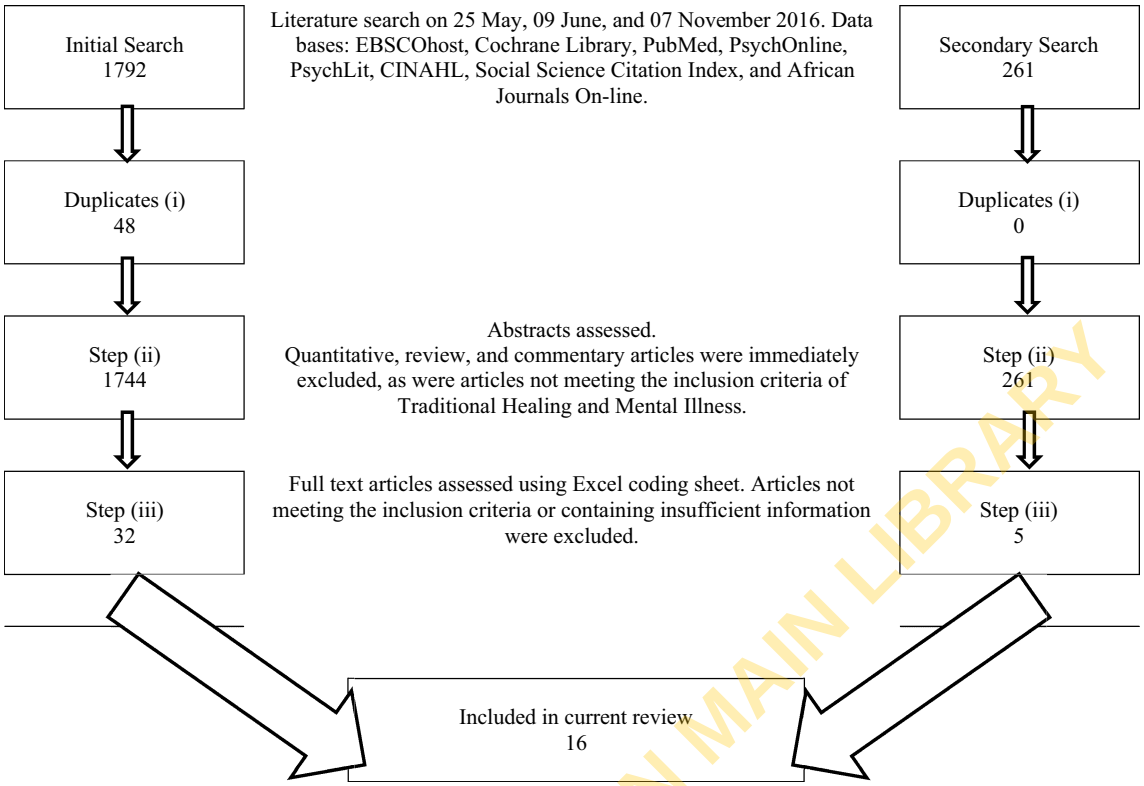

Fig. 1 Literature search

in the broadest sense of *does it or does it not work*. As such, *perceived effectiveness* in this review refers to the subjective impact of TH and FH interventions as experienced or reported by the stakeholders included in the studies, rather than objectively assessed outcomes of the interventions.

Literature search

An initial (25 May 2016 and 09 June 2016) and a secondary (7 November 2016) literature search were conducted by two library personnel (see Fig. 1). The following steps were taken with each search to determine inclusion:

1. Duplicates were deleted.
2. The first author read through the articles' abstracts. Quantitative, review, and commentary articles were immediately excluded, as were articles not meeting the inclusion criteria of TAFH and mental illness.[1] The first author consulted with the second author in cases of uncertainty.
3. The first and second authors independently assessed the full text of the remaining articles using a basic Excel coding sheet. Coding sheets were compared and disagreements resolved through discussion. Articles not meeting the inclusion criteria or containing insufficient information were excluded (Fig. 1).

Data extraction and synthesis

Initially the text of individual studies was treated as a whole while major themes and categories were identified. Basic Excel coding sheets were used to extract and denote elementary details of each study. Information and quotations regarding perceived effectiveness were highlighted and extracted into one document. The extracted data were read in their entirety in order to identify overlapping themes. Data were synthesized according to four main themes: (1) the influence of cultural context, (2) spiritual and faith healing, (3) traditional healing, and (4) concurrent biomedical treatment.

[1] Two articles [17, 18] were included in step (2) based on their abstracts. However, access could not be obtained to the full text of the articles. The two articles were subsequently excluded.

Results

Eligible papers

In varying degrees, the 16 included articles provided insights on the perceived effectiveness of TAFH in the treatment of mental illness. However, none focused exclusively on effectiveness, thus limiting the richness of data. Two articles focused specifically on meaning making (of mental illness) and how this influenced service use, two on meaning making (of illness) only, five on service use only, and seven articles focused on collaboration (see Table 1).

Quality of papers and sample information

The Consolidated Criteria for Reporting Qualitative Research (COREQ) 32-item checklist [19] was used to facilitate the critical appraisal of studies (See Appendix 1 and 2 for Application and Scoring). In general, the articles provided very little information on the research teams and on reflexivity. With the exception of Bäärnhiel and Ekblad [25], which utilized a grounded theory orientation, none of the studies applied a specified theoretical framework, simply stating that a qualitative approach was used. Descriptions of the samples (see Table 2) were often vague; while for studies that collected data in multiple phases, demographic information for each phase was not provided. Additionally, with the exception of Marsh et al. [23] and Shields et al. [32], clear operational definitions for terms such as *traditional healing* or *faith healing* were not provided.

The perceived effectiveness of traditional and faith healing

Reported perceptions of the effectiveness of TAFH varied and often dependent on whether research participants were from a biomedical orientation or not. In the following section, we discuss: (1) the influence of context, (2) spiritual and faith healing, (3) traditional healing, and (4) concurrent treatment. Participant quotes from original articles are *italicized* in quotation marks; direct quotes from articles (which are not by participants) are presented in quotation marks (not italicized).

The influence of context

The review revealed the importance of understanding the influence of context on the perceived effectiveness of mental health treatment [20–24]. For example, authors, Al-Krenawi and Graham [20] highlight the importance of understanding the familial context of a patient's psychotic symptoms which allowed a *Dervish*[2] to cure the patient through the rituals of *Tazeem* and *Hashar Al-Jinn*.[3] Likewise, Wessels [24] reported a case where the Zulu Diviner's understanding of the patient's familial situation assisted in the treatment of his psychotic symptoms through sacrifice (of a goat) and celebration.

The cultural context may also have an indirect influence on effectiveness. Participants were more likely to open-up to or accurately describe their symptoms to TAFH. Bäärnhielm and Ekblad [25] reported that participants actively avoided talking about certain symptoms to biomedical doctors. They (patients) stated that the biomedical doctors would not understand the idioms used, whereas traditional healers would: "*Sometimes I think, am I bad at explaining? Or do they not understand? Or is it my bad luck? … It continues and continues. In the end death comes*" [25, p. 445]. Thus, it is plausible that traditional healers may have a clearer, more thorough, description of patients' symptoms on which to base their treatment compared to biomedical doctors. Participants (patients) also did not want to be labelled as mentally ill by biomedical doctors [25].

The cause determines the treatment Findings indicate that the perceived cause of mental illness, as informed by the context, influenced the preferred treatment method and its perceived effectiveness. This was especially the case when the cause was perceived to be supernatural [13, 26, 27], spiritual [22, 28, 29], or religious [25]. For example, a Ghanaian prayer camp pastor explained: "*First is the spiritual, before the physical … The [psychiatric] medicine won't work [and] the physical issue won't resolve itself until the spiritual is addressed first … The healing actually comes spiritually before it manifests itself physically*" [30, p. 8]. This was also explained by a minister, a faith-based healer, and a South African traditional healer, respectively:

> Diyin God is a spirit, our inner being is also a spirit. So only spirit can affect spirit. … Peyote[4] won't heal my spirit, peyote won't heal my mind … it can heal my body only, but not my soul … the healing that comes from God is the ultimate kind of strength and healing [31, p. 532].
>
> The differentiation in this is that when the evil person is possessed, overall his problems will start reducing when he starts to do our holy rituals … in the case of mental illness, how ever[sic] many holy rituals we try

[2] Traditional Bedouin healers who treats mental and physical illnesses using a variety of religious and cultural rituals [20].

[3] Dervish healing practices comparable to the Western notion of an exorcism [20].

[4] Traditional Navajo singing [31].

Table 1 Profile of the articles included in the review

Study	Main focus	Country, sampling	Data collection method (*n*)	Data collection tools	Data collection phases	Analysis method	Analysis tools and software
[28]	Service use	Malaysia, purposive	Individual interviews (61)	Audio recording, Structured clinical interview for DSM IV	1 July–Sept 2006	Thematic analysis	NS
[20]	Collaboration	Israel, not specified (NS)	NS: possibly social worker file notes	NS: possibly social worker file notes	NS	NS	NS
[21]	Service use	Israel, NS	Semi-structured interviews (NS), participant observation, medical files	NS	1 3 months	NS	NS
[30]	Collaboration	Ghana, purposive	Individual interviews (18), group interviews (NS)	Field notes and audio recordings (n = 5 declined audio recordings)	1 June–July 2014	Constant comparative method	NS
[25]	Meaning making	Stockholm, purposive	Individual interviews (29)	Audio recordings	2 1997–1999	Inductive qualitative emic method	Nud.ist rev 4
[29]	Meaning making	New Zealand, NS	NS	NS	NS	NS	NS
[22]	Service use	Bali, NS	NS: possibly participant observation	NS	2 Oct 1976–Oct 1978 and Sep–Nov 1980	NS	NS
[31]	Collaboration	United States, NS	Participant observation, ethnographic interviews with practitioners and patients	Audio recordings	1993–1997	NS	NS
[26]	Collaboration	Indonesia, NS	In-depth interviews (9 + 7)	Audio recordings and interview notes	March–May 2014	Graneheim and Lundman	NS
[23]	Service use, meaning making	Canada, convenience	Individual interviews (17 + 4), sharing circles (2)	Audio recordings	2	Thematic analysis	NS
[27]	Collaboration	Kenya, simple random	Focus group discussions (8)	Field notes and audio recordings	2	Thematic analysis	NS
[3]	Service use	India, convenience	Individual interviews (49)	Audio recordings	July 2013	Grounded theory	Excel
[32]	Collaboration	India, convenience	Individual interviews (16)	Field notes and audio/visual recordings	1 March 2013	Thematic analysis	MAXQDA11
[11]	Service use, meaning making	South Africa, convenience	Focus groups (4), individual interviews (18)	NS	NS	Framework approach	NVivo 7.0
[24]	Collaboration	South Africa, NS	NS	NS	NS	NS	NS
[33]	Service use	Sierra Leone, purposive and convenience	Individual interviews (NS), group interviews (NS), semi-structured questionnaires (NS)	Interviewer recorded (NS) outcomes of the group interview on a flip chart and by a note taker on a laptop	1 April 2012–May 2013	Thematic content analysis (framework method)	Excel

NS not specified

Table 2 Description of the participants included in review

Study	Stakeholders included in sample			Specific mental disorder focus	Age range, mean age, gender distribution
	Non-biomedical	Biomedical	Patients and patient care givers		
[28]	None	None	61	Depression	Not specified (NS), all female
[20]	None	Social worker = 01	None	Neurosis	31-year-old male patient Demographics of social worker NS
[21]	Dervish healers = 5 Amulet writers = 5 Fortune tellers = 6 Koranic healers = 4	7 psychiatrists	20 patients	Psychosis excluded	10 male patients 24–40 (mean 27) years 10 female patients 17–46 (mean 35) years Psychiatrists NS Healers NS
[30]	Prophets = 04 Church elders = 05 Pastors = 02 Reverend = 01 Church member = 01 Caretaker = 01 Total = 14	Mental health nurses = 29 General practitioners = 02 Orderly = 01 Hospital administrator = 01 Psychiatrist = 01 Community mental health officer = 01 Community psychiatric nurse = 01 Total = 36	None	NS	NS
[25]	None	None	Turkish born migrant women = 10	Major Depressive; Dysthymic; Panic with Agoraphobia; Generalized Anxiety; Somatization; Pain	31–48 years 35 years 10 women; 0 men
[29]	Culture specific consultant from Maori child adolescent and family mental health service	Psychiatrist = 1	1	Psychosis	17-year-old male patient Demographics of psychiatrist and cultural consultant NS
[22]	Balian healers NS Case 3: 40-year-old male Balian	None	Case 1: 20-year-old female Case 2: 30-year-old male with his family Case 4: 35-year-old male Case 5: 21-year-old male	NS	5 case studies (4 male) 20–40 years
[31]	Practitioners (95): Native American Church, Pentecostal Christian healing; Traditional Navajo healing	None	Patients (84)	Alcohol and substance dependence	NS
[26]	None	None	Family members = 16	Psychosis	27–68 (mean 47) years 8 males, 8 females
[23]	None	Sharing Circle facilitators = 04	Aboriginal Seeking Safety group = 17	Intergenerational trauma; Substance Use	24–68 years 35 years 12 women, 12 men

Table 2 (continued)

Study	Stakeholders included in sample			Specific mental disorder focus	Age range, mean age, gender distribution
	Non-biomedical	Biomedical	Patients and patient care givers		
[27]	Phase 1 NS Phase 2 Traditional healers = 04 Faith healers = 05 Total = 09	Phase 1 NS Phase 2 Clinicians = 08	Phase 1 NS Phase 2:None	Depression	NS Equal ratio of women and men
[3]	None	None	Community member = 14 Patients = 35	NS	29 male, 29 female Mean age 43.1 (12.2)
[32]	Allopathic = 03 Mujavars = 03 Total = 06	None	Clients = 03 Carers = 07 Total = 10	NS	NS
[13]	Traditional healers = 50	None	None	NS	64% female Mean age 45 (0.59)
[24]	None	None	Patient = 1	NS	29-year-old male
[33]	Christian healing = 05 Traditional healers = 08 Total = 13	Health care providers = 10	Special needs teachers = 02 Primary and secondary school teachers = 04 Parents/caregivers = 05 Total = 11	NS	NS 27 men, 17 women

NS not specified

> to do, there is no improvement. So we realize that this person is suffering from mental illness [32, p. 376].
> It is true that a person gets mentally disturbed if they don't do their family rituals, or traditions … and then you find that some people have a calling, to become traditional healer. We can help patients who have a mental illness caused by African reasons [13, p. 286].

Spiritual and faith healing

In the case of spiritual causes of mental illness, it was generally believed that the "*bomoh can cure my illness… she gave holy water … she asked me to chant every time after I perform my prayer. I did it … I feel relief*" [28, p. 459], as was stated by a service user. According to the aforementioned authors, another spiritual treatment method perceived to be effective was fasting, explicitly mentioned in the Bible (Matthew 17:21). Fasting is perceived to provide strength for the spirit, irrespective of whether the patient or his/her loved ones fasted on his/her behalf [30]. According to the authors, prayer was also perceived to be effective in treating mental illness [29, 31–33].

One manner through which faith healing, specifically, was perceived to be effective, was through strengthening faith, as was stated by a service user: "*I do believe the bomoh*[5] *will help me strengthen my faith … I do believe the power of will inside me will help me against my illness*" [28, pp. 459–460]. Stronger religion or faith was, therefore, perceived to result in improved health [21, 28, 30, 31].

Ineffective faith healing Abdul and Bifulco [28] noted, however, that for one participant spiritual treatment "seems not to have had an effect" (p. 458). Faith healing and faith healers have not always been deemed to be effective in treating mental illness [3, 25, 28, 30]. The doctors and psychiatric nurses interviewed by Arias et al. [30] highlighted that it "was difficult to assess whether mental illnesses were biomedical or spiritual in nature, and that it was, therefore, necessary to first administer biomedical treatment" [30, p. 8]. In particular, the use of caning (which is often associated with spiritual treatment) was vehemently rejected as it was considered ineffective [30, 33]. Notably, many TAFH also rejected caning [30]. As stated by a Ghanaian Prophetess:

> [I am] disgusted to think of that because we don't [beat patients] here, because the person is suffering and they are already afflicted, so how [can] you inflict pain on [such] a person? We have never done that and will never do that [30, p. 9].

[5] Local traditional Malaysian healers [28].

Chaining, another treatment method often associated with spiritual treatment, was also perceived to be ineffective: "*maybe they will chain them … that will not help*" [30, p. 12]. However, it should be noted that whilst chaining was perceived by many to be an ineffective treatment method, the prayer camp staff described chaining to be a practical (and often the only available) means of keeping patients from running away [30].

Traditional healing

Bäärnhielm and Ekblad [25] reported that an amulet was perceived to be effective in treating mental illness, stating that "her [the patients'] feeling of being worried decreased" (p. 442). Amulets were perceived to be even more effective when used in combination with a *hoca*,[6] as one service user described: "*He reads the Koran and then the amulet helps … It depends on your belief*" [25, p. 443]. Similarly, a male patient described how Indigenous Aboriginal Elders "*facilitated the healing power of the smudging, drumming songs and the sacred Bundle; the Elders brought the spirituality to the circle*" [23, p. 11]. Another traditional treatment which was perceived as effective was described by a patient:

> You know we have a sort of natural water … Warm springs yes. You lay in the warm water … It is not hama [Turkish bath] … We have an old custom. We burn a little piece of paper. You put the paper in a glass. You put the glass on your back. It draws from the flesh of the back … You get something like a bruise. It helped … One day they saw my bruise at work … They got upset. I explained. It did not matter what I explained. They asked if my husband had been beating me [25, pp. 442–443].

The traditional Māori treatment of *whakawetewete*[7] was perceived to be effective and the young patient reported that he "had not heard any more voices and he and his mother could not recall the last time he had had a seizure like episode" [29, p. 350]. Similarly, Connor [22] reported three specific cases in which *Balian* ritualistic treatments were effective in treating mental illness. Additionally, Connor [22] states that "in many cases I encountered … the patient recovered after only a short course of traditional treatment" [22, p. 785]. Other effective traditional treatments included Tobacco Smoking Way, Turning of the Basket [31], sacred

[6] A *hoca* is a folk healer who could be a teacher versed in the scriptures serving in mosques and Koranic schools as well as functioning as a prayer-leader and an interpreter of the Koran [25].

[7] Whakawetewete is a Māori ritual of forgiveness and releasing past hurts [29].

bundles, drumming, smudging, sweat lodges [23], herbs, *muti*[8] [13, 27], and traditional Gujarat rituals [3].

Lack of effectiveness of traditional treatment methods Traditional treatment methods were not always perceived as effective [3, 22, 26, 27, 31]. Sorsdahl et al. [11, 13] reported that traditional healers will refer patients to a Western doctor if traditional medicine is not effective in treating patients with mental illness. Connor [22] described two specific cases in which *Balian* traditional treatments were not effective in treating mental illness, and patients were left at mental hospitals as the custodial institutions. In these cases, the patients' curses were deemed too strong for treatment by *Balian* healers and for treatment by mental hospitals. Similarly, Garrity [31] found some Navajo perceived traditional healing methods lacked the power to cure substance abuse, especially since substances are a recent phenomenon. This was described by one participant:

> A person that's become addicted to wine, alcoholic drugs, there is no such ceremony for this. The ceremonies were created I don't know how many million years ago. Wine or alcoholic drugs were created just recently; therefore there are not ceremonies for it. Marijuana is another one that is without a ceremony so there's really nothing that you can do … because it's a recent invention [31, p. 525].

Musyimi et al. [27] reported a traditional healer as saying: "*They [clinicians] tease the patients we refer to them by discrediting their use of herbs and warning the patients they might die if they continue using herbal medicine*" (p. 5).

Concurrent treatment

In many of the studies, participants received biomedical treatment concurrently (n = 8) with TAFH [3, 20–24, 28, 32]; or participants received biomedical treatment shortly prior (n = 2) to receiving TAFH [22, 29]. It was, therefore, difficult to determine the effectiveness of any particular treatment method exclusively. Some perceived the combination of treatment to be effective [3, 23, 32] or as the best treatment [28].

Other participants found that "the traditional system helped them more than the biomedical" [21, p. 232]. Al-Krenawi and Graham [21] noted that female patients were more likely to attribute improvements to traditional treatments when they were used concurrently with biomedical treatments. Similarly, the effectiveness of biomedical treatment was attributed to the power of God and not necessarily to the medication itself [23, 25, 30]. This is illustrated when a Ghanaian prayer camp Pastor stated:

> [We] believe that the knowledge, the intellect that God has given man, which man is [using in] producing drugs, is also a gift of God. We don't have to despise it, as God has given somebody the gift of healing. When we despise the gift of the drugs that God has provided for somebody to be given during sickness, then it seems we are not appreciating what God is doing because the knowledge and the wisdom have been imparted … from God [30, p. 10].

Interestingly, some traditional healers from Sierra Leone attributed the lack of improvement in a child's mental health to the will of God: "*Some are made like that by God. We don't go against this*" [33, p. 6]. The same traditional healers expressed particular difficulties in treating children with mental illness [33].

Discussion

Sixteen articles met the inclusion criteria for the current systematic review comprising qualitative studies of the treatment of mental illness by TAFHs. However, none of the articles focused exclusively on perceived effectiveness or provided a comprehensive or clearly-defined assessment of effectiveness. The articles tended to focus on a range of features, other than effectiveness, including collaboration between biomedical and TAFHs, illness meaning and understanding, service use, or local explanations and stigma. Nonetheless, the studies contained qualitative data which provided some insights into the subjective or perceived effectiveness of TAFHs in treating mental illness. Whilst some studies specified the type of mental illness (for example, major depressive, dysthymic, panic with agoraphobia, generalized anxiety, somatization, and pain), the data were not specific in indicating which healing method was used to treat which illness—with the exception of the *Two-Eyed Seeing Approach* used to treat intergenerational trauma and substance use [23]. Thus, from the studies included, it is not possible to comment more definitively on objectively verifiable effectiveness of TAFHs in treating specific mental illness.

Perceived effectiveness

The review revealed the importance of understanding the influence of context on the perceived effectiveness of mental health treatment. TAFH's understanding of the familial and cultural context of their patients' symptoms allowed them to

[8] South African term used to refer to a mixture of herbs and other materials. Healers are generally secretive and unwilling to name the contents of the muti. One healer mentioned a muti containing Methylated spirit, Benzine, Indonya, vingar, and umdlebe [13].

provide culturally relevant treatments which were generally deemed effective [20–25]. Additionally, contextual and cultural beliefs regarding the causation of mental illness seemed to have influenced the type of treatment sought. If the cause of an illness was deemed to be religious, spiritual, cultural, or supernatural, it was generally believed that traditional and faith healing treatment would be effective [13, 22, 25–32] and biomedical treatment would be ineffective.

Spiritual and faith healing were perceived to be both effective and ineffective. The reliance on God [34, 35], and prayer [36, 37] in treating mental illness, has previously been documented. Specifically, research has indicated a significant reduction in depression symptoms using prayer as treatment [36, 37]. However, not all spiritual and faith healing methods were perceived as effective or acceptable. Caning, often associated with faith healing, was vehemently rejected [30, 33]. Previous research has also documented the potentially harmful effects (at Sudanese shrines) of beating patients with schizophrenia [38] and other mental illnesses [34]. Whilst Sorketti et al. [38], found a statistically significant reduction in Positive and Negative Syndrome Scale (PANSS) scores, this may not be attributable to beating since the intervention included various other treatment forms.

Similarly, traditional healing was perceived to be both effective and ineffective. The use of traditional rituals has been documented previously [2] with a suggestion that it promotes successful outcomes through increased expectancy and belief in the healer [39]. However, due to the diversity and often poor operational definitions of the traditional healing methods included in the current review, it is not possible to define which methods are perceived as effective and which not. Nonetheless, it would appear that when ineffectiveness was perceived, rather than the traditional treatment *per se*, the cause was often ascribed to the illness and/or curse being *too strong* [22, 31].

The present findings highlight the importance of the healing effects of *belief*, be it in the treatment mode or the treatment provider, and what Alling [40] argues to be what has been called the *placebo effect*—and should rather be referred to as the *power of belief*. According to Alling [40], the placebo effect refers to but one aspect of several complex self-healing processes within our minds and bodies. The mind has the ability to relieve pain and suffering without our awareness, under certain conditions, and is the basis for the powerful healing effect of belief in the treatment mode or the treatment provider, to activate self-healing [40]. Various studies have indicated the healing abilities of the placebo effect (or power of belief); including in, for example, depression [41, 42]. Thus, even though some of the above-mentioned traditional and faith healing treatments lack the biomedical-required evidence of objective efficacy required, the healing power of belief should not be ignored. As stated by Kleinman [44], the maximization of a placebo effect (or power of belief) "should be applauded rather than condemned for exploiting a useful therapeutic process which is underutilized by the health care industry."

Conclusion

Despite the recent increased interest in the perceived effectiveness of TAFHs in treating mental illness within the psychiatric paradigm, studies remain few and the use of qualitative methodologies sub-optimal. While this limits critical appraisal of the available evidence, current findings suggest that TAFHs are perceived as effective in treating mental illnesses. This was especially highlighted when TAFHs were used in combination with biomedical treatment, with stakeholders expressing appreciation for the culturally relevant approach. This is particularly optimistic in light of the resource scarcity in mental health care and the need for collaboration between conventional and complementary health providers in low to middle income countries. Policy makers and future researchers should note that patients will continue to seek treatment from TAFHs for mental illness (if they perceive it to be effective), regardless of alternative biomedical advice. As such, more rigorous qualitative research on perceived effectiveness is necessary to better understand stakeholders' perspectives of effectiveness. These findings should be incorporated into any program targeting collaboration. The WHO, more than 15 years ago, noted the paucity of data and the lack of methodological rigour when surveying the evidence on traditional and faith healing [43]. However, as evidenced in this review, qualitative research that has been conducted since then still falls short on quality. Of specific relevance to future researchers and policy makers, is the lack of a clear working definition of *traditional healing* in research and in policy documents. For example, the South African Traditional Health Practitioners Act of 2007 defines a *herbalist* as "a person who engages in traditional health practice and is registered a herbalist under this Act" (p. 6). Similarly, a *traditional birth attendant* is defined as "a person who engages in traditional health practice and is registered a *traditional birth attendant* under this Act" (p. 6). The same definition is also used for a traditional health practitioner and a traditional surgeon. In truth, there is thus no clear distinction between different healers groups according to the Act. As traditional and faith healing practices have developed within different cultures and in different regions, TAFHs' practices differ and did not necessarily develop parallel to each other [43]. Thus, such ambiguous definitions in policies—and research papers—are inadequate for application or drawing any substantial evidence for the efficacy of traditional and faith healing.

Limitations and recommendations

The exclusion of papers not published in English, given the language ability of the first two authors and the high cost of translations, is a consistent weakness in terms of representativeness. Future reviews should consider including papers published in other languages. Another limitation of the current review is the lack of a secondary blinded literature search and review (due to time and resource constraints).

The use of DSM or ICD definitions of mental illness to determine eligibility limited the papers which could be included in the current review. Many studies provide loose/unsystematic descriptions of mental illness and these studies were excluded. In considering the cultural phenotypes of mental illness, DSM and ICD classifications may have their limitations. While the current review focussed specifically on the DSM and ICD definitions of mental illness, future studies should consider broader definitions to include more diverse studies.

Generally, the quality of the studies included in the current review was cause for concern. There are three main limitations that need to be considered in interpreting these findings. First, with the exception of Marsh et al. [23] and Shields et al. [32], no operational definitions for terms such as *traditional healing* or *faith healing* were provided, making it difficult to pinpoint the exact methods of healing used to treat mental illness. The lack of operational definitions was also challenging when assessing the literature for inclusion of studies in the current review; it was often up to the authors to subjectively assess eligibility based on vague descriptions of TAFHs and traditional and faith healing practices. Consequently, we cannot purport that this review is exhaustive as it is possible that eligible studies were overlooked. Whilst we do not suggest that a *blanket* definition of TAFHs is necessarily possible given its inherent nature, this does not excuse the lack of operational definitions being applied. Considering the diversity of TAFHs globally, it is surprising that definitions and descriptions of the type of traditional and/or faith healing have not been applied. Thus, we recommend that future researchers provide clear operational definitions when conducting research on this topic.

Quotations were often not contextualized thereby creating confusion as to whose perspective was being reported or which mental illness/treatment methods were being referred to. Additionally, since the included studies did not focus exclusively on the perceived effectiveness of TAFHs, extracting information that was thought to be pertinent proved challenging and prone to misinterpretation. Subsequently, we are only able to report more generally on the perceived effectiveness of TAFHs.

Last, demographic data were not always clearly reported. Information was sometimes contradictory or only described as it pertained to quantitative sections of the manuscript. Additionally, the cultural specificity of traditional and faith healing [14, 44] requires very detailed contextual data to facilitate generalizability. The sparse demographic data combined with the lack of contextual data suggest that the findings of these studies may have limited generalizability.

The problems we have faced in conducting this systematic review is a combination of the (1) source content for the review (paucity of studies, methodological weaknesses and variable quality of studies, and low levels of evidence) and (2) the theoretical limits of addressing the question of effectiveness of traditional and faith healing interventions (from both quantitative and qualitative perspectives) in view of wide-ranging and mixed practices, cultural diversity, and the dominance of ICD/DSM diagnostic systems which lack parsimony with traditional concepts of mental illness. Whilst the fairness of subjecting TAFHs to an essentially biomedical systematic review is open to debate, we argue that the present review is still a useful, albeit imperfect synthesis of the existing evidence. Nonetheless, we would recommend a mixed-method design to investigate the effectiveness of TAFHs in treating mental illness that includes ethnographic approaches, and in particular, extensive person-centred ethnography.

These limitations highlight the lack of high quality qualitative studies on the perceived effectiveness of TAFHs in the treatment of mental illness. Future research should provide clearer definitions of TAFHs as part of their methodology. Additionally, richer, more nuanced, and better contextualized data will allow for more informed conclusions on the effectiveness of *specific* traditional and faith healing methods in the treatment of *specific* mental illnesses. Finally, future studies should follow a more rigorous approach in terms of the recording and reporting of demographic data to enhance the generalizability of findings.

Acknowledgements This review was supported by the South African Research Chair (SARCHI) in Post-Traumatic Stress Disorder hosted by Stellenbosch University and funded by the Department of Science and Technology, and the National Research Foundation, South Africa. SARCHI had no role in the methods, preparation, writing, or decision to publish the Review. We thank Alvina Matthee and Linda Bellairs for their assistance in the literature search. Additionally, we would like to thank the PaM-D team, including L. Kola, J. Appiah-Poku, C. Othieno, B. Harris, O. Esan, V, Makanjuola, and L.N. Price; for their contributions.

Compliance with ethical standards

Conflict of interest On behalf of all of the authors, the corresponding author states that there is no conflict of interest.

References

1. Mbwayo A, Ndetei D, Mutiso V, Khasakhala L (2013) Traditional healers and provision of mental health services in

cosmopolitan informal settlements in Nairobi, Kenya. Afr J Psychiatry 16(2):134–140
2. Nortje G, Oladeji B, Gureje O, Seedat S (2016) Effectiveness of traditional healers in treating mental disorders: a systematic review. Lancet Psychiatry 3(2):154–170
3. Schoonover J et al (2014) Perceptions of traditional healing for mental illness in rural Gujarat. Ann Glob Health 80:96–102
4. Gureje 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(2):168–177
5. The WHO World Mental Health Survey Consortium (2004) Prevalence, severity, and unmet need for treatment of mental disorders in the world health organization world mental health surveys. JAMA 291(21):2581–2590
6. Ndetei DM, Khasakhala LI, Kingori J, Oginga A, Raja S The complementary role of traditional and faith healers and potential liaisons with western-style mental health services in Kenya. Retrieved from http://www.utsouthwestern.edu/psychiatryandfreedom
7. Ngoma MC, Prince M, Mann A (2003) Common mental disorders among those attending primary health clinics and traditional healers in urban Tanzania. Br J Psychiatry 183:349–355
8. Otsyula W (1973) Native and western healing: the dilemma of East African psychiatry. J Nerv Ment Dis 156:297–299
9. Madamombe I (2006) Traditional healers boost primary health care. Afr Renew 19(4):10
10. Koon OC (1999) Intellectual property protection of traditional medicine and treatments in Malaysia. In: Perspectives on intellectual property. Intellectual property aspects of ethnobiology, vol 6. Sweet & Maxwell, London
11. Sorsdahl K, Stein DJ, Flisher AJ (2010) Traditional healer attitudes and beliefs regarding referral of the mentally Ill to western doctors in South Africa. Transcult Psychiatry 47(4):591–609
12. Abbo C (2011) Profiles and outcome of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda. Glob Health Action 4:7117
13. Sorsdahl K, Flisher AJ, Stein DJ (2010) Explanatory models of mental disorders and treatment practices among traditional healers in Mpumulanga, South Africa. Afr J Psychiatry 13:284–290
14. Steel Z et al (2009) International and indigenous diagnoses of mental disorder among Vietnamese living in Vietnam and Australia. Br J Psychiatry 194(4):326–333
15. Bhikha G, Farooq S, Chaudhry N, Husain N (2012) A systematic review of explanatory models of illness for psychosis in developing countries. Int Rev Psychiatry 24(5):450–462
16. American Psychiatric Association (2013) Diagnostic and statistical manual of mental disorders, 5th edn. Author, Washington
17. Messerli-Rohrbach V, Bosch J (2000) Spiritual healing at a public psychiatric insitution. Forsch Komplementarmed Klass Naturheilkd 7(6):275–285
18. Zabicky G, Sollis LR (2000) Swearing: a not medical manoeuver collaborating in the management of subjects with pathologic ethanol intake in Mexico. Initial approximation. Salud Ment 23(4):22–27
19. Tong P, Sainsbury, Craig J (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care 19(6):349–357
20. Al-Krenawi A, Graham JR (1997) Spirit possession and exorcism in the treatment of a Bedouin psychiatric patient. Clin Soc Work J 25(2):211–222
21. Al-Krenawi A, Graham JR (1999) Gender and biomedical/traditional mental health utilization among the Bedouin-Arabs of the Negev. Cult Med Psychiatry 23:219–243
22. Connor LH (1982) Ships of fools and vessels of the divine: mental hospitals and madness, a case study. Soc Sci Med 16:783–794
23. Marsh TN et al (2016) Indigenous healing and seeking safety: a blended implementation project for intergenerational trauma and substance use disorders. Int Indig Policy J 7(2):3
24. Wessels WH (1985) The traditional healer and psychiatry. Aust NZ J Psychiatry 19:283–286
25. Bäärnhielm S, Ekblad S (2000) Turkish migrant women encountering health care in Stockholm: a qualitative study of somatization and illness meaning. Cult Med Psychiatry 24:431–452
26. Marthoenis M, Aichberger MC, Schouler-Ocak M (2016) Patterns and determinants of treatment seeking among previously untreated psychotic patients in Aceh province, Indonesia: a qualitative study. Scientifica 2016:1–7
27. Musyimi W, Mutiso VN, Nandoya ES, Ndetei DM (2016) Forming a joint dialogue among faith healers, traditional healers and formal health workers in mental health in a Kenyan setting: towards common grounds. J Ethnobiol Ethnomed 12(1):4
28. Abdul Kadir NB, Bifulco A (2010) Malaysian Moslem mothers' experience of depression and service use. Cult Med Psychiatry 34(3):443–467
29. Bush A, NiaNia W (2012) Voice hearing and pseudoseizures in a Maori teenager: an example of mate Maori and Maori traditional healing. Aust Psychiatry 20(4):348–351
30. Arias L, Taylor A, Ofori-Atta, Bradley EH (2016) Prayer camps and biomedical care in Ghana: is collaboration in mental health care possible? PloS One 11(9):e0162305
31. Garrity JF (2000) Jesus, Peyote, and the Holy People: alcohol abuse and the ethos of power in Navajo healing. Med Anthropol Q 14(4):521–542
32. Shields L, Chauhan A, Bakre R, Hamlai M, Lynch D, Bunders J (2016) How can mental health and faith-based practitioners work together? A case study of collaborative mental health in Gujarat, India. Transcult Psychiatry 53(3):368–391
33. Yoder HNC, Tol WA, Reis R, de Jong JTVM (2016) Child mental health in Sierra Leone: a survey and exploratory qualitative study. Int J Ment Health Syst 10(1):48
34. Ae-Ngibise K et al (2010) "Whether you like it or not people with mental problems are going to go to them": a qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. Int Rev Psychiatry 22(6):558–567
35. Kale R (1995) Traditional healers in South Africa: a parallel health care system. BMJ 310(6988):1182
36. Boelens PA, Reeves RR, Replogle WH, Koenig HG (2012) The effect of prayer on depression and anxiety: maintenance of positive influence 1 year after prayer intervention. Int J Psychiatry Med 43(1):85–98
37. Hurst GA, Qilliams MG, King JE, Viken R (2008) Faith-based intervention in depression, anxiety, and other mental disturbances. South Med J 101:388–392
38. Sorketti NZ, Zainal, Habil MH (2012) The characteristics of people with mental illness who are under treatment in traditional healer centres in Sudan. Int J Soc Psychiatry 58(2):204–216
39. Csordas TJ (1988) Elements of charismatic persuasion and healing. Med Anthropol Q 2(2):121–142
40. Alling A (2015) The healing effects of belief in medical practices and spirituality. EXPLORE J Sci Heal 11(4):273–280
41. Leuchter F, Cook I, Witte AE, Morgan AM, Abrams M (2002) Changes in brain function of depressed subjects during treatment wiht placebo. Am J Psychiatry, 159, 122–129
42. Kirsch I (2005) Placebo psychotherapy: synonym or oxymoron?. J Clin Psychol 61(7):791–803
43. World Health Organization et al (2002) WHO traditional medicine strategy 2002–2005. Retrieved from http://apps.who.int/iris/bitstream/10665/67163/1/WHO_EDM_TRM_2002.1_eng.pdf
44. Kleinman A (2004) Culture and depression. N Engl J Med 351:951–953