Routledge
Taylor & Francis Group

Mental Health, Religion & Culture

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/cmhr20

How do Muslim service users, caregivers, and community members in Malappuram, Kerala, use their faith to address the challenges associated with mental ill health?

Raghu Raghavan, Brian Brown, Saliah Hussain, Sanjana Kumar, Amanda Wilson, Nadia Svirydzenka, Manoj Kumar, Ameer Ali, Anagha Chandrasekharan, Asha Banu Soletti, Monica Lakhanpaul, Meena Iyer, Chitra Venkateswaran, Chandra Dasan, Muthusamy Sivakami, Sam Manickam, Andy Barrett & Mike Wilson

To cite this article: Raghu Raghavan, Brian Brown, Saliah Hussain, Sanjana Kumar, Amanda Wilson, Nadia Svirydzenka, Manoj Kumar, Ameer Ali, Anagha Chandrasekharan, Asha Banu Soletti, Monica Lakhanpaul, Meena Iyer, Chitra Venkateswaran, Chandra Dasan, Muthusamy Sivakami, Sam Manickam, Andy Barrett & Mike Wilson (2023): How do Muslim service users, caregivers, and community members in Malappuram, Kerala, use their faith to address the challenges associated with mental ill health?, Mental Health, Religion & Culture, DOI: 10.1080/13674676.2023.2169268

To link to this article: https://doi.org/10.1080/13674676.2023.2169268

Published online: 11 May 2023.

MENTAL HEALTH, RELIGION & CULTURE
https://doi.org/10.1080/13674676.2023.2169268

Routledge
Taylor & Francis Group

How do Muslim service users, caregivers, and community members in Malappuram, Kerala, use their faith to address the challenges associated with mental ill health?

Raghu Raghavan [a], Brian Brown [a], Saliah Hussain[a], Sanjana Kumar[a], Amanda Wilson [a], Nadia Svirydzenka [a], Manoj Kumar[b], Ameer Ali[a], Anagha Chandrasekharan[b], Asha Banu Soletti[c], Monica Lakhanpaul [d], Meena Iyer[e], Chitra Venkateswaran[f], Chandra Dasan[g], Muthusamy Sivakami [h], Sam Manickam[b], Andy Barrett[i] and Mike Wilson [j]

[a]Mary Seacole Research Centre, De Montfort University, Leicester, UK; [b]Mental Health Action Trust, Kozhikode, India; [c]Tata Institute of Social Sciences School of Social Work, Deonar, Mumbai, India; [d]Department of Population, Policy and Practice, University College, London, UK; [e]National Institute of Mental Health and Neurosciences, Bangalore, India; [f]MEHAC Foundation Vazhakkala, Kochi, India; [g]Lokadharmi Theatre, Kochi, India; [h]Tata Institute of Social Sciences, Deonar, Mumbai, India; [i]Excavate Theatre, Nottingham, UK; [j]School of Design and Creative Arts, Loughborough University, Loughborough, UK

ABSTRACT

Our aim was to explore the role religion and spiritual beliefs play in dealing with the challenges associated with mental ill health among the Muslim community in Malappuram, Kerala. Twenty-four interviews were conducted with patients of Islamic faith diagnosed with a mental health condition ($n = 10$) in urban (Ponnani) and rural (Vailathur) area of Malappuram, a Muslim majority district in Kerala, their family carers ($n = 8$) and community members ($n = 6$). Four key themes were derived, namely (1) Attribution to supernatural factors, (2) Relying on "God's will", (3) Prayer, and (4) Traditional healing. Faith was seen to be a prerequisite for any treatment, including modern medicine, to work. Even within a single faith group there can be considerable variation in belief and practice, with more pious participants disapproving of the reliance on local traditional healers and belief systems, highlighting the value of paying attention to the detail of local beliefs and practices.

ARTICLE HISTORY
Received 5 May 2022
Accepted 8 January 2023

KEYWORDS
Mental illness; culture; religion; Islamic faith; prayer; mental health literacy

Introduction

The challenge of poor mental health is a global concern, with one in four people said to be affected by a mental or neurological disorder worldwide (The World Health Organization, 2001; 2013) comprising a major cause of illness burden. This is a particular concern among low-to-middle-income countries (LMICs) such as India, where limited resources are directed towards mental health (Semrau et al., 2015; World Health Organisation, 2013). Individuals may face a variety of challenges associated with poor mental health, but an

CONTACT Brian Brown brown@dmu.ac.uk

important common factor concerns the role of beliefs, attitudes, and cultural resources which have a bearing on mental ill-health. In this paper, we will explore the role of religion and spirituality in dealing with the challenges associated with mental illness among Muslim mental health service users, informal caregivers, and community members in a semi-urban district in Kerala, India – Malappuram.

Our study was conducted in South India, in the State of Kerala, with an estimated population of 36 million, home to almost 3% of India's population and its land is three times more densely settled than the rest of the country. Kerala has a Human Development Index (HDI) of .79, which is "very high" and the highest of any state in India. It has the highest literacy rates among all Indian states at 98.9%, and a life expectancy of 74 years which is among the highest in the country. Kerala has one of the lowest fertility rates in India, which has caused a demographic shift as seen in many developed countries with 12% of its population over the age of 60. Malappuram is a partly urbanised district in Kerala, with a population of approximately 4.5 million in 2018 (Government of Kerala, 2019). From a socio-economic perspective, Malappuram has the fourth largest proportion of families living below the poverty line in the state of Kerala, with insufficient education and health amenities to meet the needs of the population. Around 19% of the district's income is believed to derive from workers who have migrated to the Gulf states sending money back to relatives in the area (Radhakrishnan, 2017). However, the district has a lower suicide rate, compared to the average in Kerala (Ahammed & Mukharjee, 2013). It has been suggested that this may be because of religious faith acting as a protective factor (Lester, 2017; Vijaykumar, 2007). Yet we know far less of the detail of how religious faith mitigates the day-to-day difficulties of living with a mental health problem in the district. Therefore, this study will explore the role of religion, in particular Islamic faith in navigating the challenges associated with mental ill health among service users with mental health problems, informal caregivers and community members.

Religion, culture, coping, and mental health

The role of religion and spirituality has been considered important when understanding how individuals deal with the challenges associated with mental illnesses, providing a sense of meaning and purpose during times of difficulty (Francis et al., 2019). Religion can promote a positive, optimistic, and hopeful perception of the world; provide role models from within sacred writing; give individuals a sense of indirect control over their situations and offers a community of support, both from humans and the divine, reducing the feeling of isolation and loneliness. Unlike other coping mechanisms, religious coping is available anywhere and anytime, regardless of any personal, financial, social, or physical and mental circumstances (Koenig, 2012).

Individuals suffering from mental ill-health and caregivers have found that religious beliefs and practices to be a source of peace and strength (Tepper et al., 2001). Religious practices such as praying engendered "gratitude" and "hope". Gratitude correlated with higher levels of contentment and a reduction in the presentation of symptoms associated with anxiety and depression (McCullough et al., 2002). Although within a Christian population, McCullough et al.'s study found emotions such as gratefulness to be associated with an increase in churchgoing, praying, reading religious literature, and a closer relationship

with God. Koenig et al. (2001) however state that there could be a delay or failure in seeking medical or psychological intervention due to an over-reliance in religious activities. Several other issues have also been associated with a reliance on religion including internal struggles where religious conflicts exist and a frustration in prayers not being answered.

There are a number of studies exploring coping and religiosity in the Islamic world. For example, Abu-Raiya et al. (2019) identified associations between Islamic faith and positive religions coping and satisfaction with life in a number of countries. Khaki and Habibabad (2021) reported that a spiritual education intervention enhanced feelings of wellbeing and decreased depressive symptoms.

Numerous studies have explored perceptions towards mental illness in the Muslim community, particularly in the UK. Amongst believers, supernatural factors have often been blamed, such as spirits called Jinn, and black magic (Sihr). In the UK, Dein et al. (2008) asked Muslims from the Bangladeshi community with diagnoses of depression and schizophrenia about their understandings of misfortune. Participants were likely to attribute misfortune to Jinns especially in times of psychological disturbance and unexplained physical symptoms. Islamic religious practices such as praying and reciting the Quran have also been mentioned in several studies as a coping mechanism for mental illnesses. The Quran is considered a spiritual, social, psychological, and economic guide in the understanding of human behaviours and experiences (Rassool, 2020). In his examination of religious coping in the UK, Bhui et al. (2007) found that Muslims and Black Caribbean Christians to adopt religious coping practices more than other religious groups. Among Muslim participants, practices such as prayer, using prayer beads, reciting verses from the Quran and listening to religious tapes were considered to be helpful. Muslim participant's background also reported less distress and were able to solve problems when adopting religious practices such as praying. Compared to other religions, studies have also found that prayer and faith among Muslims were more helpful in coping with depression (Loewenthal et al., 2001). Within Islam also, the sense of obligation and accountability towards one's community has been described as contributing to mental health (Tekke et al., 2020) and positive engagement in community welfare.

Mental ill-health can be perceived in various ways in relation to both religion and culture. According to research on the stigma of mental illness by Ng (1997), culture can have a huge influence on both the perceptions and experiences of mental illnesses for patients and others as well. This can be considered highly relevant in the Indian context, where various explanations of mental illness exist including supernatural, religious, and moralistic. It is therefore essential to explore the role of religion in informing the perceptions of service users, informal caregivers, and community members in a small town in the district of Kerala where the suicide rate appears to be low. According to Bhui and Bhugra (2002), capturing the worldview of a patient is essential in understanding the meaning they attach to their problems and recovery and in planning effective and acceptable mental health services.

Whilst research has been undertaken on the prevalence of mental illness in India and the effectiveness of coping mechanisms, there is little addressing the process of dealing with mental ill health for service, users, caregivers, and community members. Whilst research has been conducted on Islam, mental health, and wellbeing elsewhere, material from this part of India, especially within semi-urban and rural contexts in India; which this study will aim to address.

Aim

The aim of our study was to gain understanding of the role religion and spiritual beliefs play in dealing with the challenges associated with mental ill health among the Muslim community in Malappuram, Kerala. By doing so, a rich, all-round perspective can be gained on the role faith plays in knowledge, beliefs, coping mechanisms, and help-seeking behaviour. This is part of a larger UKRI-funded study exploring culturally appropriate mental health literacy in urban and rural Kerala, India.

Method

Location

Interviews were carried out at Ponnani-Taluk, a semi-urban district and a smaller village in Tirur called Vailathur in the district of Malappuram, Kerala. Malappuram is the only district with a large Muslim population in Kerala and has a poor literacy rate according to the 2011 census. The two areas differing in their level of urbanisation were selected to reflect the variety of living situations found in the area. As previous work (e.g., Raghavan et al., 2022a, 2022b) has shown, there are important collective dimensions to mental health experience in Kerala, and perhaps India more generally, where care within the family and the wider community climate are related to matters of faith and the prevailing social dynamics. Mental health provision in the areas involves a variety of statutory, private and charitable provision, but as our service user participants were all on low incomes, they predominantly made use of the latter.

Participants

Twenty-four participants were interviewed, split into three separate profiles, caregivers of people with a mental illness ($N = 8$, Mean age: 50.6, SD 16.27), community members ($N = 6$, Mean age: 47, SD 13.33) and service users with a diagnosis of mental disorder ($N = 10$, Mean age: 46.1, SD 9.11). In total there were 12 females and 12 males. All participants were Muslim. Interviews were carried out in Malayalam.

Recruitment proceeded with the help of mental health partner charity, the Mental Health Action Trust which had a well-regarded presence in the areas concerned. Contact between potential participants and research fieldworkers familiar with the neighbourhoods and fluent in the local Malayalam language was facilitated by these organisations. As the study was focussed on social relationships rather than diagnoses, participants were not selected to represent a specific category of disorder. A variety of diagnoses had been received, including schizophrenia and bipolar disorder, but also depression and anxiety conditions were mentioned. All service user participants had capacity to give consent and undertake an interview.

Interviews

The study was ethically approved at De Montfort University and partner institutions in India and as part of the recruitment process, participants were provided with information on their rights to withdraw, the voluntary nature of their participation, anonymity, and

confidentiality. In-depth interviews using an interview guide were undertaken. The topics covered were determined by pilot work and consultation with the partner charity already working in the area and local community members to yield a set of prompts aligned with the beliefs and concerns which were prevalent in the local areas. Further fine tuning of the interviews was possible, based on the experience of interviewers and participants during the fieldwork. The interviews focused on individual beliefs in relation to the experiences of mental illness from the perspective of service users, caregivers, and community members. As the population of Malappuram is largely Muslim, focus was placed on the role of Islamic beliefs in the understanding of and attitudes towards mental illness.

The interviews were carried out in Ponnani and Vailathur in the district of Malappuram by researchers trained to undertake qualitative interviews. The caregiver, community workers, and patients were interviewed after obtaining informed consent. The interviews were recorded, translated, and transcribed. Following this, thematic analysis was conducted to analyse the data (Braun & Clarke, 2021) and this was further informed by the approach to lived experience found in descriptive phenomenology (Davidsen, 2013). We deployed this approach, we explored how mental health problems, their causes, and possible remedies were conceptualised by participants. Thematic analysis was deployed flexibly to enable us to negotiate interpretive decisions to yield a plausible, defensible analysis. We considered both latent and explicit meanings (Giorgi & Giorgi, 2008). Themes were delineated and prioritised according to their apparent significance (Braun & Clarke, 2021) so as to create an account of participants' personal and collective experience of their reality. An iterative analytic process was adopted, which involved reading and re-reading the interviews, by one author (SH) initially, following which the emergent pattern of features was discussed by the wider authorship team and the emerging landscape of spiritual aspects of mental health and coping was further thematised.

Findings

All groups of participants relied extensively on traditional and religious beliefs when explaining how the challenges associated with mental ill-health were dealt with and guiding help-seeking behaviour. The majority of the residents in Malappuram (approximately 70%) belong to the Islamic faith, and participants made considerable reference to their religious beliefs when explaining the challenges associated with mental ill health. Analysis of the data revealed four key themes; (1) Attribution to supernatural factors, (2) Relying on the "Will of God", (3) Prayer, and (4) Use of traditional healing methods. Running through all these themes is the notion that culture and faith inform the attributions, perceptions, and hence coping with mental ill health, distress, and disorientation.

(1) *Attribution to supernatural factors*

It is commonplace for Muslims to believe that God created angels, humans, and Jinns. Jinns are believed to be created from fire and live in their own space. On the basis of sources from Quran and the Hadith, Jinns are said to be invisible to humans but are capable of making themselves visible if they wish and also in interfering with humans

in powerful ways. A Muslim service user with a diagnosis of Bipolar Affective Disorder shares her experience regarding Jinns during the onset of her illness:

> I also saw a good jinn, a small one! After that I felt I was more concerned about reciting Quran, performing prayers and keeping clean. I still haven't been able to get rid of that jinn, all this is happening because of the jinn in my body. I feel that jinn is still inside my body. (Service user, 35, Female – Vailathur)

Some participants consulted enchanters or faith healers, who were also likely to believe that mental ill health resulted from black magic. However, a lack of relief on following the enchanter's remedies, yielded some doubt on the part of participants:

> I was also taken to several enchanters for treatment who would say that my illness was the result of black magic or sorcery and I need to take remedies for it. But my illness persisted. (Service user, 61, Male, Vailathur)

Service users also described making use of other alternative modes of treatment such as "Black magicians and muslaiyars" (Musliyar is an honorific associated with South Indian, chiefly Malayali, scholars of Islam) because "the doctors could not do anything" (Service user 41, Male – Ponnani).

Despite there being a belief in such methods of treatment, users were also doubtful about the efficacy of such remedies. One service user was particularly critical of the idea of magic by stating that help is sought from "Sihr and some senseless things" (Service user, 47, Male – Vailathur).

The belief in Jinn and Sihr (Magic) were mostly found among service users. Caregivers and community members were more likely to be circumspect, mentioning such possibilities but displaying some scepticism:

> The thangals and musaliyars said that since she got married to a rich man, somebody felt that she should not live peacefully and did some kind of black magic on them. (Caregiver, 55, Female – Vailathur)

Although they did seek an opinion from Thangals (who are a social group among the Muslims of Kerala, who are often regarded as roughly equivalent to the more general Sayyids/Sharifs: descendants of the Islamic prophet Muhammad of the wider Islamic culture) and Musaliyars (a term for Malayali Islamic scholars). The caregiver however displays their lack of belief in such views: "We don't believe in that, if we have to believe she should become alright, isn't it?".

A member of the community reflecting on actions taken in relation to mental illness, stated that:

> Among Muslims we had Musaliyars and Jinn Grannies. The patients were taken to these people they were given chants and writing on the plate and similar things which I have seen. These are all beliefs, and some people must have benefitted from this and their problem must have got solved. (Community member, 50, Male – Ponnani)

This participant describes how some of the belief systems within the Muslim community in Malappuram and the actions taken. Whilst belief in Jinn and magic are widespread in Islam, a good deal of the practice is specific to the local culture, such as visiting Jinn Grannies or Musaliyars. The same community member even indicated this to be a money-making scheme:

> Ladies are the ones who are falling prey for such poojas and black magic because it is easy to take them for a ride, especially ladies from the Muslim community. (Community member, 50, Male – Ponnani)

Although some people viewed these beliefs and practitioners sceptically, they sought remedies from them in order to get some form of relief, even if only a little. The participant above believed it was women who were more susceptible to seeking help from these alternative practitioners whom he viewed as apt to exploit them in order to make money.

(2) *Relying on the "Will of God"*

The notion that health and illness came from God was present among all three participant groups, reflecting their strong belief that they are part of the plan of God. According to one service user:

> This (mental illness) is what God has given me. (Servicer user, 47, female – Ponnani)

Similar perceptions were echoed by caregivers and members of the community. One caregiver shared a similar viewpoint:

> All this is given by the God and it will get over, is what I think.
>
> (Caregiver, 72, Male – Vailathur)

One community member linked his belief in God and any daily action or change with the concept of Thavakul. As mentioned by the participant, Thavakul refers to reliance on God or trust in God's plan and is strongly held within the Islamic belief system:

> We should have staunch belief in Allah or the God, who created us, because whatever is happening in our life, will not happen to our plans. It all happens according to Allah's decision. Without the blessings of Allah nothing will happen. We are not even breathing or moving our hands according to our wish, it is as per His decision and His help that should be the basic foundation in life. In Arabic we call it Iman or Thavakul. Thavakul is entrusting everything in Allah. We should have strong belief in Allah, belief is not Allah is there but Allah is giving us all, including the air we breathe or the food we eat and the water we drink. Our full system is controlled by Allah, it is Allah who is giving birth and taking away from us in the form of death. Allah is the creator so have firm faith in the creator, which should be the first one. Only then the foundation will be strong. Only then we can approach Him when there is any problem. It is called Iman or thavakul, it is called thavakul. (Community member, 50, Male – Vailathur)

Individuals may feel helpless and feel a lack of control over their mental health problem. Belief and trust in the will of God is considered by some to be an important prerequisite for treatment to be effective:

> It all depends on his luck, it all depends on the God above us, and you won't know what he has planned for this guy. It will happen according to the plans of the God. If treatment is given and then there is change then he will escape. I told about that person who works in the electrical shop? He used to roam around all the graveyards and he wear the dress and walk around. If anyone buys him food he will eat otherwise he will not do that also. But now, in the past two years, he has changed and he is active and driving a vehicle also and working. He is a completely changed man. (Community member, 50, Male – Ponnani)

Providing a real-world example, this participant states that God can change the condition or state of individuals when he wills. The Will of God, a constant theme across the interviews, was emphasised as the source of anything good or bad that had occurred. From their Islamic viewpoint, nothing can come into existence without it being allowed through the Will and knowledge of God. Having a particular illness and the healing process are attributed to God. Any assistance provided by a doctor, psychologist or alternative practitioner is perceived as a means through which God's will manifests. As everything is considered only possible through God's will, participants considered the role of God a vital part of their lives, informing their everyday decisions and their response to challenges. Being aware of and maintaining this relationship with God was significant to them in dealing with challenges of mental ill health and was seen as a precondition of treatments or therapies working. Moreover, illness could be interpreted as a process of purification, whereby any form of distress is a form of spiritual development, bringing the person back to God.

(3) *Prayer*

According to the Islamic belief system, the process of dua or prayer is like a conversation with Allah in which Muslims put their needs before God and ask for his help in the resolution of their problems. According to a Hadith from the Prophet Muhammad (PBUH), "Allah did not send down any disease without sending down its cure" (Sahih al-Bukhari). While Islam encourages individuals to seek medical treatment, it is also a part of the religion to seek help from God. Thus, the need for dua and prayer. Praying was used for two reasons; healing the mental health problem and providing strength to deal with any problem they were facing. This was the case for both service users and caregivers. A service user shared her ordeal in living with a mental illness and her reason for praying:

> I always pray to God and ask them not to give this illness to anyone else. I can't bear the sickness. No one can bear it the way I do. Let no such thing happen to anyone. A kind of sadness in my mind … not sadness, but a kind of uncertainty as to what to do in life … with no aim … sometimes I try to sleep it off, but it is difficult for me to fall asleep. When that happens, what would it be like? I don't want this to happen to anyone else. I do my prayers when this happens. I don't pray for anything apart from this. (Service user, 61, Male – Vailathur)

This service user finds their mental illness to be so challenging, that they wouldn't wish it upon anyone. Hence, the reason for praying. Praying was also done as a method of relief when their symptoms appeared to be more prevalent. Another service user explains the notion of praying in a very practical way – reflected in their everyday actions:

> I pray to God for creating everybody here and I pray for the people. If I am sitting in the sky and doing well for the people here, you people who are in the earth should also do something good for the people here. (Service user, 52, Male – Vailathur)

The belief in Islam, God and the practice of praying is seen as something very spiritual and meaningful according to this participant. Adopting this spiritual sense can be reflected in everyday actions such as helping others. Not only does this result in peace and contentment for individuals but is also a method of putting their life in order. Alongside the spiritual side of prayer, essentially many participants connected prayer with the notion of

practice. Here a caregiver shares how their caree prays for improvement in their condition and the practices they adopt:

> Yes, he reads a lot. After the thahajudh prayer he chants the Quran or read books. All this happens when he is in good condition. He then prays to God for better physical condition. He is not able to do that now is what he is saying. He is not able to offer prayers and go to the mosque is what he tells always. He is not able to chant Quran is what he tells me. Nowadays he gets up at only 9 am. Some days he gets up at 4 and goes to the mosque to offer prayers. (Caregiver, 44, Female – Vailathur)

The caregiver shares that this participant carves out time devoted only to praying, whether this is reading the tahajjud prayer or the Quran. However, their illness limits the time they can devote to praying. Interestingly, the tahajjud prayer that this participant mentions is an optional prayer, prayed in the middle of the night as a means to get closer to God and invite his blessings in every aspect of our lives. The tahajjud prayer is also thought to give inner strength and mental peace and is prayed at a time where any wishes or duas are more likely to be accepted. Similarly, the Quran is also read as a method of praying. The Quran is thought to be sent as a form of guidance for the whole of mankind. However, as the Quran is written in Arabic, most individuals read it to sustain a connection with God as a means of peace and contentment.

Community members also shared their experience of praying, their beliefs, and the practices they incorporate in their everyday regimes to assist them in their everyday challenges as a form of spiritual relief and treatment.

> Only prayer is trustworthy. The main thing is prayer and nothing else. Other than prayer there nothing else. That I have experienced. For whatever reason, we pray to God sincerely, we will feel better soon. That is true 100%. (Community member, 40, Female – Vailathur)

And

> Prayers can remove all this to a certain extent is the belief. (Community member, 70, Male – Ponnani)

The above quotes underscore the importance of praying and faith in the world view of participants. For many, faith and prayer held a primary importance and it was through these that anything else was possible, and underlay the effectiveness of medical treatments and was a preeminent source of relief and healing in its own right.

(4) *Traditional Healing Methods*

In Kerala, Islamic faith healers include Thangals, Usthads, and Maulvis. According to believers, faith healers may not only understand the cause of the illness, specific to a person; but also suggest remedies and ways to manage the condition. Most faith healers attribute mental illness to a supernatural phenomenon such as possession by a Jinn, Shaitan, or demonic spirits. These traditional practices may involve a variety of amulet-like devices. For example, a service user mentioned the practice of tying a thread to treat the problem:

> I was really frightened then. I felt like running out. Such problems I had. In our caste there a person called Usthad, he came and tied a thread. Then I had no problem after that. (Service user, 35, Female – Ponnani)

Another service user from Ponnani stated how her belief in faith healers and Thangals led to them selling the family's jewellery in order to fund unsuccessful treatment before resorting to seeking medical help in a hospital:

> Many times, I went to the Thangal. My daughter's chain and earrings are all gone. We had to sell all those jewels to go to them and when we realized that they cannot do anything we went to Tirur and was admitted in Anzari hospital. (Service user, 47, Female – Ponnani)

Despite widespread help-seeking from faith healers there were some who considered these practices nonsensical. One participant highlighted the lack of belief in alternate practices among certain people; "Mujahids" (or those who were particularly zealous in their Islamic faith) as indicated in the quote below.

> Mujahid people don't like it, isn't it? They don't like such things.

Instead of questioning the effectiveness of treatment, this service user instead displayed scepticism towards the belief of "Mujahids" themselves and the attempts of the latter to eliminate the community's reliance on faith healing. In the community then the more educated or pious Muslims were likely to deem the faith healing system to be unorthodox and not true to the tenets of Islam. Even among those who had engaged in spiritual healing or traditional practices expressed some scepticism about its effectiveness.

> My family used to tell me about other people's suggestions. But the final decision was mine. Usthad, Thangal and enchanters, there were all kinds of advices and I listened to them. They told me that it is a result of black magic or sorcery and that it is part of my blood. I followed their suggestions twice. I went to Mannarkaad and Chooriyod with Nair under Ustad's care-off to complete all the rituals that were asked of me. That didn't make any difference to my illness. (Service user, 61, Female – Vailathur)

Families are often involved in the choice of treatment, and Thangals and Usthads are often consulted first, and other avenues are tried when traditional methods do not appear to be working. Faith healers are often the initial point of access for many Muslims in this district. Faith healers are usually based in the community and are easily approachable and secondly, the belief system they promote regarding causation readily aligns with that of local people. One participant highlights the usual pattern of help-seeking in the area:

> … there is an order of choice of management among religious people in my community; first they go to spiritual healers, then they try ayurvedic medicine, and if nothing works, finally Western medicine.

In line with the comments above about more pious believers being sceptical of traditional healing methods, a community member who is a religious scholar in Vailathur stated:

> For a person with Islamic beliefs this is not a good ritual because what we have is a single god belief. So, in such cases we are forgetting Allah and going to another God and doing a pooja there. (Community member, 31, Male – Vailathur)

Such views appeared to be specific to a particular subgroup who identified themselves as being more pious and scholarly than the others. In the wider community a variety of alternative traditional practices were followed, which drew upon a number of longstanding ritual and spiritual traditions. One reason for this preference could be the stigma

attached to mental ill-health and limited mental health facilities in the region (Jalal et al., 2020); resulting in a reliance on cultural and religious practice over medical or psychological approaches.

Discussion

Our aim was to understand how religious and spiritual beliefs guide Muslims in Malappuram in navigating the challenges associated with mental ill health. The findings indicate that the "Muslim" identity informs a large part of the belief systems and choices individuals make regarding mental illness. Religion gives meaning to one's life, providing explanations for when things have not gone favourably and enables the problem to be personified and understood. Participants' accounts emphasised four religio-spiritual factors that guided them in navigating the challenges associated with mental ill health. These included (1) Attribution to supernatural factors, (2) Relying on "God's will", (3) Prayer, and (4) Traditional healing.

Participants drew on a rich repertoire of beliefs and practices to explain how they navigated the challenges associated with mental ill health. These beliefs ranged from more orthodox religion and local beliefs and practices to community resources and medico-psychological practices.

Most participants attributed everything occurring in their life, including mental illness to be the "Will of God". This notion provided them with peace and hope. Religiosity and faith have been associated with positive coping and reduced mental health symptoms in other parts of the Islamic world (Abu-Raiya et al., 2019; Khaki & Habibabad, 2021;Tekke et al., 2020). The relationship Muslims have with God and with the wider community is core when dealing with any challenges. Previous studies have found that Muslims had the trust that God will listen to their prayers, providing them with comfort (Cinnirella & Loewenthal, 1999) and that treatment is only successful if via God (Hussain & Cochrane, 2002). The strategies individuals incorporated were different, depending on their circumstances and belief systems. Overall, the relationship with God was believed to be positive and supportive one, despite individuals still experiencing negative thoughts such as isolation, blame, and hopelessness. Thus, a combination of multiple coping mechanisms derived from traditional practices, religion, and contemporary medicine was evident, although the latter was often engaged as a last resort.

In this paper then we have been able to flesh out the relationship between religiosity and positive coping noted elsewhere in the literature. Previous work has tended to conceptualise this factor as an individual trait that confers a degree of resilience and coping capacity (e.g., Abu-Raiya et al., 2019; Tekke et al., 2020). However, here the issue of faith and coping is revealed to be more complex. It is often a collective process involving relatives and carers as well as local wise men and women. Moreover, it is often about doing particular things – performing prayers and rituals – as much as it is about belief itself. Furthermore, belief is by no means homogenous. The more educated or theologically orthodox participants expressed distance or disapproval of traditional healing practices, yet these were widely employed when dealing with mental ill-health. These traditional healing practices involved an amalgamation of both faith and cultural beliefs and included help from faith healers such as Thangals, Usthads, and Musliyars. Most of these sources of support were readily and easily available. Faith healers were often the

first point of contact, preferred over psychologists or medical professionals, similar to other researchers' findings (Cinnirella & Loewenthal, 1999; Subudhi et al., 2020).

Even though participants partook in modalities of mainstream scientific medicine to deal with the challenges, many participants believed that this worked as a result of their faith in God. Faith was perceived as a medium by which medical treatment was effective and a condition of its working. In this respect, our work offers a different perspective to earlier work in the field that sees religiosity as a trait or coping resource.

In participants' narratives, mental ill-health was often attributed to the supernatural. As these concepts are faith-based, they suggest the need for health and social care professionals to have adequate knowledge about Muslim belief systems especially in a Muslim-majority district like Malappuram. Local explanatory models can make diagnosis a challenge for those who are not aware of these beliefs. For example, to describe one's troubles as the result of Jinn may present a challenge for professionals. Firstly, how can the power and influence of a Jinn on a human body be undone by medical means? Secondly, this belief could readily be interpreted by health professionals as a symptom of schizophrenia. The belief that they are troubled by a Jinn may also result in more psychological burden and worsening symptomology.

Limitations

This study is based on a relatively small sample compared to some others in the literature on Islam religiosity and coping. It originates from two geographical areas that are near to each other in Kerala. Consequently, caution is advised in generalising the results to other populations, geographical areas, or different communities' instantiations of Islamic faith.

Conclusion

This study has highlighted how belief and practice may vary, even within a single religious denomination. Consequently, it is important for researchers and health service providers to acknowledge this possible variation and not assume that because a person belongs to a particular faith they will subscribe to a uniform set of beliefs. In everyday life, individuals may seek support from multiple sources; including religion, culture, and medicine, all of which may contribute to how individuals deal with challenges. Further research exploring individual religious beliefs and the intersection of religion and culture with modern "scientific" medicine in informing their beliefs is therefore needed.

Our research has also underscored the value of exploring local concepts of mental ill-health and grasping the detail and day-to-day practice of individuals in LMICs. Not all adherents of a particular religion will believe or practice in the same way. Hence the individual's and their family's cultural and religious belief systems need consideration in the assessment, intervention, and recovery from mental health conditions.

Acknowledgements

We wish to thank all the people and their families who agreed to participate in this study. This paper is based on the findings from UKRI funded research project "Mental health literacy in urban and rural communities in Kerala India" ES/S00145X/1.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Economic and Social Research Council [grant number ES/S00145X/1, Kochi, Kerala, India, School of Health Systems Studies, Venkateswaran, lssmanickam@gmail.com, meenaksiyer@gmail.com]; UKRI [grant number ES/S00145X/1]; UK Research and Innovation [grant number ES/S00145X/1].

ORCID

Raghu Raghavan http://orcid.org/0000-0002-3346-0877
Brian Brown https://orcid.org/0000-0003-0670-0924
Amanda Wilson http://orcid.org/0000-0002-4381-689X
Nadia Svirydzenka http://orcid.org/0000-0003-3085-6785
Monica Lakhanpaul http://orcid.org/0000-0002-9855-2043
Muthusamy Sivakami http://orcid.org/0000-0001-6861-7603
Mike Wilson http://orcid.org/0000-0003-0217-7646

References

Abu-Raiya, H., Ayten, A., Tekke, M., & Agbaria, Q. (2019). On the links between positive religious coping, satisfaction with life and depressive symptoms among a multinational sample of Muslims. *International Journal of Psychology*, *54*(5), 678–686. https://doi.org/10.1002/ijop.12521

Ahammed, A., & Mukharjee, T. (2013 June 19). *Influence of religious schools on attitude formation against suicide: A perspective from Malappuram, Kerala*. https://www.academia.edu/5673249/INFLUENCE_OF_RELIGIOUS_SCHOOLS_ON_ATTITUDE_FORMATION_AGAINST_SUICIDE_A_PERSPECTIVE_FROM_MALAPPURAM_KERALA

Bhui, K., & Bhugra, D. (2002). Mental illness in Black and Asian ethnic minorities: Pathways to care and outcomes. *Advances in Psychiatric Treatment*, *8*(1), 26–33. https://doi.org/10.1192/apt.8.1.26

Bhui, K., King, M., Dein, S., & O'Connor, W. (2007). Ethnicity and religious coping with mental distress. *Journal of Mental Health*, *17*(2), 141–151. https://doi.org/10.1080/09638230701498408

Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. Sage.

Cinnirella, M., & Loewenthal, K. M. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology*, *72*(4), 505–524. https://doi.org/10.1348/000711299160202

Davidsen, A. S. (2013). Phenomenological approaches in psychology and health sciences. *Qualitative Research in Psychology*, *10*(3), 318–339. https://doi.org/10.1080/14780887.2011.608466

Dein, S., Alexander, M., & Napier, A. D. (2008). Jinn, psychiatry and contested notions of misfortune among East London Bangladeshis. *Transcultural Psychiatry*, *35*(1), 31–55. https://doi.org/10.1177/1363461507087997

Francis, B., Gill, J. S., Yit Han, N., Petrus, C. F., Azhar, F. L., Ahmad Sabki, Z., Said, M. A., Ong Hui, K., Chong Guan, N., & Sulaiman, A. H. (2019). Religious coping, religiosity, depression and anxiety among medical students in a multi-religious setting. *International Journal of Environmental Research and Public Health*, *16*(2), 259. https://doi.org/10.3390/ijerph16020259

Giorgi, A. P., & Giorgi, B. (2008). Phenomenological psychology. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 165–178). Sage. https://doi.org/10.1037/ipp0000094

Government of Kerala. (2019 February 5). *Vital Statistics 2018*. http://www.ecostat.kerala.gov.in/images/pdf/publications/Vital_Statistics/data/vital_statistics_2018.pdf

Hussain, F., & Cochrane, R. (2002). Depression in South Asian women: Asians women's beliefs on causes and cures. *Mental Health, Religion & Culture*, *5*(3), 285–311. https://doi.org/10.1080/13674670210130036

Jalal, A., Premnath, A., Suni, M. S., Velayudhan, R., Kumar, M., & Raghuran, T. M. (2020). Delay and treatment factors of psychiatric treatment among patients seeking faith healers. *Kerala Journal of Psychiatry*, *33*(1), 42–51.

Khaki, A., & Habibabad, A. S. (2021). Investigating the effect of religious and Islamic teachings on the calmness and mental health in educational spaces. *Journal of Religion and Health*, *60*(4), 2632–2645. https://doi.org/10.1007/s10943-020-01022-7

Koenig, H. (2012). Religion, spirituality, and health: The research and clinical implications. *ISRN Psychiatry*, *2012*, 1–33. https://doi.org/10.5402/2012/278730

Koenig, H., McCullough, M., & Larson, D. (2001). *Handbook of religion and health*. Oxford University Press.

Lester, D. (2017). Does religiosity predict suicidal behavior? *Religions*, *8*(11), 238. https://doi.org/10.3390/rel8110238

Loewenthal, K. M., Cinnirella, M., Evdoka, G., & Murphy, P. (2001). Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. *British Journal of Medical Psychology*, *74*(3), 293–303. https://doi.org/10.1348/000711201160993

McCullough, M. E., Emmons, R. A., & Tsang, J. (2002). The grateful disposition: A conceptual and empirical topography. *Journal of Personality and Social Psychology*, *82*(1), 112–127. https://doi.org/10.1037/0022-3514.82.1.112

Ng, C. (1997). The stigma of mental illness in Asian cultures. *Australian & New Zealand Journal of Psychiatry*, *31*(3), 382–390. https://doi.org/10.3109/00048679709073848

Radhakrishnan, A. I. (2017 December 14). Engaging Kerala's non-resident diaspora, *The Hindu*, https://www.thehindu.com/news/national/kerala/engaging-the-diaspora/article30307914.ece

Raghavan, R., Brown, B., Horne, F., Kamal, S. R., Parameswaran, U., Raghu, A., Wilson, A., Venkateswaran, C., Svirydzenka, N., Lakhanpaul, M., & Dasan, C. (2022a). Multiple mental health literacies in a traditional temple site in Kerala: The intersection between beliefs, spiritual and healing regimes. *Culture, Medicine and Psychiatry*. https://doi.org/10.1007/s11013-022-09800-6. (in press).

Raghavan, R., Brown, B., Horne, F., Kumar, S., Parameswaram, U., Bin Ali, A., Raghu, A., Wilson, A., Svirydzenka, N., Venkateswaran, C., Kumar, M., Ram Kamal, S., Barrett, A., Dasan, C., Varma, A., & Banu, A. (2022b). Stigma and mental health problems in an Indian context: Perceptions of people with mental disorders in urban, rural, and tribal areas of Kerala. *International Journal of Social Psychiatry*. https://doi.org/10.1177/00207640221091187. (in press).

Rassool, G. H. (2020). *Evil eye, Jinn possession, and mental health issues: An Islamic perspective*. Routledge.

Semrau, M., Evans-Lacko, S., Koschorke, M., Ashenafi, L., & Thornicroft, G. (2015). Stigma and discrimination related to mental illness in low- and middle-income countries. *Epidemiology and Psychiatric Sciences*, *24*(5), 382–394. https://doi.org/10.1017/S2045796015000359

Subudhi, C., Biswal, R., & Meenakshi, J. (2020). Healing preferences among tribal patients with mental illness in India. *Journal of Neurosciences in Rural Practice*, *11*(2), 361–362. https://doi.org/10.1055/s-0040-1709374

Tekke, M., Watson, P. J., Kayadibi, S., & Chen, Z. J. (2020). Amanah and Muslim identity: Relationships with religious and psychological adjustment in Malaysia. *Journal of Religion and Health*, *59*, 891–904. https://doi.org/10.1007/s10943-018-0690-3

Tepper, L., Rogers, S. A., Coleman, E. M., & Malony, H. N. (2001). Prevalence of religious coping among persons with persistent mental illness. *Psychiatric Services*, *52*(5), 660–665. https://doi.org/10.1176/appi.ps.52.5.660

Vijaykumar, L. (2007). Suicide and its prevention: The urgent need in India. *Indian Journal of Psychiatry*, *49*(2), 81–84. https://doi.org/10.4103/0019-5545.33252

World Health Organisation. (2001). *Mental health: New understanding, new hope*. World Health Organization.

World Health Organization. (2013 May 16). *World health statistics 2013*. https://www.who.int/publications/i/item/9789241564588