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Review Article

When Belief Becomes a Barrier: Paranormal Health Beliefs and Mental Health Care in India

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Abstract

Health beliefs influence how individuals interpret symptoms, understand illness, seek help and respond to treatment. In psychiatry, supernatural and paranormal explanations may coexist with biomedical, psychosocial and religious explanations of mental illness. Such beliefs should not automatically be considered psychopathological, particularly when they are culturally shared and provide meaning, identity or coping. They become clinically important when they contribute to treatment delay, reinforce stigma, encourage harmful practices or interfere with evidence-based care. A study examining paranormal health beliefs demonstrated associations with health locus of control and religious coping, highlighting the potential role of belief systems in health-related behaviour. Indian studies similarly demonstrate that patients, caregivers and communities frequently hold multiple explanatory models of mental illness, including supernatural, psychosocial and biomedical explanations. Faith healers and traditional practitioners may also constitute important first points of contact before psychiatric services. This viewpoint argues that psychiatry should move beyond judging beliefs and instead examine their meaning, function and consequences. The Cultural Formulation Interview provides a useful framework for exploring explanatory models, cultural identity, spirituality and previous help-seeking. A practical BELIEF framework Belief, Explanation, Link to behaviour, Interference, Engagement and Follow-up is proposed for routine psychiatric assessment. Rather than positioning science and faith as competing systems, culturally responsive psychiatry should acknowledge culturally meaningful beliefs while ensuring that patients remain connected to safe and evidence-based care.

Keywords: *Paranormal Beliefs; Supernatural Beliefs; Mental Illness; Faith Healing; Explanatory Models; Help-Seeking; Cultural Psychiatry; India*

Introduction

Health beliefs influence how people interpret symptoms, understand illness, seek help and respond to treatment. In psychiatry, these processes can become particularly complex because experiences such as hallucinations, unusual behaviour, anxiety, dissociation or persistent somatic complaints may be interpreted through cultural, religious, spiritual or supernatural frameworks.

The conceptual starting point for this viewpoint is the study by Donizzetti, which examined paranormal health beliefs in relation to social dominance orientation, God-centred health locus of control, religious coping and perceived illness. In a sample of 432 adults, paranormal health beliefs were associated with several psychological and health-related constructs, highlighting the potential role of belief systems in shaping responses to health and illness [1]. Although conducted in Italy and not directly generalizable to India, the study provides an important framework for considering how health beliefs may influence health-related behaviour and decisions.

At the same time, the presence of a paranormal or supernatural explanation should not automatically be interpreted as psychopathology. Contemporary cultural psychiatry emphasizes the importance of understanding beliefs within their cultural and social context [2]. The Cultural Formulation Interview (CFI) provides a structured approach to exploring cultural identity, explanatory models, coping, spirituality, social supports and previous help-seeking, thereby allowing clinicians to understand how patients and families conceptualize their difficulties [3].

This distinction is particularly relevant in India, where biomedical, traditional, religious and spiritual explanatory systems frequently coexist. Patients and families may consult general physicians, psychiatrists, faith healers and traditional practitioners either sequentially or simultaneously. Indian studies have demonstrated that individuals and families may hold multiple explanatory models of mental illness rather than adhering exclusively to either biomedical or supernatural explanations [4-6].

The issue, therefore, is not whether psychiatrists or clinical psychologists should begin assessing cultural or supernatural beliefs; such domains are already part of comprehensive psychiatric and psychological assessment. Rather, the question is whether paranormal and supernatural health beliefs deserve greater attention as potential determinants of help-seeking, treatment engagement and the pathway to care.

This distinction is particularly important because a culturally meaningful belief may be supportive or neutral in one context but may contribute to treatment delay, medication discontinuation, stigma or potentially harmful practices in another. The clinical significance of the belief may therefore lie less in its content than in its function and consequences.

In India, where significant gaps remain between the need for mental healthcare and access to appropriate treatment, understanding these pathways may have practical implications for clinical practice and community mental health [7]. Rather than positioning science and faith as competing systems, psychiatry may benefit from a culturally responsive approach that respects patients' explanatory frameworks while ensuring continued access to evidence-based care.

Belief is not synonymous with psychopathology

One of the most important clinical distinctions is between a culturally shared belief and a psychopathological belief.

A supernatural explanation should not automatically be labelled a delusion simply because it lacks empirical verification. Psychiatric assessment requires consideration of cultural context, degree of conviction, flexibility, associated distress, functional consequences and whether the belief is shared within the individual's cultural or religious group [2,3].

The DSM-5 Cultural Formulation Interview (CFI) was developed to operationalize the assessment of cultural context in psychiatric practice. Its domains include cultural identity, illness understanding, psychosocial environment, supports, coping and help-seeking. Studies conducted in India have demonstrated that the CFI can elicit clinically relevant information about explanatory models and help-seeking that may not emerge during conventional symptom-focused assessment [2,3].

Psychiatrists and clinical psychologists routinely explore patients' explanatory models, cultural and religious beliefs, degree of conviction, insight, associated distress, functional consequences and treatment-related behaviour as part of comprehensive clinical assessment. The issue, therefore, is not to propose an entirely new domain of psychiatric evaluation, but to highlight the clinical significance

of paranormal and supernatural health beliefs as potential determinants of help-seeking and treatment engagement. In appropriate cases, clinicians may benefit from explicitly exploring whether such beliefs have influenced the choice of initial help, delayed psychiatric consultation, altered medication adherence, or encouraged potentially harmful practices. Such an approach would strengthen rather than replace existing psychiatric assessment, allowing culturally embedded beliefs to be understood in relation to their clinical function and consequences without unnecessarily pathologising cultural or religious identity.

Multiple explanatory models can coexist

Arthur Kleinman's concept of explanatory models remains particularly relevant to this discussion. Patients and clinicians may hold different understandings of the causes, consequences and appropriate treatment of illness. In India, these models may overlap rather than exist as mutually exclusive alternatives.

A qualitative study conducted in Pune using the CFI demonstrated recurrent themes involving cultural identity, illness explanatory models, social relationships and previous help-seeking [2]. Similarly, research among caregivers of people receiving psychiatric rehabilitation services found that families could endorse multiple explanatory models simultaneously, rather than adhering exclusively to either biomedical or supernatural explanations [9].

This is clinically important. A family may believe that a patient is affected by black magic while simultaneously accepting psychiatric treatment. Another may understand depression as stress-related but seek religious support for coping. A third may move between several explanations depending on the clinical response.

Therefore, the presence of a supernatural belief does not necessarily predict refusal of psychiatric care.

The clinically important question is whether the belief changes the pathway of care.

From belief to help-seeking

The influence of explanatory beliefs becomes clearer when the pathway to psychiatric care is examined.

Indian studies have repeatedly demonstrated that patients may encounter multiple sources of help before reaching psychiatric services. In a study from Delhi, 41.5% of patients with severe mental disorders had first contacted faith healers, whereas only 14.6% initially contacted psychiatrists [4].

A study from central India found that 69% of psychiatric patients had first contacted faith healers, while a psychiatrist was the first contact for only 9.2% [5]. A Jaipur study similarly identified faith healers as the most popular gateway to care, with patients typically encountering multiple carers before reaching mental health services [6].

More recent evidence suggests that this pattern may be changing in some settings. A 2022 Indian study found that 73% of participants reported a general practitioner or mental health professional as their first contact, suggesting an increasing role of biomedical services, although substantial delays remained for psychotic and substance-use disorders [7].

Importantly, a recent comparison of first-episode psychosis in North and South India found substantial regional differences. Faith healers were the most common first encounter in North India, while in South India they were the second most common first contact; in South India, faith-healer contact was associated with longer duration of untreated psychosis [8].

These findings reinforce an important point: belief is one component of a complex pathway rather than the sole determinant of treatment delay.

Accessibility, cost, stigma, family decision-making, mental health literacy and availability of services all contribute.

Supernatural explanations in psychiatric disorders

Supernatural beliefs are not confined to psychotic disorders.

In a North Indian study of patients with schizophrenia, substantial proportions endorsed beliefs involving sorcery, ghosts, spirit intrusion, divine wrath and other supernatural explanations. Approximately 40% attributed mental illness to more than one explanatory model, demonstrating that biomedical and supernatural explanations could coexist [10].

Similarly, a study of patients with obsessive-compulsive disorder found that 54% believed in supernatural causes and 57.3% attributed their illness to supernatural causes. Many simultaneously endorsed stress-related or biological explanations [11].

Community studies provide a similar picture. In rural coastal Karnataka, approximately 40% of respondents interpreted a depression vignette as tension, stress or excessive worrying rather than mental illness, while about one-fifth attributed the condition to evil spirits or black magic [12].

These findings suggest that supernatural explanatory models should not be regarded as a phenomenon limited to schizophrenia. They may influence the recognition and interpretation of depression, anxiety, obsessive-compulsive disorder and somatic presentations as well.

Faith healing: Barrier or potential bridge?

Faith healing should not be conceptualized only as an obstacle.

Traditional and faith healers may be trusted, geographically accessible and culturally familiar. In some communities they may be the first people approached when families experience behavioural or emotional problems. Research from rural South India has demonstrated that traditional healers possess distinct explanatory models for common mental disorders, and understanding these perspectives may help modern medicine provide more culturally acceptable care [13].

Similarly, a study of faith healers in Gujarat found that people approached them for diverse problems, including perceived supernatural possession and family difficulties, and suggested that there may be scope for an integrated approach to healthcare [14].

This raises a more constructive question for psychiatry.

Instead of asking "How can people be prevented from approaching faith healers?", perhaps we should ask: "How can existing community pathways be made safer and more connected to appropriate mental healthcare?"

This does not mean validating supernatural explanations as medical facts. It means recognizing the social position of community healers and considering whether responsible referral pathways can be developed.

Evidence from first-episode psychosis in India has itself suggested that collaborative relationships between faith healers and mental health professionals could contribute to educational initiatives and earlier access to care [8].

Faith can coexist with evidence-based treatment

It is equally important not to frame religion itself as harmful.

Religion and spirituality can provide meaning, social support, hope and coping during periods of psychological distress. Research has demonstrated that positive religious coping may be associated with better psychological adjustment, whereas negative religious coping can be associated with poorer mental health outcomes [15,16].

Psychiatric practice should therefore distinguish between supportive spirituality and treatment-replacing spirituality.

Prayer, meditation, religious community support and other culturally meaningful practices may coexist with psychiatric treatment.

The concern arises when a person is advised to discontinue medication, avoid psychiatric evaluation, undergo harmful rituals or postpone emergency treatment because a spiritual intervention is considered sufficient.

A useful clinical principle may therefore be: Faith may accompany treatment; it should not prevent necessary treatment.

Avoiding therapeutic confrontation

A dismissive response may inadvertently strengthen disengagement from psychiatric care.

Statements such as "This is just superstition" or "Your family is ignorant" can undermine therapeutic alliance. Patients who perceive psychiatry as disrespectful of their religion or culture may become less willing to discuss their beliefs and may withdraw from treatment.

A culturally responsive approach is therefore preferable.

The clinician can first explore the belief, understand its meaning and determine its consequences before introducing alternative explanations.

For example: "I understand that your family feels that a supernatural cause may be responsible. Some of the experiences you describe can also occur in treatable psychiatric conditions. Would you be comfortable if we considered both your understanding and the medical explanation while we work toward reducing the symptoms?"

Such communication neither endorses supernatural causation nor ridicules it.

A practical clinical lens: The BELIEF framework

Psychiatrists and clinical psychologists already explore explanatory models, cultural beliefs, conviction, insight, coping, help-seeking and treatment-related behaviour as part of routine assessment. The purpose of the BELIEF framework is therefore not to introduce a new diagnostic instrument, but to provide a simple way of organizing these existing domains when paranormal or supernatural health beliefs appear clinically relevant.

B – Belief

- What does the patient or family believe is causing the illness?
- The clinician explores the patient's explanatory model, including supernatural, spiritual, religious, psychosocial and biomedical explanations where relevant.

E – Effect and meaning

- What does the belief mean to the patient, and how does it affect their understanding of the illness?
- The same belief may provide reassurance and meaning for one person while generating fear, helplessness or stigma for another.

L – Link to help seeking

- Has the belief influenced where, when or from whom help was sought?
- This may include previous consultation with faith healers, traditional practitioners, religious leaders or other sources of help before or alongside formal healthcare.

I – Interference

- Has the belief interfered with assessment, treatment or follow-up?
- Clinicians may explore whether the belief has contributed to delayed psychiatric consultation, refusal or discontinuation of medication, avoidance of investigations, or potentially harmful practices.

E – Engagement

- Can the belief be discussed while maintaining therapeutic alliance and cultural respect?
- The objective is neither to endorse an unsubstantiated explanation nor to dismiss the patient's cultural or religious framework, but to introduce alternative explanations and evidence-based treatment without unnecessary confrontation.

F – Function and clinical consequence

- What is the overall clinical function and consequence of the belief?
- The belief may be supportive, neutral or potentially harmful. Its clinical significance should therefore be judged by its relationship with distress, functioning, help-seeking, treatment engagement and patient safety rather than by its content alone.

The BELIEF framework is not intended to replace existing psychiatric or psychological assessment, nor to classify culturally shared beliefs as psychopathology. Rather, it offers a focused clinical lens for identifying when paranormal or supernatural health beliefs become relevant to the pathway of care. Its central premise is simple: the clinical significance of a belief lies not only in what the person believes, but in what that belief leads the person or family to do.

Implications for Indian psychiatry

India's mental health treatment gap makes this issue especially important. The National Mental Health Survey estimated a treatment gap of 84.5% for mental morbidity [17]. Although the treatment gap is caused by multiple supply- and demand-side factors, cultural beliefs, stigma and help-seeking pathways are among the factors that influence service utilization [18].

Consequently, cultural assessment should not be treated as an optional addition to psychiatric history-taking.

Clinicians should routinely explore:

- The patient's explanation for the illness;
- Previous consultations with faith or traditional healers;
- Rituals or alternative treatments already attempted;
- Medication discontinuation because of alternative explanations;
- Family beliefs regarding mental illness; and
- Whether cultural or religious beliefs are influencing treatment decisions.

A recent qualitative study from Western India demonstrated the usefulness of the CFI in identifying cultural and societal attitudes, trust, expectations from healthcare and faith-healing-related beliefs influencing treatment adherence and help-seeking [19].

This suggests that cultural formulation can be clinically relevant even within routine psychiatric practice.

Toward collaboration rather than confrontation

The future of culturally responsive psychiatry may lie in collaboration.

Primary-care physicians, community health workers, psychiatrists, religious leaders and traditional practitioners occupy different positions within the social network of patients. Training selected community stakeholders to recognize warning signs of severe mental illness and encourage timely referral may be more effective than simply attempting to eliminate traditional systems.

This principle should extend beyond faith healers. A study of community health workers in South India found that some did not recognize chronic psychosis as a medical condition and attributed it to black magic, evil spirits or poverty [20]. The authors emphasized that training should first elicit and discuss local beliefs before introducing biomedical models.

This is a powerful lesson for mental health education: Before changing beliefs, understand them.

Future directions

Indian research should move beyond simply measuring the prevalence of supernatural beliefs.

Future studies should examine whether particular explanatory models are associated with:

- Duration of untreated psychosis;
- Delay before psychiatric consultation;
- Medication discontinuation;
- Repeated consultation with unregulated practitioners;
- Treatment dropout;
- Emergency presentations;
- Family stigma; and
- Clinical outcomes.

Longitudinal and qualitative studies may be particularly valuable because beliefs can change over time and may respond to treatment.

Research should also examine the perspectives of faith healers and community leaders, identifying opportunities for safe referral rather than assuming that all traditional practitioners have identical practices.

Finally, the cultural beliefs of healthcare professionals themselves deserve greater attention. Community explanatory models can influence treatment pathways, but clinicians also bring assumptions into the therapeutic encounter.

Conclusion

Paranormal and supernatural health beliefs occupy an important but often neglected position in psychiatric practice.

They may provide meaning, identity, hope and coping. Under some circumstances, however, they may also contribute to stigma, treatment delay, harmful practices or disengagement from evidence-based care.

The answer is unlikely to be a confrontation between science and faith.

The task of psychiatry is more nuanced: to understand the belief, determine its function, identify when it becomes harmful, and keep the patient connected to safe and effective care.

The central clinical question should therefore shift from:

"Do you believe in supernatural causes?"

to:

"How does that belief affect what you do about the illness?"

This shift from judging beliefs to understanding their consequences may allow Indian psychiatry to move from cultural confrontation toward culturally responsive care, while preserving the central commitment to scientific and evidence-based treatment.

Ethical Approval

Not applicable. This article is a view point based on secondary data and published literature.

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