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Research Paper

Belief and Biomedicine: Mental Health Professionals' Perspectives on Faith Healing in Kashmir

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ABSTRACT

Faith healing remains embedded in pathways of mental healthcare in Kashmir, yet the perspectives of mental health professionals who routinely encounter faith-based explanations of distress remain underexplored. Drawing on qualitative interviews with 22 mental health professionals, including 18 psychiatrists and four clinical psychologists, this study examines how professionals understand and negotiate faith healing within clinical practice. Reflexive thematic analysis generated five interrelated themes: faith healing as meaning making and culturally legitimate care; faith healing as psycho social support; perceived benefit in milder forms of psychological distress; the Qur'an as a source of solace and religious coping; and synergy through training and referral. Professionals did not uniformly position faith healing against biomedicine. They recognised that spiritual explanations can render distress intelligible within patients' cultural worlds and that faith may sustain hope, reassurance, and emotional expression. Collaboration is considered appropriate only where faith-based practices are supportive, non abusive, and compatible with patient wellbeing and dignity.

Keywords: *Faith Healing, Mental Health Professionals, Religion, Qur'an, Cultural Psychiatry, Medical Pluralism, Kashmir*

Mental illness is rarely encountered as a purely biomedical phenomenon. Experiences of mental suffering are interpreted through cultural, social, and moral worlds that shape how suffering is recognised, explained, and responded to. While contemporary psychiatry has made substantial advances in understanding the biological and psychological mechanisms of mental disorders, individuals and families frequently draw upon broader explanatory frameworks that include religion, spirituality, local beliefs, and lived experience (Kleinman, 1980; Good, 1995; Kirmayer & Bhugra, 2009). Mental illness is therefore not only a clinical condition but also a culturally mediated experience, understood through multiple and often overlapping systems of meaning. Religion and spirituality occupy a particularly significant place within these interpretive processes. Across diverse societies, religious beliefs provide explanatory frameworks for suffering, shape coping strategies, influence help seeking, and offer culturally meaningful pathways to healing (Koenig, 2012; Abu Raiya & Pargament, 2015; Lucchetti et al., 2021). Faith healing, whether through prayer, sacred texts, rituals, or spiritual counselling, frequently becomes a

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source of hope, emotional reassurance, and meaning during periods of psychological distress. At the same time, faith based healing remains clinically contested. While it may provide culturally resonant support, concerns persist regarding delayed psychiatric treatment, coercive practices, and the management of severe mental illness (Burns & Tomita, 2015; Kaminga et al., 2020; van der Watt et al., 2018).

Framing faith healing and psychiatry as opposing systems, however, overlooks the realities of therapeutic pluralism. People rarely move through a single system of care. They may seek help from religious healers, consult psychiatrists, use psychiatric medication, engage in prayer, and rely on family support within the same illness trajectory. Such movements reflect negotiations between different ways of understanding suffering rather than a straightforward rejection of biomedical care (Kleinman, 1980; Dein, 2020). Increasingly, scholars have argued that understanding these negotiations requires attention not only to patients' beliefs but also to the cultural contexts within which clinical practice unfolds (World Health Organization, 2016).

Arthur Kleinman's concept of explanatory models provides a useful lens for understanding these therapeutic negotiations. Rather than assuming that illness possesses a single objective meaning, Kleinman (1980) argues that patients, families, and healers construct different explanations of illness that shape symptom recognition, help seeking, and treatment decisions. This perspective is particularly valuable in understanding how faith healing acquires cultural legitimacy, not simply as an alternative to psychiatry, but as a culturally meaningful framework through which psychological distress is interpreted and responded to. These negotiations are particularly salient in Kashmir, where religious and spiritual traditions remain deeply embedded within everyday social life. Experiences of psychological distress are often interpreted through locally meaningful concepts such as *nazar* (evil eye), *sehar* (sorcery), and *khotchun*, *jinn* (possession), making faith healers an important part of many individuals' pathways to care. Although previous research has documented the role of faith healing in mental health help seeking, considerably less attention has been paid to how psychiatrists and clinical psychologists themselves understand these practices while working within this culturally plural therapeutic landscape. As clinicians trained in biomedical psychiatry yet practising among patients whose understandings of illness are frequently shaped by spiritual and supernatural beliefs, mental health professionals occupy a distinctive position from which to negotiate the relationship between belief and biomedicine.

Against this backdrop, this study examines how mental health professionals in Kashmir understand the cultural and therapeutic significance of faith healing. Specifically, it asks how psychiatrists and clinical psychologists interpret faith based practices within everyday clinical encounters, what forms of benefit, if any, they attribute to such practices, and where they draw the clinical and ethical boundaries of acceptable therapeutic engagement. Drawing on qualitative interviews with mental health professionals, the paper argues that professional perspectives are characterised by a qualified form of acceptance rather than categorical rejection or uncritical endorsement. Faith healing is recognised as a culturally intelligible source of meaning making, hope, reassurance, and emotional support, particularly in experiences of milder psychological distress. Within this The Qur'an occupies a distinctive place as a source of religious coping and solace, even among professionals who remain cautious towards certain faith healing practices. At the same time, this recognition is bounded by concerns regarding severe mental illness, delayed psychiatric intervention, abusive practices, and patient safety. Belief and biomedicine therefore emerge not as

competing therapeutic systems but as a negotiated clinical terrain shaped by cultural legitimacy, professional judgement, and ethical responsibility.

METHODOLOGY

Study design and setting

This paper forms part of a broader qualitative study examining faith healing and mental health in Kashmir. The present analysis focuses exclusively on one objective regarding mental health professional perspectives on faith healing within mental healthcare system. A qualitative design was used because the study sought to understand clinically situated interpretations and reasoning rather than measure positive or negative attitudes. The analysis adopted an experiential and interpretive orientation, attending to how professionals made sense of recurring encounters with patients and families who had engaged with faith healing.

Participants

The study included 22 mental health professionals, comprising 18 psychiatrists and four clinical psychologists. Participants were recruited purposively on the basis of direct clinical experience with people experiencing mental illness and regular encounters with patients who had consulted faith healers or interpreted distress through religious or supernatural explanations. Participants were drawn primarily from the Institute of Mental Health and Neurosciences, Government Medical College Srinagar. Professional experience varied across the sample.

Construction of tool and validation

The primary data collection instrument for the present study was a semi-structured interview guide, The interview guides were developed through a systematic and multi-stage process to ensure conceptual clarity, cultural appropriateness, and methodological rigour. The separate set of interview schedule was developed for the mental health professionals tailored to the experiences and expertise of the field.

Following the development of the preliminary interview schedules, the instruments underwent a process of expert review to establish content validity, relevance, and cultural appropriateness. Following expert review and translation, pilot interviews were conducted to assess the feasibility, clarity, and practical applicability of the interview schedules. The pilot phase enabled the researcher to evaluate participants' comprehension of the questions, identify potentially ambiguous or sensitive items, and assess the overall flow of the interviews. The final interview schedules were designed to balance flexibility with consistency, allowing participants to narrate their experiences in their own terms while ensuring that key themes relevant to the study objectives were systematically explored.

Ethical consideration and informed consent

The research proposal was initially reviewed and approved by the Departmental Research Committee (DRC), Department of Psychology, University of Kashmir, followed by approval from the Board of Research Studies (BORS), Dean Research, University of Kashmir, Srinagar. Following these institutional approvals, permission to conduct the study at the Government Medical College Srinagar was sought. The research protocol was subsequently reviewed and approved by the Institutional Review Board (IRB) of Government Medical College. Data collection commenced only after all institutional and ethical approvals had been obtained.

Data Collection

In depth, semi structured interviews explored participants' experiences and interpretations of treating patients who had consulted faith healers, their understanding of patients' reliance on faith based practices, perceived benefits and limitations of faith healing, Interviews were conducted in English or Urdu according to participant preference. With informed consent, interviews were audio recorded and transcribed verbatim. Participants received information about the study, confidentiality, voluntary participation, and the right to withdraw. Informed consent was obtained before interviews. Identifying information was removed from transcripts and reported extracts.

Data Analysis

The interviews were analysed using reflexive thematic analysis, following Braun and Clarke's approach (Braun & Clarke, 2006, 2021). Analysis involved both manual and the use of software analysis repeated reading of transcripts, initial coding, development of candidate patterns of shared meaning, and iterative review and refinement of themes. Coding attended to professionals' accounts of cultural legitimacy of faith healing, perceived psychosocial effects of faith, religious coping, referral, and harm. Theme development was recursive rather than a linear process, and the researchers returned repeatedly to the transcripts to examine coherence, variation, and tensions within professional accounts. Five themes were developed: faith healing as meaning making and culturally legitimate care; hope, reassurance, and catharsis as psychosocial resources; perceived benefit in milder forms of psychological distress; finding solace in the Qur'an; and cautious synergy through training, referral, and clinical vigilance.

Findings and Interpretations

Psychiatrists' narratives did not position faith healing as a singular or fixed phenomenon. Rather, their accounts revealed an interpretive process through which different forms of spiritual healing were evaluated according to their ethical conduct, therapeutic value, and implications for patient care. While participants consistently affirmed the importance of biomedical treatment, they also acknowledged that healing unfolds within cultural and religious worlds that shape help seeking, meaning making, and recovery. Consequently, faith healing emerged as a contested yet differentiated domain, with psychiatrists continually negotiating the boundaries between cultural legitimacy, professional responsibility, and therapeutic harm. The themes that follow examine these negotiations in detail.

Faith Healing as Meaning Making and Culturally Legitimate Care

The study findings reveal that professionals frequently understood faith healing through its capacity to provide culturally lucid explanations of mental illnesses. Patients did not necessarily recognise unusual emotions, behavioural changes, fear, withdrawal, or perceptual disturbances through psychiatric terminology. Rather than being immediately understood through biomedical categories, mental distress was frequently interpreted through culturally embedded explanatory frameworks involving spirit possession, the evil eye, sorcery, or other supernatural influences. Within these locally shared understandings, seeking help from faith healers constituted a culturally legitimate and socially expected response to suffering, reflecting this argument one psychiatrist articulated, "*Most of the patients who come to us have already gone to a faith healer. Even some of the patients are referred by Peer Sahab (faith healer) himself."* This account illustrates the enduring cultural legitimacy of faith healing within Kashmiri society. Rather than functioning as an alternative outside the healthcare system, faith healers occupy a socially recognised position within local therapeutic pathways. Their authority is rooted in shared religious traditions,

communal trust, and cultural expectations, making consultation with a *Peer Sahab* an ordinary and legitimate response to psychological distress. Importantly, the reference to patients being referred by the *Peer Sahab* complicates assumptions of an inherent antagonism between faith healing and psychiatry. Moreover, referrals from faith healers indicate that therapeutic legitimacy is not exclusively claimed by either religious or psychiatric authority but can be negotiated through complementary forms of recognition, where spiritual and biomedical practitioners are understood as addressing different dimensions of suffering. One psychiatrist described the interpretive role of the faith healer succinctly: "*A faith healer gives them the term, Khoxchun, which gives them, (patients), the meaning, that make some sense to them."* (Psychiatrist, 8 years' experience). This account illustrates that faith healers offer more than a spiritual intervention; they provide an interpretive framework through which distress becomes meaning full. By naming the experience as *Khoxchun*, they transform uncertainty into a culturally meaningful explanation that resonates with patients' lived worlds. Rather than merely assigning a label, the diagnosis offers coherence, reduces ambiguity, and enables individuals and their families to make sense of otherwise confusing experiences. The phrase "it makes sense for people" is important. The psychiatrist was not endorsing a supernatural explanation of illness. Rather, the account recognised why such interpretations become intelligible within a shared cultural world. Behaviours perceived as extraordinary were explained through concepts already available to patients and families. In this way, faith healing derives part of its legitimacy from its capacity to produce culturally meaningful narratives that render suffering understandable. This echoes the broader function of cultural concepts of distress as locally intelligible ways of organising and communicating suffering (Kohrt et al., 2014).

A clinical psychologist made the relationship between cultural legitimacy, stigma, and help seeking explicit:

> *"In our valley, faith healing or going to a faith healer is very normal, acceptable, and there is no wrong or shame associated with it, unlike coming to a mental hospital. Our patients still believe in the supernatural causation of mental diseases, so they go to some spiritual person who can ward off this spiritual effect, be it evil eye, possession, sehar or whatever you call it. And importantly, the faith healer says to them this is because of evil eye or this is possession. They believe in it, accept it, and it makes some sense to them."* (Clinical psychologist, 8 years' experience)

The clinical psychologist's account highlights that the legitimacy of faith healing extends beyond religious belief to encompass social acceptability and cultural meaning. Unlike visiting a psychiatric hospital, which may expose individuals to stigma, consulting a faith healer is perceived as a routine and morally unproblematic response to distress. Within this cultural context, explanations such as the evil eye, possession, or *sehar* resonate with widely shared beliefs, enabling individuals to interpret their experiences through familiar moral and spiritual frameworks. By offering culturally intelligible explanations, faith healers reduce uncertainty and provide narratives that patients can recognise, accept, and incorporate into their understanding of illness. Their legitimacy therefore lies not merely in the promise of healing but in their capacity to render suffering meaningful within the cultural and religious lifeworlds of Kashmir. Collectively, these accounts suggest that faith healing functions as a culturally legitimate form of meaning making, shaping how psychological distress is understood and why it frequently constitutes the initial point of care.

Faith Healing as Psychosocial Support

Beyond providing culturally meaningful explanations for distress, psychiatrists also recognised that faith healing can serve important psychosocial functions. Participants described faith based spaces as sources of hope, emotional reassurance, validation, and opportunities for cathartic expression, particularly during periods of psychological uncertainty. Rather than viewing these dimensions as inherently incompatible with psychiatric care, several mental health professionals acknowledged that faith healing often addresses emotional and relational needs that extend beyond symptom management. One of the psychiatrist stated, *"Faith healing gives people a sense of hope, which is essential clinically; this is something that helps them."* (Psychiatrist/ 10 years' experience). This statement highlights the psychiatrist's recognition of faith healing as a psychosocial source of hope and emotional support during mental distress. Clinically, the psychiatrist views hope as an important therapeutic element that helps patients cope with suffering, sustain emotional resilience, and remain psychologically engaged in the recovery process. From this perspective, faith healing functions as a supportive mechanism that provides reassurance, comfort, and emotional strength within culturally meaningful frameworks.

In many societies, particularly where mental health awareness and psychiatric accessibility remain limited, faith-based spaces often become the first point of emotional expression and support. Which is beign reported by scholarships like (Kar, 2008, … Psychiatric scholarship, therefore, does not view faith solely as a religious phenomenon, but also as a psychosocial resource that can influence help-seeking behaviour, symptom interpretation, recovery processes, and the individual's capacity to endure emotional suffering. Within this context, the following narration illustrates how faith becomes intertwined with the experience and management of psychological distress.

> *"We find a lot of patients who actually have gone to faith healers; in fact, faith healers are like the first contact when patients experience mental health problems. Definitely it gives a sense of hope, and it is in sync with belief systems and value system of an individual, so really it will help. People have belief and faith because that is how our minds work."* (Psychiatrist, 10 years' experience)

This statement illustrates how faith healers often function as an important form of psychosocial support during the early stages of mental distress. Faith healers being first contact suggests that patients frequently seek emotional reassurance, comfort, guidance, and culturally meaningful explanations before entering formal psychiatric systems. Psychiatrists recognize that these faith-based spaces can provide patients and families with a sense of hope, emotional containment, social support, and psychological relief at moments of fear, confusion, and uncertainty.

In addition to this, clinicians additionally emphasised the affective environment associated with faith healing spaces, describing them as locations where patients experience emotional release, reassurance, and psychological comfort.

> *"Peer sahib has already this ambience, you know, that while entering his place, the patient feels relaxed until faith healer is not a fake healer themselves…, it gives patient reassurance, a place of catharsis and vent out in culturally legitimate way."* (Psychiatrist/ 20 years of experience)

This account highlights how faith healing spaces may function therapeutically through processes extending beyond doctrinal belief alone. The notions of reassurance, catharsis, and

emotional ventilation suggest that faith-based settings can provide socially acceptable spaces for expressing suffering, vulnerability, and emotional exhaustion. Clinicians thus appeared to recognise that the therapeutic effects of faith healing may partly emerge through interpersonal trust, symbolic comfort, collective recognition, and emotional release.

This interpretation is consistent with literature that identifies meaning and positive religious coping as potential resources in psychological adjustment, while cautioning against assuming uniformly beneficial effects (Abu Raiya & Pargament, 2015; Lucchetti et al., 2021). Adding to it another psychiatrist elaborated: Here, the perceived psychological effect of faith was linked to congruence with the patient's belief and value system. Faith based care may reassure because it does not require the person to abandon an existing worldview at the moment of distress. Belief was treated as part of the patient's psychological reality rather than an external cultural variable.

Perceived Benefit in Milder Forms of Psychological Distress

A prominent theme emerging from the narratives of mental health professionals was the perceived therapeutic usefulness of faith healing in milder forms of psychological distress. Psychiatrists frequently described conditions such as anxiety, depressive states, dissociative experiences, conversion disorders, obsessive-compulsive symptoms, and stress-related emotional disturbances as more responsive to faith-based interventions, particularly during the early stages of illness or where symptoms had not yet progressed into severe psychiatric impairment. Within these accounts, faith healing was viewed as curative and capable of producing temporary emotional relief, symptom reduction, reassurance, and psychological stabilisation in selected cases. In this regard one psychiatrist explained: *"...If I talk from the diagnostic perspective like conversion, malingering or factitious or dissociative disorders, they improve, but talking about other diagnoses like mania, they worsen…"* (Psychiatrist, 7 years' experience)

This account reflects a clinically differentiated understanding of faith healing, where perceived therapeutic benefit was considered contingent upon the nature and severity of the disorder. The psychiatrist distinguishes between conditions characterised by emotional distress, dissociative symptoms, or heightened psychological suggestibility, and more severe psychiatric disorders involving significant mood dysregulation or psychosis. Implicit within this distinction is the view that faith healing may provide emotional containment and symbolic resolution in milder or psychologically mediated conditions, while remaining insufficient in illnesses requiring intensive biomedical management. A similar observation was expressed about mild disorders by another psychiatrist: *"...But the patients with the mild disorders, say dissociations or conversions, they are commonly benefited…"* (Psychiatrist, 23 years' experience)

This narrative further illustrates how professionals associated faith healing with comparatively favourable outcomes in less severe presentations of disorder. Importantly, the perceived improvement was not always attributed solely to spiritual efficacy, but also to the emotional reassurance, cultural familiarity, and psychosocial support embedded within faith-based healing environments. Several clinicians noted that patients often experienced a sense of relief simply through being listened to, emotionally validated, and situated within culturally meaningful explanatory systems.

Professionals also suggested that faith healing occasionally facilitated continued engagement with broader therapeutic processes. Early experiences of relief or reassurance were

perceived to encourage some patients and families to persist in help-seeking behaviours, whether through ongoing spiritual care or eventual psychiatric consultation. In certain situations, clinicians themselves acknowledged accommodating patients' spiritual or faith-based orientations within treatment trajectories, "*If the patient has a strong belief and the family is of the same nature, I would suggest."* (Psychiatrist, 20 years' experience). This statement reflects a pragmatic and culturally sensitive clinical approach in which patients' belief systems were incorporated into therapeutic decision-making rather than dismissed outright. The psychiatrist's willingness to consider faith-based intervention suggests recognition that treatment acceptability and emotional engagement are often shaped by culturally embedded understandings of illness and recovery.

At the same time, mental health professionals consistently emphasised that the perceived effectiveness of faith healing was largely restricted to milder or early-stage conditions. Severe psychiatric illnesses such as schizophrenia, bipolar affective disorder, severe mania, and chronic substance dependence were generally understood as requiring biomedical intervention, particularly where symptoms involved psychosis, significant functional impairment, or risks to self and others. Within these accounts, faith healing was positioned as supplementary rather than sufficient in the management of severe psychiatric disorders.

Overall, professional narratives reflected a nuanced and differentiated understanding of faith healing within mental health care. Rather than rejecting faith-based practices entirely, clinicians acknowledged their psychosocial and culturally meaningful role in alleviating milder forms of distress, fostering hope, and facilitating emotional support. However, this recognition remained bounded by clinical distinctions regarding illness severity, prognosis, and the perceived necessity of psychiatric intervention in more serious conditions.

The systematic qualitative literature similarly suggests that perceived effectiveness of traditional and faith healing often involves psychological and social processes rather than a single therapeutic mechanism (van der Watt et al., 2018).

Qur'an as a Therapeutic Source of Relief

The Qur'an occupied a distinctive position within professional narratives. While participants expressed varying degrees of caution towards individual faith healers, some psychiatrists and clinical psychologists spoke more comfortably about Qur'anic recitation as a source of solace, reassurance, and religious coping. One psychiatrist articulated the distinction clearly:

> *"I have not referred my patients to faith healer. I would rather say to them to read specific verses themselves, such as Aayatul Kursi or Char Qul, the verses from the Quran. That is what I say to them*." (Psychiatrist/ 10 years of experience)

The distinction between sacred text and the individual healer is analytically significant. The psychiatrist did not transfer therapeutic authority to a faith healer and did not present Qur'anic recitation as a substitute for psychiatric treatment. Yet the clinician was willing to accommodate direct engagement with sacred text within the patient's broader treatment trajectory.

This finding is consistent with calls for mental health professionals to enquire sensitively about religious and spiritual resources that matter to patients (Lucchetti et al., 2021). It also supports the need to distinguish personal religious coping from organised faith healing. The

two may overlap in patients' lives, but professionals did not necessarily accord them the same legitimacy.

In these accounts, the Qur'an carried a form of religious legitimacy distinct from the credibility of individual healers. Concerns about exploitation, inappropriate practices, or authenticity did not automatically extend to patients' direct engagement with sacred text. Qur'anic recitation could therefore be accommodated as a source of solace without being positioned as an alternative clinical treatment.

This selective accommodation complicates the familiar faith versus biomedicine binary. The psychiatrist who recommends Qur'anic recitation while declining to refer patients to faith healers is neither secularising the clinical encounter nor merging psychiatry with faith healing. The professional retains clinical responsibility while recognising a religious resource that is meaningful within the patient's moral and emotional world.

Towards Therapeutic Synergy: Referral, Training, and Clinical Vigilance

Although psychiatrists consistently affirmed the primacy of biomedical treatment, several participants resisted framing faith healing and psychiatry as inherently opposing systems of care. Instead, they articulated a more nuanced position in which collaboration was considered both possible and desirable, provided that patient welfare remained the overriding concern. As one psychiatrist reflected:

> *"I don't find it as if we are loggerheads with each other... biomedical treatment or faith healing practices. We are not loggerheads. It is more of a collaborative kind of thing, as long as faith healing practices are non-abusive, reassuring, and in sync with an individual's belief system. You cannot isolate beliefs and values from the mental health fabric of an individual... Integrating faith healing practices with biomedical management is really the key rather than getting into loggerheads with faith healing."* (Psychiatrist, 12 years' experience)

Rather than positioning faith healing and psychiatry as competing systems of therapeutic authority, this account reconceptualises their relationship as one of cautious coexistence. The psychiatrist acknowledges that mental illness cannot be understood independently of the cultural, moral, and religious worlds through which individuals experience suffering. Healing, therefore, is not solely a clinical enterprise but also a cultural and existential one. Collaboration is not presented as an epistemological fusion between religion and biomedicine, but as an ethical commitment to engaging patients within their own belief systems while safeguarding their wellbeing. Importantly, this collaboration remains conditional upon faith based practices being non abusive, emotionally reassuring, and compatible with appropriate psychiatric care.

This orientation towards therapeutic synergy was further reinforced through participants' descriptions of the biopsychosocial-spiritual model as an approach that accommodates patients' religious beliefs without compromising clinical practice. One psychiatrist explained: *"We have a model of what we call the biopsychosocial model. We work through this model. We do give due credit to the patient's faith and belief; otherwise we will lose the patient."* (Psychiatrist, 10 years' experience)

Here, acknowledging faith emerges as a clinical necessity rather than a concession to non biomedical beliefs. Participants recognised that patients' values, religious commitments, and explanatory models shape trust, treatment engagement, and adherence. Respecting these

beliefs was therefore understood as strengthening the therapeutic alliance, enabling psychiatrists to provide care that is both clinically effective and culturally responsive.

This pragmatic orientation was also reflected in participants' observations that some *Peer Sahabs* referred individuals to psychiatric services when symptoms required specialised medical intervention. Such referrals suggest that therapeutic authority is not always exercised in isolation but can involve recognition of the limits of one's own healing domain. Rather than sustaining rigid boundaries between faith healing and psychiatry, these accounts point towards the possibility of reciprocal engagement centred on the best interests of the patient.

Nevertheless, participants consistently emphasised that collaboration requires clear ethical safeguards. They distinguished spiritually supportive practices, including prayer, Quranic recitation, reassurance, and emotional guidance, from practices involving coercion, physical abuse, financial exploitation, or delays in accessing psychiatric treatment. Several psychiatrists further highlighted the need for greater awareness among faith healers regarding severe mental illness and timely referral to psychiatric services, alongside enhanced cultural competence among mental health professionals in engaging patients' religious beliefs. Collectively, these narratives point towards a cautious therapeutic synergy grounded in mutual respect, reciprocal referral, culturally responsive practice, and ongoing clinical vigilance. Rather than dissolving the boundaries between faith and biomedicine, participants envisaged a model in which both could contribute to care while remaining accountable to the ethical imperative of reducing human suffering.

DISCUSSION

This study examined how psychiatrists and clinical psychologists in Kashmir understand and negotiate faith healing within mental healthcare. The findings reveal a professional position more complex than biomedical rejection or cultural endorsement. Clinicians recognised the cultural intelligibility and psychosocial significance of faith based practices, and some attributed perceived benefit to selected, milder presentations. Yet acceptance remained qualified by diagnostic judgement, concerns about severe mental illness, and the possibility of harm.

The first contribution concerns meaning making. Professionals recognised that faith healers can render distress intelligible by naming it through culturally familiar concepts such as *Khoxchun, jinn*, which translates as possession or *nazar* (evil eye), or *sehar* (socercy). These explanations did not correspond with clinicians' biomedical accounts, but professionals understood why they "make sense" to patients. This is consistent with Kleinman's (1980) explanatory model framework and with scholarship on cultural concepts of distress, which emphasises that local idioms and causal accounts shape the recognition and communication of suffering (Kohrt et al., 2014). The findings extend this discussion by showing that biomedical professionals themselves can recognise the interpretive efficacy of an explanation without accepting its causal truth.

Cultural legitimacy was also linked to stigma. Participants contrasted the normality of consulting a faith healer with the shame associated with attending a mental hospital. Faith healing may therefore offer a socially safer route through distress. Indian pathway studies have similarly identified faith healers as common early contacts (Kar, 2008; Sharma et al., 2020; Subudhi et al., 2020). The present findings suggest that first contact is sustained by more than lack of awareness. Faith healing offers an explanation in a familiar cultural

vocabulary and may allow suffering to be acknowledged without immediately assuming a stigmatised psychiatric identity.

The second contribution concerns the distinction between psychosocial significance and biomedical efficacy. Professionals repeatedly referred to hope, reassurance, catharsis, and emotional ventilation. The qualitative literature on perceived effectiveness of traditional and faith healing identifies similar psychological and social processes (van der Watt et al., 2018). Religious coping research also shows that religious frameworks can shape appraisal and coping, although outcomes depend on how religion is used and experienced (Abu Raiya & Pargament, 2015; Koenig, 2012). The clinicians in this study did not generally claim that faith healing cures psychiatric disorders. Their accounts instead recognised that it may alter the subjective experience of suffering.

This distinction helps explain the diagnostic differentiation evident in the data. Participants were more willing to recognise perceived benefit in dissociative and conversion presentations and became more cautious in relation to mania and severe psychiatric illness. Their accounts should not be read as evidence of clinical effectiveness, because the study did not evaluate outcomes. Rather, they reveal how professionals themselves reason about possible mechanisms of benefit. Suggestion, expectation, reassurance, catharsis, and cultural congruence were implicitly or explicitly invoked as processes that may matter in selected cases. This resonates with the systematic review by van der Watt et al. (2018), which found that perceived effectiveness is frequently attributed to intertwined spiritual, psychological, and social mechanisms.

The third contribution is the distinction between the Qur'an as a religious coping resource and the therapeutic authority of the faith healer. One psychiatrist explicitly refused referral to faith healers while encouraging patients to recite Aayatul Kursi or the Char Qul. This is a particularly important finding for the study of religion and mental health. Faith healing, sacred text, and religious coping are often grouped together analytically, yet professionals may differentiate sharply between them. The Qur'an could be accommodated as a source of solace within treatment without being presented as a substitute for psychiatric intervention.

This selective accommodation aligns with broader recommendations that clinicians should enquire about religion and spirituality when these are important to patients and integrate such knowledge into person centred care without imposing religious practices or making unsupported therapeutic claims (Lucchetti et al., 2021). In the present study, professional accommodation did not dissolve biomedical boundaries. Clinical authority remained with the mental health professional, while the patient's religious world was recognised as psychologically and culturally relevant.

The final contribution concerns collaboration. Traditional and faith healers are often deeply embedded in pathways to mental healthcare, and systematic reviews show that many patients reach formal services after first contacting such healers (Burns & Tomita, 2015). Collaborative models have therefore attracted increasing interest. Gureje et al. (2020) reported improved psychosis outcomes in a cluster randomised trial of collaborative care involving traditional and faith healers and primary healthcare workers in Nigeria and Ghana. Saha et al. (2021) described a distinctive Indian model of collaboration at the Mira Datar Dargah. A recent scoping review identified several models of collaboration but also underscored heterogeneity in implementation and evidence (Jilka et al., 2025).

The Kashmir professionals' position was narrower and more cautious. Their emphasis was on training faith healers to recognise severe illness and facilitate referral, rather than merging therapeutic systems. This distinction matters because participants also reported abuse, including concern for children. Collaboration cannot be justified solely by cultural legitimacy or community trust. It requires explicit safeguards, role clarity, and mechanisms for timely referral.

Taken together, the findings reveal a form of clinical pragmatism. Professionals acknowledge belief because it forms part of the patient's psychological and cultural world. They recognise meaning, hope, reassurance, and emotional expression as potentially significant. Some accommodate Qur'anic recitation as religious coping. Yet biomedical responsibility is reasserted when severity, delay, or safety becomes clinically salient. The relationship between belief and biomedicine is therefore negotiated through selective recognition rather than simple opposition or seamless integration.

Clinical and policy implications

Mental health assessment in Kashmir may benefit from more routine, non judgemental enquiry into patients' religious explanatory models, prior consultation with faith healers, and use of faith based practices. Such enquiry can clarify treatment expectations and identify whether faith based practices are being used alongside or instead of psychiatric care. The findings also support carefully structured training for faith healers who routinely encounter people experiencing psychological distress. Training should focus on recognition of severe symptoms, risk to self or others, child safeguarding, avoidance of coercive or harmful practices, and timely referral. The goal should be referral competence rather than the uncritical integration of therapeutic systems.

Mental health professionals may also benefit from greater cultural and religious competence. The distinction between personal Qur'anic recitation and referral to a faith healer illustrates why clinicians need a more precise vocabulary for discussing religion in care. Recognising a patient's religious coping can support culturally responsive engagement while preserving clinical boundaries and evidence based treatment.

Strengths and limitations

This study provides an in depth account of faith healing from the perspective of psychiatrists and clinical psychologists working within a culturally and religiously embedded mental health context. The inclusion of professionals with direct experience of patients who had consulted faith healers enabled the analysis to focus on clinically situated reasoning rather than abstract attitudes. Several limitations should be acknowledged. The study was conducted in Kashmir and reflects the region's particular religious, cultural, and mental health landscape; the findings should not be generalised to all Muslim communities or mental health systems. The sample included substantially more psychiatrists than clinical psychologists, and psychiatric perspectives may therefore be more prominent. The study examined professionals' accounts rather than observing clinical encounters, referral practices, or patient outcomes. Claims concerning benefit in milder disorders consequently represent professional perceptions, not evidence of therapeutic effectiveness. Future research should examine how faith based beliefs are negotiated in consultations and evaluate referral-oriented training initiatives with attention to safety and treatment delay.

CONCLUSION

Mental health professionals in Kashmir encounter faith healing as an established part of patients' pathways through psychological distress. Their perspectives reveal neither categorical rejection nor unqualified acceptance. Faith healing is recognised as culturally legitimate because it can provide familiar explanations of suffering and make distress intelligible within shared systems of belief. Professionals also identify hope, reassurance, and catharsis as psychosocial resources associated with faith based care, particularly in selected milder presentations.

The Qur'an occupies a distinctive position within this therapeutic landscape. Some professionals accommodate Qur'anic recitation as a source of solace and religious coping while remaining cautious about referral to faith healers. This distinction shows that religion, sacred text, and faith healing should not be treated as interchangeable categories in mental health research.

Professional acceptance nevertheless has clear limits. Severe psychiatric illness, delayed biomedical treatment, and abusive practices generate clinical concern. Engagement with faith healers is consequently framed through cautious synergy, with emphasis on training, recognition of severe symptoms, safeguarding, and timely referral. In Kashmir, culturally responsive psychiatry may require neither the rejection of faith nor the romanticisation of faith healing. It requires attention to the meanings through which patients understand suffering, recognition of the psychosocial resources embedded in belief, and continued clinical vigilance where safety and timely psychiatric intervention are at stake.

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