

**Establishing A Potential Collaboration Between  
Faith Healers and Health Professionals to Provide  
Mental Health Care:  
The Case of Kuwait**

**Meshal Almutairi, MD**

**Doctor of Philosophy**

**University of York  
Health Sciences**

**August 2022**

## **Abstract**

Faith healing practices are popular sources of mental treatment that continued to be utilized throughout the entire world from the ancient times to the present. Indeed, this study emphasized on the undeniable important role of faith healers in delivering culturally appropriate and socially accepted mental health care to the Kuwaiti society. Calls for the involvement of all different traditional health care practices within the health care facilities has consistently been made by the World Health Organization. Thus, this thesis intends to discover and describe the appropriate mechanisms that can help in forming collaborations between the two main mental health care providers in Kuwait (psychiatrists and faith healers). The overall aim of this research is to explore and examine the views for faith healers and psychiatrists to collaborate to provide care in the context of Kuwait.

This study has followed the phenomenological methodological framework to answer the research questions. Nineteen Semi-structured interviews were conducted with 10 psychiatrists and 9 faith healers who delivered mental health care treatments in Kuwait. Scoping review and auto-ethnography methods were also employed in this study.

The conducted scoping review was the first narrative review of its types that provides an understanding of challenges that might face the collaboration ambition and, also provides different suggested mechanisms of how to establish a feasible collaboration project. The auto-ethnographic section has permitted me to visualize the real picture of the interactions between mental health care professionals and faith healers. Lastly, in this study, a collaborative framework to establish the collaboration between mental health professionals and faith healers has been developed and analysed.

No other published studies have explored the idea of exploring the chance of discovering strategies of establishing collaboration between mental health professionals and faith healers in Kuwait.

## List of Contents

Contents	Page number
<b>Abstract</b>	4
<b>List of Tables</b>	8
<b>List of Figures</b>	8
<b>Acknowledgment</b>	9
<b>Declaration</b>	10
<b>Chapter One: Introduction</b>	11
1.1 Introduction	11
1.2 Impact of COVID-19 Pandemic on Conducting this Research	11
1.3 The Purpose of this Study	13
1.4 Importance of this Research and Rationale	14
1.5 Aim and objectives	19
1.6 Research Questions	19
1.7 Methodological Framework	20
1.8 Key Findings	20
1.9 Structure of the thesis	23
1.10 Conclusion	25
<b>Chapter Two: Background</b>	26
2.1. Introduction	26
2.2. General Background of Kuwait	26
2.2.1. Religion	28
2.2.2. Education	29
2.2.3. Economy	30
2.3. Population Health and Health Care in Kuwait	31
2.4. Biomedical Health Care System	31
2.5 Health System Structure	33
2.5.1. Ministry of Health	33
2.5.2. Health regions	33
2.5.3. Health Services Provision	34
2.5.4. HealthCare Financing	34
2.6. Mental Health System	35
2.6.1. Health Facilities	35

2.6.2 Health Care Personnel	35
2.6.3 Mental Health Policy	36
2.7. Faith and Faith Healing in Kuwait	36
2.8. The Challenges between Policy and Practice of Faith Healing	40
2.9. Rationale of the Research	41
2.10. Conclusion	42
<b>chapter 3: Literature Review</b>	43
3.1 Introduction	43
3.2 Background	43
3.2.1 Introduction	43
3.2.2 Mental Health and Mental Illness	43
3.2.3 Burden of Mental Illness Globally	44
3.2.4 The Significant Role of Traditional Healing Practices	44
3.2.5 Definition of Traditional Healing Practices	45
3.2.6 Faith Healing Practices as One of the Traditional Methods	45
3.2.7 Islamic Perspective of Mental illness	46
3.2.8 The Origin of Islamic Faith Healing Practice	47
3.2.9 The Inevitable Collaboration Between the Two sides	47
3.2.10 Mental Health Care in Kuwait	48
3.3 Literature Review Approach	50
3.3.1 Identifying the Research Questions	50
3.3.2 Identifying Relevant Literature:	51
3.3.3 Selecting Studies	52
3.3.4 Charting the Data	53
3.4 Results	53
3.5 Discussion	56
3.5.1 Mental Health policies concerning faith healing practices in Kuwait	56
3.5.2 Barriers preventing collaboration between Faith healers and health professionals	57
3.5.3 Mechanisms of Establishing collaboration	61

3.6 Conclusion	65
<b>Chapter 4: Research Methodology and Methods</b>	66
4.1 Introduction	66
4.2 Justification of a Qualitative Approach	66
4.3 Ontological and Epistemological Standpoint	67
4.4 Rationale for choosing Phenomenology Approach	69
4.5 Research Methods	71
4.6 Ethical Consideration	73
4.7 Study Area	74
4.8 Study Population	74
4.9 Recruitment Method	75
4.10 Study Size	76
4.11 Sampling Technique	77
4.12 Data collection method	77
4.13 Data Analysis Plan	79
4.14 Validity and Reliability and Research Rigor	84
4.15 Limitations of this Study	86
4.16 Conclusion	91
<b>Chapter 5: Findings</b>	92
5.1. Introduction	92
5.2. Background	92
5.3. Thematic Analysis – Faith Healers Interviews	96
5.4. Summary of Findings from Thematic Analysis – Faith Healers	110
5.5. Thematic Analysis – Psychiatrists Interviews	111
5.6. Summary of Thematic Analysis – Psychiatrists	123
5.7. Reflections on Faith Healing and Psychiatry	125
5.8 The Impact of the Collaboration on Stigma in Kuwait	130
5.9. Conclusion	132
<b>Chapter 6: Theoretical Discussion</b>	133
6.1 Introduction	133
6.2 Examining Mental Health in the Context of Kuwait	134

6.3 Understandings of mental health problems by faith healers and psychiatrists	143
6.4 Forms of collaborations between traditional and modern medicine	149
6.5 The Interactions between Faith Healers and Psychiatry	157
6.6 Broader Understanding of Mental Illness	163
6.7 Conclusion	166
<b>Chapter 7: Practical Discussion</b>	168
7.1 Introduction	168
7.2 Collaboration Between Traditional and Modern Medicine	169
7.3 Examining the Challenges for Collaboration between Faith Healers and Psychiatrists in Kuwait	175
7.4 Proposed methodology for collaboration between faith healers and psychiatrists in Kuwait	180
7.5 Examining the possibilities for collaboration between faith healers and psychiatrists in Kuwait	185
7.6 Advantages and disadvantages of the proposed collaboration programme	188
7.7 Conclusion	191
<b>Chapter Eight: Emerging Framework (Recommendations)</b>	192
8.1. Introduction	192
8.2. Combining Theory and Practice	192
8.3. Possible Collaboration between the Two approaches	196
8.4. Proposed Framework for Collaboration	201
8.4.1 The Multi-sectoral partnership between Ministry of Health and Ministry of Islamic Affairs	202
8.4.2 Collaborative Plan through mutual agreement	203
8.4.3 Training, Education and Awareness	204
8.4.4 Developing of Guidelines, Procedures, and Protocols	207
8.4.5 Development of Multisectoral Collaborative Platform	208
8.4.6 Implementation of Collaborative Activities, Referral Pathways	209
8.4.7 Monitoring and Evaluation for Quality Assurance	211
8.4.8 Annual Education Training and Awareness	213

8.5. Policy Implications of the Proposed Framework	213
8.6. Practical Implications of the Proposed Framework	217
8.7 Conclusion	219
<b>Chapter 9: Reflection</b>	221
9.1. Introduction	221
9.2. Why this PhD?	222
9.3. Experience of the PhD: Conceptual to Reality	223
9.3.1. Engagement with Literature	223
9.3.2. Developing the Methodological Framework	225
9.3.3. Scoping Review	227
9.3.4. Fieldwork	229
9.3.5. Analysis	234
9.4. Learning from this PhD Process	236
9.5. Conclusion	238
<b>Chapter 10: Conclusion</b>	240
10.1 Introduction	240
10.2 Contribution of the Research	242
10.3 The Way Forward	244
10.4 Conclusion	247
<b>Appendices</b>	250
<b>Abbreviations</b>	274
<b>References</b>	276

## List of Tables

Table 1.1 Research Question and the Applied Methods to obtain Answers	22
Table 2.1 The non-Kuwaiti Population in Kuwait	28
Table 2.2: Percentage distribution of male and female Kuwaitis by certain Background Characteristics	30
Table 3.1 Sample database search result	52
Table 4.1 Examples of the generated themes	82
Table 5.1 Details of the faith healers participated in this study	95
Table 5.2 Details of the psychiatrists participated in this study	96

## List of Figures

Figure 2.1: Map of the State of Kuwait	27
Figure 2.2: Governorates of Kuwait	27
Figure 3.1: Prisma Flow Chart showing literatures selection	55
Figure 8.1: The proposed Framework for the collaboration between faith healers and psychiatrists in Kuwait	201



## **Acknowledgements**

Firstly, I must appreciate and thank God for granting me the patience, fortitude, strength, and good health to accomplish my thesis.

Secondly and chiefly, I would like to thank my wonderful and brilliant supervisors, Dr Janaka Jayawickrama and Dr Jerome Wright, for their unwavering support, academic guidance, unceasing encouragement, and kind, reassuring words during the entire journey of my PhD. Words can't express my gratitude and appreciation for your support. Indeed, you were always there when I needed you.

Furthermore, I thank my Thesis Advisory Panel (TAP) members, Prof Karl Atkin and Dr Omara Dogar, for their professional guidance and exceptional advice. I appreciate your time, support, and encouragement.

It is also crucial to express my most profound appreciation and thanks to the Kuwaiti government for giving me the scholarship to do my PhD programme at the University of York.

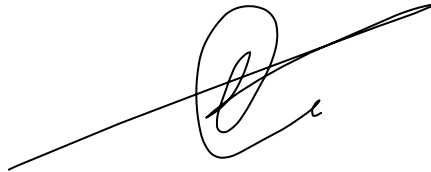
Finally, I would like to thank my family: my mother, Shafeyeh; my sisters Shehana, Jouza, Maryam, Aisha, Fatmah, and Maha; and my brother Fahad, for their unceasing love and constant prayers. Thank you for boosting my confidence by firmly believing in me and granting me happiness and joy during this course and in my life. I love you.

## Declaration

*I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as References.*

Name: Meshal Almutairi

Signature:

A handwritten signature in black ink, consisting of a large, stylized 'M' followed by a long horizontal stroke and a small flourish at the end.

15 August, 2022

# **Chapter 1**

## **Introduction**

### **1.1 Introduction**

This thesis presents the findings of a study exploring and examining the opportunities for faith healers and mental health professionals to collaborate in providing care in the context of Kuwait. No other published studies have investigated the possibility of discovering strategies for establishing collaboration between mental health professionals and faith healers in Kuwait. Thus, this study was conducted primarily in Kuwait as it would reveal new knowledge in this field, ultimately improving mental healthcare in the country. The purpose of this chapter is to provide the rationale for this study, present the aim and objectives of the study, state the research questions, outline the methodological framework, and explain the organisation and structure of this thesis.

### **1.2 Impact of COVID-19 Pandemic on Conducting This Research**

It is crucial from the beginning to highlight the impact of the COVID-19 pandemic on my research since it genuinely influenced the research structure, methodologies and general progress of my research. Several obstacles and challenges have been created by the impact of the COVID-19 pandemic on the writing process of my research. Indeed, I faced a unique situation when the pandemic spread all over the globe, disrupting the normal academic atmosphere as all the university's doors were closed in front of me suddenly. This is because all the universities in the United Kingdom had to follow the instructions and the guidelines of the NHS related to the outbreak restrictions. These exceptional circumstances prevented me from normally engaging with my university and my study as there was a sudden lack of accessibility to libraries and some literature resources, which created an uncomfortable environment that negatively affected my academic productivity. I was anxious about being able to carry out my academic tasks on time under these challenging circumstances, as time management is a priority for me and all students in academia. Indeed, the time pressure was undeniable in my case since the COVID-19 pandemic restrictions, and the lockdown coincided with my intended research fieldwork (March 2020), so I could not accomplish my research's previously planned fieldwork on the proposed time. Therefore, I was apprehensive

about how to compensate for the lost time and how to restore the pending and unfinished thesis.

Furthermore, the uncertainty about when this pandemic crisis will end and when academic life will return to normal has provoked fear and anxiety in me. There was internal conflict as I was concerned about whether I would be able to continue with my research under these circumstances. When the initial period of the pandemic passed, it was mandatory to adapt to the new situation of working at home. All supervision meetings became online, so there were no face-to-face meetings, and all my research tasks and work were done at home. This contributed to feelings of loneliness and isolation, mainly because there was a travel ban at the beginning of the crisis, so I couldn't return home for a considerable period, which led to minimal progress in my writing process. Indeed, maintaining a stable mental condition was my primary concern. On several occasions, I felt unmotivated to pursue my PhD programme and unable to manage the overload of the situation as I thought I was living in an unstable world. I experienced imposter syndrome as I started doubting my academic capabilities and felt I was not adequately skilled and qualified to accomplish my research. In academia, imposter syndrome is a troubling phenomenon where researchers experience self-doubt and anxiety as they continuously question their successes and credit their achievements to luck (Bothello and Roulet, 2018).

As I have mentioned, my research fieldwork has been negatively influenced by the COVID-19 pandemic. Indeed, my research methodology has been significantly modified and adjusted several times to adapt to the new situation with the spread of COVID-19 in Kuwait. I discussed with my supervisors at York and my supervisor at Kuwait University the possibility of carrying out my fieldwork with the situation of COVID-19 in Kuwait and the impact of the related restrictions and precautions. We agreed that the interview part of my research could be done through video conferencing. However, the observation part of my research has been dropped. Initially, non-participant observation was the third chosen method. However, it was omitted because of the situation of COVID-19 in Kuwait and the impact of the related restrictions and precautions. I was very keen and enthusiastic to conduct the observation because the observation methods can help obtain the actual vision of what happened in reality, providing knowledge that interviews cannot reveal. However, it was omitted as we agreed it couldn't be done with the COVID-19 outbreak in Kuwait at that moment. Therefore, I have decided to examine my personal and professional experiences

with psychiatrists and faith healers in the past as an auto-ethnographical exercise (supported by Ellis, 2002; Maréchal, 2010). I will only be examining my own experiences and will not engage anyone beyond the psychiatrists and faith healers as per my approved ethics application.

### **1.3 The Purpose of This Study**

The purpose of this PhD thesis is to explore and examine the views of faith healers and mental health professionals about collaborating to provide mental healthcare in the context of Kuwait. It intends to analyse the role of faith healers and mental health professionals in providing mental healthcare and to evaluate the significance of mental health services in Kuwait. This study aims to understand the cultural context of mental health beliefs and treatment expectations among Kuwait's faith healers and mental health professionals. There appears to be a gap in the research about the role of faith healers and their perceptions regarding integrating their practices into mental health services. No other published studies have examined the idea of exploring the chance of discovering strategies for establishing collaboration between mental health professionals and faith healers in Kuwait. This is important as it may reveal new ways of delivering comprehensive mental healthcare in the country. Calls for the involvement of all different traditional healthcare practices within the healthcare facilities have been constantly made by the World Health Organisation (WHO). For instance, two WHO plans formerly ratify the recognition of traditional healers in healthcare: the WHO's traditional and complementary medicine strategy (2014–2023), which support and reinforce traditional healers as a potential element in providing comprehensive healthcare; and the WHO mental health action plan (2013–2020), which highlights and emphasises on establishing collaboration with traditional healers to promote mental health (WHO, 2013). Accordingly, this thesis intends to discover and describe the appropriate mechanisms to help form partnerships between the two leading mental healthcare providers in Kuwait. This is crucial as mental healthcare practice is challenging in Kuwait and the Middle East. This sector's stigmatisation affects the patients, their relatives, and mental health providers. Therefore, there is a need to provide a mental health service that is culturally sensitive, so mental health professionals must provide services that are culturally appropriate for the people in Kuwait.

## **1.4 Importance of This Research and Rationale**

The WHO defined mental health as a state of well-being where people can effectively overcome daily challenges and take advantage of their abilities and skills to produce efficient work. Therefore, from this definition, it can be said that to have a healthy and normal life, it is crucial to be mentally stable (Prince et al., 2007). The concept of health is not merely to have a good physical state but also includes having positive mental and social resources that eventually produce a better quality of life (WHO, 2003). The former definitions illustrated that mental health is “a sense of productive and optimistic well-being” rather than merely not being affected by mental healthcare problems. Thus, mental health encapsulates the promotion of well-being, deterrence of mental healthcare disorders, and the treatment and rehabilitation of the patients who suffer from mental healthcare problems.

On the other hand, mental illness is a medical term that describes disorders affecting people’s mood, actions, emotions, and way of thinking (Duckworth, 2013). Indeed, several medical disorders are labelled as mental illnesses, such as personality disorder, bipolar disorder, depression, panic disorder, schizophrenia, eating disorder, obsessive-compulsive disorder, and addictive behaviours (Almutairi, 2015). It is essential to highlight that mental disorders are similar to physical disorders in terms of their variations in symptoms and severity from one patient to another (Carulla et al., 2011). Indeed, mental disorders can affect all ages, so they can be manifested at any age. Individuals affected by mental healthcare problems could experience a different case scenario (WHO, 2003). Mental health problems are becoming a common health issue globally, consuming a considerable proportion of the financial resources of many healthcare systems, thus affecting the economies of many countries (Haque, 2005; Almazeedi and Alsuwaidan, 2014).

The WHO has recognised that about one-quarter of the world’s population has been affected by mental health problems (WHO, 2013). Indeed, psychiatric disorders represent 37% of all healthy life years lost, making psychiatric conditions one of the chief reasons for disabilities worldwide (Jack-Ide and Uys, 2013). Furthermore, the burden of mental disorders is constantly increasing; thus, in 2030, unipolar depressive disease is predicted to be the third leading cause of disease burden globally (Mathers and Loncar, 2006). Despite the statistics

showing the high burden of mental illness, several healthcare systems worldwide have ignored mental healthcare in their total health expenditure as less than 1% was allocated to mental healthcare in numerous countries (WHO, 2008). In addition, 40.5% of international healthcare systems have no mental health strategies, and 30.3% haven't established mental health programmes (WHO, 2001). Indeed, it is noticeable globally that patients experiencing acute mental illness are left untreated, even in some developed countries that have established accessible mental healthcare facilities (Wang et al., 2007). In low- and middle-income countries (LMIC), the situation is worse where the treatment gap for mental illness has exceeded 85% (Musyimi et al., 2016). Several hindrances hamper approaching mental healthcare facilities in LIMC have been identified including stigma surrounding psychiatric settings, approaching traditional and faith healers, and difficulties in reaching the mental healthcare services (Ghanizadeh et al., 2008; Kessler, 2000).

The fear of social stigmatisation impacts patients who have mental illness by preventing delivering prompt mental healthcare to the patients when needed (Coverdale et al., 2002). Therefore, when considering the provision of mental healthcare, it is vital to understand the cultural impact. Culture means all the beliefs, values, and knowledge that are inherited within the community that will affect the understanding of mental disorders and also shape the expectations of how mental disorders can be treated, ultimately affecting how people interact with mental illness, thus guiding the help-seeking behaviours of the people and also has an impact on the relationship with mental healthcare providers. Indeed, cultural perspectives play a significant role in determining the mental healthcare approaches as several studies have shown that culture and mental illness are closely related. Thus, mental healthcare workers should comprehend this phenomenon by understanding their interactions and considering them (Guarnaccia and Rodriguez, 1996). In some cultures, being diagnosed with mental illness will have adverse and undesirable implications. This is the situation in Kuwait, where people avoid seeking help at the Psychological Medicine Hospital due to the stigma attached to their mental health problems (Thornicroft et al., 2007). Indeed, within Arabic communities, those who suffer from mental health problems are commonly stigmatised, disregarded, and ridiculed. The reason is that mental illness has been typically connected to evil forces, the evil eye, malevolent magic, violence, addiction, suicide, and sin (Pridmore and Pasha, 2004). This will lead to guilt and shame when family members are affected by a mental disorder, neglect the mental problem, and do not receive treatment (Farooqi, 2006).

Instead, people might seek help, and medical treatment from primary healthcare professionals since society accepts them more. Nevertheless, primary healthcare professionals do not have sufficient mental healthcare knowledge and proficiency, so they might not be able to provide proper mental healthcare. What makes the situation worse is the high refusal rate among people to be referred to mental healthcare professionals (Almazeedi and Alsuwaidan, 2014).

The situation in Kuwait is similar and different simultaneously, as the government of Kuwait has expended a high amount of its income on the health sector. Consequently, advanced accessible mental health services were developed in Kuwait. Indeed, Kuwait is a wealthy country, and its high-income status allowed the Kuwaiti government to establish a high-standard healthcare system where all citizens have free access to all health services.

However, in November 2015, Dr Khalid Al-Sahlawi, the Undersecretary of the Ministry of Health of Kuwait, declared that about one-third of the population of Kuwait had been previously diagnosed with one mental health disorder (Abdelmaaboud, 2015). Despite the high pervasiveness of mental health disorders, and the easy access to mental healthcare facilities, people of Kuwait tend to avoid approaching mental health services as the stigma towards these services is considered an expected behaviour (Almazeedi and Alsuwaidan, 2014). Indeed, mental health services in Kuwait and the Middle East are regularly stigmatised, and not only the patients are stigmatised from accessing the psychiatric settings, but also their families and the mental healthcare providers are stigmatised (Scull et al., 2014). This stigmatisation is a serious issue because it discourages people from accessing mental health services.

Consequently, Arabic people would contemplate and consider approaching another source of mental treatment devoid of stigmatisation. This way of thinking is confirmed by many studies completed in different Arabic countries such as Saudi Arabia, as the studies there showed that more than 50% of patients have sought help and accessed a faith or traditional healer firstly to receive mental treatment (Al-habeeb, 2003; Thomas et al., 2015). Similarly, the Kuwaiti people are approaching faith healers as alternative mental healthcare providers. Faith healers are undoubtedly crucial mental healthcare providers in Kuwait. Indeed, the religion of Islam is considered an essential element in the lives of the people of Kuwait, as the vast majority are Muslims. Based on Islamic teachings, psychiatric problems are strongly related to supernatural forces or spirits called jinn, and Muslims firmly believe in the evil eye and its



relationship with misfortune (Al-habeeb, 2003). Thus, Muslim patients tend to visit faith healers who deliver mental healthcare services derived from the Holy Qur'an and the sayings of the Prophet Muhammad (PBUH) (Alosaimi et al., 2015). In Kuwait, faith healers are called by several local names, such as Sheikh or Mutawa. The work of those Sheikhs is not officially recognised, and there is no need to obtain a specific academic qualification to become a Sheikh. However, some of them have obtained Islamic qualifications from Islamic universities. They are public figures regarding their capabilities and success in offering proper mental healthcare and treatments. They have acquired skills and abilities to provide such work from family heritage, relying on God's power and herbal remedies (Birhan et al., 2011). Indeed, the few pieces of research conducted in Kuwait have harmonious conclusions and agreement that Kuwaiti people believe that some inappropriate actions and unstable personalities are explained by jinn possession, the impact of magic, or the evil eye (Scull et al., 2014). This religious and cultural perspective must be understood as they could hinder accessing the mental care professionals.

Based on the statistics of the WHO (2002), more than 80% of the people in Africa rely on traditional healers to receive treatments for their medical issues. In the research conducted in the developing world, there is a consensus that conventional healers represent the key and primary mental healthcare providers (Al Riyami et al., 2009; Sorketti et al., 2011; Sorsdahl et al., 2010). For instance, a study conducted in Africa revealed that approximately 50% of African people access traditional healers initially to receive healthcare for their mental health problems before planning to approach medical healthcare services (Burns and Tomita, 2014). However, the documentation about faith healing practices in Kuwait is very scarce. There are no studies conducted in Kuwait discussing faith healers' work. Moreover, faith healing practices are neglected by policymakers in Kuwait and have never been included in Kuwait Ministry of Health policies or agendas.

Having mentioned that, faith healers in Kuwait represent a vital source of mental healthcare provision, but the legal authorities still deny and neglect these facts. Indeed, the mental health service decision makers and stakeholders in Kuwait have prioritised international western medicine in planning and developing mental health policies, leaving faith healers as illegal mental healthcare providers. Formalising the work of faith healers and forming a collaborative scheme between them and mental healthcare professionals could result in more comprehensive and holistic mental healthcare in Kuwait. In addition, the formal recognition

of faith healing practices could regulate their work, which would probably be beneficial in managing complex cases and protecting them from deterioration. Although it is common among faith healers to think that allopathic practitioners perceive their work disrespectfully, successful collaborative work has been accomplished in Africa in managing tuberculosis and HIV counselling and screening (Burns and Tomita, 2014; Sorketti et al., 2011). Concerning mental health, a study done in Kenya showed that the faith healers were keen and enthusiastic about initiating an open discussion with formal health practitioners and working closely with them to treat the patients (Musyimi et al., 2016).

Collaboration can be considered a public mental health intervention. The concept of public mental health can extend remarkably to cover several aspects beyond mental health promotion, such as supporting and encouraging the whole population to approach mental healthcare by focusing on and targeting those people at risk to prevent mental illness and promote mental health (Hannah and Halliday, 2002). Indeed, public mental health supports and encourages understanding and grasping the broad perspective of mental illness rather than concentrating only on treatment and care. Thus, it helps discover the association between mental and physical health and the connection between mental health and social factors. Therefore, the public mental health model extends beyond the traditional biomedical model to include the social aspects of managing mental issues.

Therefore, the perspectives of faith healers and mental health professionals in Kuwait about forming a potential collaboration between them need to be examined to explore the possibility of developing such cooperation. Such collaborative work could be beneficial in eliminating the disrespect and mistrust between the two sides. Forming collaboration between the two providers may also lead to licencing the practice of faith healers. Both sides would get benefits after receiving training in a new discipline. Furthermore, the collaboration programme would help encourage the referral between the two sides so patients could receive proper treatment without delay. The collaboration could be an efficient solution for underutilising mental health services in Kuwait. However, the documentation about faith healing practices in Kuwait is very scarce. There is nearly no study conducted in Kuwait discussing faith healers' work. Specifically, there is no previous study conducted in Kuwait examining the relationship between the faith healers and mental health professionals in Kuwait and exploring the chance to form a collaboration between them.

## **1.5 Aim and Objectives**

The overall aim of my research was to explore and examine the views of faith healers and mental health professionals about collaborating to provide mental healthcare in the context of Kuwait. It had the following specific objectives:

Objective 1: To describe and analyse the role of faith healers in providing mental healthcare in Kuwait.

Objective 2: To critically examine the significance of professional and faith-based mental health services in Kuwait.

Objective 3: To discover and describe the appropriate mechanisms to establish collaborations.

## **1.6 Research Questions**

The research questions originated from several sources. Firstly, the questions were derived from the researcher's clinical experience as a medical doctor managing mental health disorders. Secondly, the research aims to explore the interactions between the leading mental healthcare providers and how the best way to form a collaboration between them has shaped the research questions. Finally, a scoping review of the literature, which showed that there was a lack of evidence on the role played by faith healers in Kuwait in providing mental health services, has also shaped the research questions.

### **Main Question**

What are the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait?

Five underlying study sub-questions support the primary study question:

### **Sub-questions**

1. What constitutes faith healing?
2. What is the role of faith healers in providing mental healthcare?
3. What is the role of professional mental health services?
4. What are the commonalities and differences between faith healing and professional mental healthcare?

5. What mechanisms establish collaborations between official mental health services and faith healers?

By addressing these questions and obtaining answers, this study is expected to add new knowledge to the existing literature and fill the gap in this field in this region. Thus, I hope this study will help improve Kuwait's mental healthcare services.

## **1.7 Methodological Framework**

My thesis is a qualitative study that explores and examines the opportunities for faith healers and mental health professionals to collaborate in providing mental healthcare in the context of Kuwait. Therefore, the perspectives of mental health professionals and faith healers need to be examined to address the research questions. Thus, in addressing the research questions of this study, the study has adopted a methodology of phenomenology. This is because phenomenology is a theoretical approach that can yield new knowledge based on people's experiences with a particular phenomenon (Hesse-Biber and Leavy, 2011). Indeed, the phenomenological approach aims to explore and examine the lived experience of people concerning the phenomenon of interest to understand it (Daly 2007, p. 97; Creswell 2012). Thus, the purpose of phenomenological study is to explain and describe the experience of the participants in their daily world based on their perspectives and how they view and comprehend things (Daly 2007, p. 98; Willis 2007; Carpenter and Suto 2008; Padgett 2008). Therefore, phenomenological researchers regularly employ in-depth interviews to obtain an extensive description of a particular reality (Daly 2007; Patton 2002; Todres 2005; Willis 2007). However, some other tools or methods are frequently utilised by phenomenologists, such as observation, in-depth interviews, life history, and narrative. Also, phenomenologists might study and investigate documented archives of experiences such as diaries, journals, art, poetry, and music (Daly 2007; Creswell 2012).

## **1.8 Key Findings**

The findings of the scoping review conducted in this research revealed a lack of accurate data regarding faith healing practices in Kuwait, indicating the urgent need for future research that focuses on the faith healer's role as a mental healthcare provider in Kuwait. In addition, the review's findings suggested several effective interventions or methods to achieve collaboration. Still, it seems it is more applicable to combine the identified mechanisms in a step-by-step process by firstly building mutual respect through collaborative discussions,

licensing the practice of faith healers to improve the transparency of their work and encourage their cooperation, educating and training faith healers about mental disorders, forming an advisory group with a representative of faith healers, and finally developing well-established referral systems between the two fields. On the other hand, the findings of our scoping review indicated and highlighted various obstacles that might hamper forming the collaboration between the two sectors. Thus, to overcome these difficulties, multisectoral support is required to ensure developing political will, financial aid, and governmental acceptance and approval. This has contributed to answering the research questions: What are the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait? And What are the mechanisms to establish collaborations between official mental health services and faith healers? (as shown in Table 1.1).

The interviews in this study revealed that the faith healers in Kuwait are motivated and willing to collaborate with mental health professionals as they think such collaboration will yield more comprehensive and convincing mental health services in Kuwait. However, they recognised the reality of barriers to establishing such cooperation, such as the unofficial recognition of faith healing practices, inherited disrespect, and mistrust among mental health professionals. At the same time, the psychiatrists were hesitant to collaborate with the faith healers because they only trust and believe in practices based on scientific evidence. However, psychiatrists admitted that many patients had prior access to faith healing centres.

Both sides suggested that the collaboration must be established under the supervision of multi-sectorial official authorities' partnerships such as the ministry of health and Islamic affairs. The faith healers were more unrestricted towards collaboration. At the same time, psychiatrists could only accept the collaboration concept if they dominated the work and the mutual work became under thorough supervision from their side. Thus, the interviews have successfully answered the targeted research questions, as shown in Table 1.1.

This study showed that theoretically speaking, it is possible to arrange the strategies of establishing the collaboration as the two sectors are responsible for framing the shape of mental health status in Kuwait. Indeed, the two fields are the primary source of mental health services in Kuwait. Furthermore, there were several successful examples of establishing

potential collaboration between the two sectors globally, indicating an absolute opportunity to structure the collaboration plan theoretically. Although the two sides in Kuwait have different understandings of mental illness, interactions occurred between them, which assert that it is possible that a collaboration could be established.

Indeed, this study presented various efficacious collaboration examples from different countries, indicating that collaboration is practically manageable to be formed. Also, the challenges that might face conducting the collaboration programme have been identified, such as the illegal recognition of their work, inherited disrespect, and mistrust among mental health professionals. Several proposed collaboration mechanisms were suggested and examined from a practical perspective. For instance, it was recommended that the collaboration be established under the supervision of multi-sectorial official authorities' partnerships such as the ministry of health and the ministry of Islamic affairs. After that, the expected advantages of establishing the collaboration process have been investigated and recognised, such as improving the utilisation of mental health services in Kuwait, enhancing the understanding of mental illness among both mental healthcare providers in Kuwait, and also obtaining better regulation on the faith healers' work after authorising their job. It can be stated that it is practically feasible and economically favourable to establish a well-organised collaboration programme between faith healers and mental health professionals in Kuwait.

**Table 1.1: Research Questions and the Applied Methods to obtain Answers**

Research questions	Methods used to obtain answers
What are the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait?	Scoping review Semi-structured interviews
What constitutes faith healing?	Semi-structured interviews Autoethnography
What is the role of faith healers in providing mental healthcare?	Semi-structured interviews
What is the role of professional mental health services?	Semi-structured interviews
What are the commonalities and differences between faith healing and professional mental healthcare?	Semi-structured interviews Autoethnography
What mechanisms establish collaborations between official mental health services and faith healers?	Scoping Review Semi-structured interviews Auto-ethnography

## **1.9 Structure of the Thesis**

This thesis has ten chapters, and this section outlines the structure of this thesis by illustrating the content of each chapter

This chapter, Chapter 1, acts as an introduction by clarifying the purpose and rationale of this study. Furthermore, it presents the aim and objectives of this study and identifies the research questions and sub questions.

Chapter 2 provides background information for the thesis. In this chapter (Background), an overview of Kuwait will be supplied, introducing its healthcare system and faith healing traditions, identifying the challenges between policy and practice of faith healing, and stating the rationale of this study.

In Chapter 3, a scoping review will be presented. The scoping review was performed by following the methodology illustrated by Arskey and O'Malley (2005). Scoping reviews are becoming a popular and common approach when researching a topic with limited literature (Peters et al., 2015). Therefore, I conducted a scoping review as my aim was to examine and map the existing literature discussing the collaboration between faith healers and health professionals. In this review, the five steps strategy that is illustrated by Arksey and O'Malley (2005) will be employed, which includes (1) identifying the research question, (2) identifying relevant literature, (3) selecting studies, (4) charting the data, and (5) collating and summarising the data.

Chapter 4 outlines the methodology and methods used in my research. This study will use a qualitative methodological framework to answer the research questions. Moreover, the limitations of this research are identified and explained in this chapter.

Chapter 5 presents the findings from the fieldwork, which involved interviews with faith healers and psychiatrists in Kuwait. Further, the experiences and observations of the researcher as a Kuwaiti national, medical doctor, and a user of faith healing were used to substantiate the field data through reflections in this chapter. In this chapter, the findings of the interviews will be presented and analysed. Consequently, the themes generated from the analysis will help answer the research questions and sub questions.

Chapter 6 presents a theoretical discussion of this study's findings by interpreting them and describing their significance in establishing collaboration between mental health

professionals and faith healers. The discussion helps to reach a new understanding of the research problems being investigated. This chapter explains and evaluates what has been discovered and ultimately connects their interpretations to what has been discussed in the introduction and the literature review to move the reader's understanding of the research argument forward and help answer the research questions.

Chapter 7 presents a practical discussion, which complements the former chapter. This discussion examines the opportunity of establishing a collaboration between faith healers and mental health professionals in Kuwait from a practical perspective to help answer the research questions of this study.

Chapter 8 presents recommendations derived from the arguments introduced in the previous chapters to develop an emerging framework. This chapter will consolidate the findings obtained in this study and will highlight how these findings participate in forming a practical framework for establishing the collaboration between psychiatrists and faith healers in Kuwait, fulfilling the motivation behind this thesis. Firstly, this chapter will start by combining theory with practice to form a solid basis for the proposed framework of the collaboration process. After that, the possible collaboration between mental health professionals and faith healers will be clarified. Then, the proposed framework for the cooperation will be identified and explained. Later, the policy and practical implications of the proposed collaboration framework will be revealed and presented to aid in improving the mental health status in Kuwait.

Chapter 9 presents a reflection on my position as the researcher and my role in the research design, data collection, data analysis, and all other steps related to conducting the study. This chapter enhances the reader's trust in this study. Thinking reflectively reduces the chance of my assumptions and experiences unintentionally interfering with the interpretations of the results of the study, especially as it is a qualitative study. The measures undertaken during the process of conducting this research to prevent this from happening have been described in this chapter.

Chapter 10 is the concluding chapter that will underscore the chief conclusions drawn from this dissertation.



## **1.10 Conclusion**

This chapter has introduced the study by identifying its purpose and rationale, stating its aim and objectives, presenting its research questions, and outlining the structure of the thesis. The next chapter will provide background information for the thesis, including an overview of Kuwait, its healthcare system, faith healing tradition, and the challenges between policy and the practice of faith healing.

## **Chapter 2**

### **Background**

#### **2.1. Introduction**

This chapter provides an overview of Kuwait, its healthcare system, faith healing traditions, and the challenges between policy and the practice of faith healing. It also presents the rationale of this study.

#### **2.2. General Background of Kuwait**

The state of Kuwait is situated on the Arabian Gulf, and it shares its borders with Saudi Arabia to the South and South-West, with Iraq to the North and West. The country's land area is approximately 17,818 km<sup>2</sup>, and its population is nearly 3.5 million, with a density of 200.2 people per square kilometre (518.4 people per square mile). Most of the land in Kuwait consists of deserts with various elevations. The country is surrounded by the Arabian Gulf from the east, where the coastal line reaches around 195 km. In contrast, the land borderlines expand to 250 km with Saudi Arabia and 240 km with Iraq.

Moreover, nine islands in the Arabian Gulf belong to Kuwait, as shown in Figure 2.1. The state of Kuwait is divided administratively into six governorates: Capital, Hawalli, Ahmadi, Jahra, Farwaniya, and Mubarak AlKabeer (Figure 2.2). The urbanisation rate in Kuwait is 2.1% per year, which implies that 98% of the Kuwaiti population lives in urbanised areas, with 83% residing in the Capital Governorate. Only a few of the people of Kuwait have lived in rural areas in the last decade. Generally, the weather in Kuwait is scorching and dry, particularly in summer (April to October), where the temperature might exceed 51°C (124°F), as it was previously recorded several times in the hottest months of June, July, and August. During winter, which lasts from November to February in Kuwait, the weather is cool, with an average temperature of 13°C (56°F) with some extremes from -2°C to 27°C (MOH, 2013).

**Figure 2.1: Map of the State of Kuwait**



**Figure 2.2: Governorates of Kuwait**



There are two main ethnic groups in Kuwait: Arabs, who come from Najd, Iraq, Bahrain, and eastern Arabia, and Persians. The Bahraini ethnic group represents the indigenous people who live in Bahrain and the eastern province of Saudi Arabia. In contrast, the Najdi people come from Najd, located in central Saudi Arabia. The annual population growth in Kuwait has recently reached 4.0% per year, although it is difficult to estimate the population growth rate in Kuwait as it fluctuates considerably. However, if the estimated growth rates continue, the population of Kuwait is expected to reach 5.9 million by 2050. In 2007, Kuwait was classified as the third country in the world's net migration rate with a calculated rate of 16.01. This is strongly related to the discovery of oil and the raised living standard that makes Kuwait a target of many immigrants worldwide (UN World Population Prospects, 2019).

Expatriates represent around 70% of the total population of Kuwait. Indeed, there are 1.1 million Arab expatriates and 1.4 million Asian expatriates living in Kuwait. It is hard for foreigners to obtain citizenship in Kuwait as the Kuwaiti government tries to maintain the status quo and national balance. As clarified earlier, it isn't easy to estimate Kuwait's population. Still, the 2011 census revealed preliminarily that the total population is approximately 3.1 million, with Kuwaiti citizens at 1.1 million and non-Kuwaitis at 2 million (UN World Population Prospects, 2019). Table 2.1 shows a breakdown of the non-Kuwaiti population based on the UN World Population Prospects (2019).

**Table 2.1: The Non-Kuwaiti Population in Kuwait**

Nationality	Population	Nationality	Population	Nationality	Population	Nationality	Population
Indians	825,000	Syrians	140,000	Nepalis	62,000	Afghans	15,000
Egyptians	517,973	Sri Lankans	130,000	Iranians	50,000	Americans	13,000
Filipinos	185,788	Pakistanis	126,000	Lebanese	42,000	Yemeni	11,000
Bangladeshis	181,265	Ethiopians	74,000	Iraqis	16,000	Indonesians	8,887

### **2.2.1. Religion**

The impact of Islam in Kuwait has been evident since the establishment of the State of Kuwait (Kuwait Government Online, 2020). Islam is Kuwait's official religion, as stated in the Kuwaiti Constitution. Therefore, the Kuwaiti laws and legislations are derived and based on Islamic law (Islamic Sharia). Most Kuwaitis are Muslims, and the influence of Islam is markedly apparent where the people of Kuwait constantly rely on Islam and Islamic Sharia in managing their life roles. Since Kuwait is in the Arab Peninsula, where the birth of Islam occurred, Kuwait has been an Islamic country from its origin, and Kuwaitis are originally Muslims. As a result, obedience and commitment to the Islamic teachings and the belief in its principles are considered part of the nature of the people of Kuwait (Kuwait Government Online, 2020).

Most Kuwaiti Muslims are Sunnis (85% to 95%). The remaining Kuwaiti Muslims are Shia'a, representing between 5% and 15%. It is completely free for other religions to practice their rituals in Kuwait if no intolerant actions occur against Islam. For instance, Christian families in Kuwait can easily practice their spiritual traditions in several churches scattered around the country. The Kuwaiti law permitted and recognised the freedom of religion, increasing the unity and harmony of the nation (WorldAtlas, 2018).

The second largest religion in Kuwait is Christianity. Kuwait is the only second country in the Gulf Cooperation Council (GCC) with non-Muslim citizens. However, the Christian people in

Kuwait are mainly expatriates, as only 259 Kuwaiti citizens were Christian in 2014. Those Kuwaiti Christian citizens have different origins. Part of them (around 25%) arrived in Kuwait from Turkey and Iraq, assimilating with the Kuwait Arabic community and sharing their language (Arabic), culture, and cuisine. The second group of Kuwaiti Christians arrived in Kuwait from Palestine in the 1950s and 1960s. Lastly, a few Kuwaiti Christian citizens have origins in Lebanon and Syria (WorldAtlas, 2018).

### **2.2.2. Education**

The discovery of oil in Kuwait and the advantage of its high revenues have allowed the Kuwaiti government to establish a well-developed and well-organised educational system, which led to an increase in the literacy rate to around 90%. The government is providing accessible and mandatory public schooling for all students of age 5 to 18. Indeed, in Kuwait the literacy rate has reached its high level in 2011 with no difference between the two genders as 98% of men and 99% of women are literates (WHO, 2011). In fact, male and female students in Kuwait have the same accessibility to education institutes at all level from primary to postgraduate as shown in Table 2.2. Indeed, during the academic year 2020/2021, the Acting Dean of Admission and Registration at Kuwait University (the only public University in Kuwait), Dr. Ali Almutairi pointed out that the acceptance of students and the competition between them for the seats at Kuwait University is solely based on the student's rates during the high schools, and he emphasized that there is no any sort of discrimination between male and female students in acceptances when applying to all collages (Kuna, 2020). Moreover, it is crucial to highlight that there are 200 Islamic teaching schools scattered throughout Kuwait which work in both morning and evening timings to teach the Qur'an and the Islamic literature for boys as well as girls (Al-Janfawi, 2022). In fact, these schools are optional and not mandatory to be enrolled by Kuwaiti pupils, but Kuwaiti parents usually prefer to send their children to these schools. This could illustrate the reason behind the persistent hold of religious and cultural belief of mental illness and the continuous utilization of faith healing treatments from one generation to another in Kuwait even within the new generations. Indeed, if the children have stronger Islamic and religious teachings, they perhaps more likely to rely on faith healing and utilize its methods for treatments. In addition, many private schools are scattered throughout the country, offering advanced curricula and competing with each other, as every school is eager and keen to be the best in the

country. In terms of tertiary education in Kuwait, there is only one public university (Kuwait University) and several private universities (MOH, 2013).

**Table 2.2: Percentage distribution of male and female Kuwaitis by certain Background Characteristics (Source: (MOH, 2013))**

Background characteristics	Kuwaiti		
	Male n=11068	Female n=11283	Total n=22381
<b>Age (years)</b>			
0-4	12.4	11.3	11.9
5-14	24.9	22.4	23.7
15-29	29.8	31.0	30.3
30-44	18.1	18.1	18.1
45-59	8.5	11.1	9.8
60-69	3.5	4.0	3.8
70-79	2.0	1.3	1.7
80+	0.6	0.5	0.5
<b>Marital status</b>			
Under marriage age*	41.9	37.3	39.6
Never married	20.1	18.9	19.4
Currently married	36.2	35.7	35.9
Separated/divorced	1.2	3.3	2.2
Widowed	0.5	4.7	2.6
<b>Education</b>			
No formal education**	18.2	22.4	20.4
Less than primary	12.5	11.8	12.2
Primary	10.5	9.5	10.0
Intermediate	21.2	17.4	19.3
Secondary	21.8	21.6	21.7
College/University	14.0	16.0	15.0
Postgraduate	1.6	1.0	1.3
<b>Number of households</b>		<b>2995</b>	

### 2.2.3. Economy

Kuwait is a wealthy country with a comparatively open economy, with proven crude oil reserves of 96 billion barrels (15 km<sup>3</sup>), accounting for about 10% of the global reserve. Indeed, Kuwait relies mainly on petroleum as nearly 50% of its GDP comes from petroleum revenues, which represents 95% of export profits, and 80% of the country's total income. Conversely, the agricultural industry is minimal because of the harsh and inhospitable climate. Kuwait relies vastly on imports to maintain food security, except for fish, which is abundantly available. In addition, potable water is mainly (75%) imported or distilled. The consequence of the Iraqi

invasion was devastating to the income of Kuwait after the war in 1990, but Kuwait regained its wealth and high financial status quickly in the mid-1990s. The Gross domestic product (GDP) for Kuwait in 2005 reached \$53.31 billion, making the per capita GDP of Kuwait around \$22,800. (MOH, 2013).

### **2.3 Population Health and Healthcare in Kuwait**

The epidemiological profile of Kuwait has dramatically changed during the last three decades. In 1973, infectious diseases were the chief cause of death in the country. These were replaced by cardiovascular diseases in 2009, causing 39.5% of deaths in Kuwait. Cardiovascular diseases, road traffic accident injuries, and cancer are the leading non-communicable diseases responsible for around 65% of all deaths in 2009, while 5.3% of deaths happened due to infectious diseases. The former statistics indicate stress on the epidemiological transition in Kuwait, especially if we add the endocrine-related deaths (diabetes 4.7%) to the total casualties of non-communicable diseases. The noticeable and prominent rise in deaths from cardiovascular disease is associated with several important factors. Generally speaking, the sedentary life that many Kuwaitis adopt because of high socioeconomic status is one of the main factors. Furthermore, high rates of obesity, inactivity, and smoking are all related factors that contribute to elevated incidence of cardiovascular diseases in Kuwait.

After evaluating the healthcare delivery system and its health outcomes and performance in Kuwait, it was found that Kuwaitis' health was enhanced over 30 years (1979–2009). Based on the vital statistics registration records, the crude death rate reduced to 3 per 1,000 Kuwaiti citizens in 2009, from 5.4 in 1979. Moreover, the essential statistics records have shown that the infant mortality rate declined to 10.3 per 1000 live births in 2009, after iron and antenatal care programmes were available in the primary healthcare centres. The immunisation coverage has improved sharply as measles immunisation coverage reached 100% compared to only 69% in 1983 (MOH, 2013).

### **2.4 Biomedical Healthcare System**

In Kuwait, biomedical healthcare services are delivered through three main sectors: the governmental, private, and oil companies. Talking about the governmental sector, the

healthcare services are provided by the Ministry of Health and is considered the critical element in delivering healthcare throughout the country via different levels: primary, secondary, and tertiary. In addition, the Ministry of Defence through Shaikh Jaber Al-Ahmad Military Hospital and the Ministry of Social Affairs through the elderly residential homes are adjuncts in providing health services and are part of the governmental sector. The primary healthcare system in the Ministry of Health is the first frontline that offers comprehensive healthcare for different specialities. The primary healthcare system consists of many primary healthcare centres scattered throughout the whole country to cover all six governorates (MOH, 2013).

Healthcare delivery services are divided into three primary levels based on the level of the provided health services.

*a) Primary Healthcare (PHC)*

This healthcare service is delivered to Kuwaiti citizens and non-Kuwaitis, who have registered themselves in the national health system through the primary healthcare centres. These centres have different services such as therapeutic treatments through general practitioners, preventive medicine, rehabilitation, maternal and child healthcare, and dental healthcare. X-rays and regular laboratory tests are available in these centres. There were 85 primary healthcare facilities in all governorates of Kuwait in 2009, and the total visits to these centres were 14.9 million (66% of Kuwaitis).

*b) Secondary Healthcare*

The secondary level of care is delivered by the six general hospitals of Kuwait: Adan, Farwaniya, Amiri, Jahra, Mubarak AlKabeer, and Al-Sabah Hospitals. Each one of these hospitals has outpatient services, inpatient healthcare, and emergency services. The provided health services in the six general hospitals include: internal medicine; general surgery; paediatrics and orthopaedics services and traumatology; ear, nose and throat (ENT); ophthalmology; psychiatry; dermatology; physical medicine; and dental services. Obstetrics and gynaecology departments are available only in three hospitals: Adan, Farwaniya, and Jahra. The total number of beds in 2009 in all six hospital was 3,517, and the bed occupancy rate was 65%, with an average length of stay of about 5.4 days (MOH, 2013).



### *c) Tertiary Care*

Tertiary healthcare is delivered through the following nine hospitals and specialised centres (MOH, 2013):

- Maternity Hospital
- Hospital for Psychiatric Medicine
- Chest Diseases Hospital Al-Razi Orthopaedic Hospital
- Physical Medicine and Rehabilitation Hospital
- Infectious Diseases Hospital
- Kuwait Centre for Cancer Control (KCCC)
- Kuwait Centre for Allergic Diseases (Abdel-Mohsen Al-Rashed Centre)
- Ibn Sina Hospital for Specialised Surgeries, which includes:
  - Neurosurgery and paediatric surgery
  - Kidney Centre (Hamed El-Essa Centre)
  - Burns and Plastic Surgery Centre (Babteen Centre)
  - Al-Bahr Ophthalmology Centre

## **2.5 Health System Structure**

The governmental health system in Kuwait is organised and designed to be in two levels: the Ministry of Health and Regional Health Areas.

### **2.5.1. Ministry of Health**

The Ministry of Health is accountable for funding, resource division and distribution, formulating health programmes, monitoring and evaluation alongside the provision of healthcare. The health system has a vertical structure combined with a broad central organisational structure at the administrative level.

### **2.5.2. Health Regions**

Since 1984, each governorate in Kuwait has had its health regions, so there are six health regions: Capital, Ahmadi, Farwania, Hawali, Jahra, and Al Subah. There is decentralisation

among these health regions, so each health region works independently as a separate administrative unit. Each health region covers a population of roughly 450,000. The purpose of having the health regions is to offer more efficient health services because of the granted autonomy at the regional level, which is achieved from decentralisation (Aladwani, 2015).

### **2.5.3. Health Services Provision**

As mentioned before, three main sectors deliver healthcare services in Kuwait: the governmental health sector, private sector, and oil companies sector. The Ministry of Health is the chief supplier since it is considered the critical element in the provision of healthcare throughout the country (more than 80% of all health services) via different levels: primary, secondary, and tertiary, and all its services are free for the whole population. The other two governmental providers are the Ministry of Defence through the Military Hospital and the Ministry of Social Affairs, which offers health services that aim to support the elderly and people with disabilities. Talking about the oil companies, only one major hospital (Ahmadi Hospital) belongs to them, and their healthcare services are allocated to help and benefit only their workers and their first-degree relatives. Therefore, those who have never worked for the oil companies are not allowed to access their health services. Whereas private healthcare services are relatively limited in Kuwait (nine private hospitals provide therapeutic healthcare services), the private sector is expanding rapidly and expecting to play a significant role in healthcare delivery (Aladwani, 2015).

### **2.5.4. Healthcare Financing**

The Kuwaiti government provides financial support to the health sector from the oil revenues. Since the economy of Kuwait rely heavily on oil revenues, which vary annually, the allocated budget to the health sector differs accordingly. The government advocates 80% of healthcare services in Kuwait, and the total expenditure on health in 2013 was 2.9 as a percentage of GDP (Al-Jarallah et al., 2009). However, if the spending on health per capita is calculated alone, it will be \$2,375, which is relatively sufficient as this number is comparable to other high-income countries (Aladwani, 2015).

## **2.6. Mental Health System**

### **2.6.1. Health Facilities**

The Psychiatric Hospital in Kuwait is the only hospital in the country that provides psychiatric inpatient healthcare services, with about 900 beds for admission (MOH, 2013). Moreover, rehabilitation services and outpatient clinics are available at the psychiatric hospital. In addition to the psychiatric hospital, psychiatric healthcare services are available in Kuwait's (five) general hospitals and some prisons and private schools (WHO, 2006). But their clinics have a restricted schedule by working only two days per week with outpatients' services. The psychiatrists come to these clinics from the psychiatric hospital since they are employed there (Al-ansari et al., 1990). There is the actual integration of mental health services within the primary settings in Kuwait as there are eight primary healthcare centres with psychiatric outpatient services that work once a week (Alkhadhari et al., 2016). Lastly, private psychiatric health services are available in several clinics in Kuwait, and their numbers have increased recently.

### **2.6.2 Healthcare Personnel**

In Kuwait, the healthcare workers are mainly expatriates since around 80% of the mental healthcare workforce in the psychiatric hospital are non-Kuwaitis, predominantly from Egypt (WHO, 2006). The psychiatric hospital in Kuwait has 48 psychiatrists, 17 psychologists, eight social workers, 294 psychiatric nurses, and 182 non-medical staff (MOH, 2013). Thus, there is a deficiency and inadequacy in the number of mental healthcare workers in Kuwait, as the country only has 3.3 psychiatrists and 2.10 psychologists per 100,000 people (WHO, 2014a). Talking about the mental healthcare workers' proficiency and competence, a study performed in Kuwait to evaluate the staff at the psychiatric hospital found that there was recognisable weakness among the staff regarding psychotherapeutic treatment (Bale, 2000). Also, the study indicated that nursing staff hadn't obtained sufficient training in psychiatry as only 7% had received adequate psychiatric training. Most of Kuwait's medical staff (60%) have graduated from universities in the Arab region where psychiatry doesn't acquire sufficient attention and care. Hence, undergraduate psychiatric education is negligible (Alansari et al., 1990). Indeed, in Kuwait, only five psychologists currently practice their job in the psychiatric hospital and have obtained a US licensed doctoral level. Only two can practice psychotherapy treatment in Arabic (Scull et al., 2014).

Moreover, the medical school at Kuwait University offer restricted hours (only 100 hours) in learning psychiatry for its undergraduate medical students (WHO, 2006). Thus, only a few medical doctors who graduated from Kuwait University (only eight Kuwaiti medical doctors) were selected and accepted to specialise in psychiatry from 2003 to 2007 (Al-jarallah, 2009). People in Kuwait seek help and mental healthcare from the general practitioners at the primary healthcare centres who are unskilled and weak in treating psychiatric conditions. Therefore, many psychiatric patients haven't received adequate treatments and are diagnosed inaccurately after approaching general practitioners in primary care centres (Alkhadhari et al., 2016). The situation is quite similar in the general hospitals in Kuwait as a lack of accurate diagnosis of mental disorders by physicians commonly occurs when psychiatric cases are referred to the psychiatric hospital when there is evident past mental history or inability to diagnose physical symptoms (Al-ansari et al., 1990).

### **2.6.3 Mental Health Policy**

In Kuwait, a mental health policy formulated in 1975 was implemented to cover several areas, including rehabilitation, advocacy, promotion, and prevention (WHO, 2006). Nevertheless, not all the identified areas have been successfully implemented. For example, there is no law for data protection in Kuwait, so the confidentiality of patients approaching mental healthcare services isn't ensured and maintained. Moreover, there are no licensing rules and professional ethic regulations in Kuwait that can protect mental health practices from maltreatment (Scull et al., 2014). Most of the approved therapeutic psychiatric medications are available at the psychiatric hospital. At the same time, the family physicians at primary healthcare centres are not allowed by law and professional regulations to prescribe some psychotherapeutic medications. In addition, guides and instructions for managing common psychiatric conditions are not provided at many primary health centres (WHO, 2014b).

## **2.7. Faith and Faith Healing in Kuwait**

Islam is the country's official religion in Kuwait, and most Kuwaitis are Muslims. People depend heavily on Islam to overcome mental health problems (Scull et al., 2014). Therefore, Kuwaitis seek help from Islamic faith healers to receive mental healthcare and support. It is crucial to distinguish between faith and traditional healers as they are used interchangeably.

Indeed, globally, the word "traditional" is often referred to things that are unscientific, illogical, backwards whereas the word "modern" is commonly used to describe things that are western, contemporary and innovative. Similarly, the Arabic interpretation, particularly within Arabic Gulf Countries, of the word "traditional" is all practices and values that have Bedouin or Islamic roots (Thomas et al., 2015). It is vital to distinguish between the different meanings of Traditional healing and Faith healing especially within the Arabic context as these terms are usually interchangeable in other contexts. Basically, the major difference between traditional and faith healers is in their healing approaches as traditional healers' treatments are mainly based on utilizing local prepared herbal medicines for the management of diseases, while faith healers or in Arabic word "Imams" are performing healing practices that are derived from the power of God mainly in a form of prayers. In Kuwait, people tend to choose whom to access (either faith or traditional healers) based on their attribution of their health problems. For instance, when they face psychological health problems, they often attributed it to a spiritual and religious causation, thus they choose to approach faith healers. Whereas, the physical health problems (such as abdominal pain, headache, musculoskeletal pain, fatigue) are attributed to physical causation, thus in such cases, Kuwaiti people tend to approach traditional healers. Therefore, faith healers in Kuwait are the ones who are mostly approached to obtain mental health care services in comparison to traditional healers who are rarely accessed to receive treatment for mental illnesses.

A study done in Kuwait showed that faith healers are undeniably important sources of mental healthcare and treatments (El-Islam, 2008). Indeed, access to faith healers is a prevalent behaviour among many Muslims worldwide. The Islamic faith healing practices are considered a religious method of treatment that originated and is based on the Holy Qur'an and sayings from the Prophet Muhammad (Thomas et al., 2015). Unfortunately, there are no published resources discussing the faith healing practices in Kuwait, so their numbers and the extent and significance of their role can't be determined, which can be understood because of the lack of official recognition of their practice.

Nevertheless, in other GCC countries that share a similar culture and religion with Kuwait, there are some published data about the practice of faith healers. A considerable number of people have approached faith healers in Oman (42%) and in Riyadh City in Saudi Arabia (50%) to obtain mental health treatments before accessing biomedical mental healthcare services (Al-Riyami et al., 2009; AlRowais et al., 2010). Most people in GCC countries who access faith healers do so because they trust their effectiveness, mistrust Western scientific medicine, and

favour natural remedies (Thomas et al., 2015). Also, the most apparent reason is that faith healing practices are considered part of Muslim and Arab culture, so no stigma is attached (Al-krenawi and Graham, 2000).

It is crucial to highlight the important role culture plays in determining which approach people follow to get mental healthcare, either by visiting medical healthcare facilities, accessing traditional or faith healers, or trying home remedies. Indeed, it is common among Kuwaitis to believe that there are supernatural forces or spirits called jinn, and jinn obsession can be manifested in abnormal actions (Scull et al., 2014). Moreover, it is culturally typical for Kuwaitis to believe in the harmful impact of envy on mental health, which happens when a person wishes terrible feelings toward another person, causing mental illness to them (El-Islam and Abu-dagga, 1992). All the previously mentioned beliefs are commonly shared by all groups of ages, from old to younger generations. As a result, those who hold cultural and religious beliefs explaining their mental health issues are unlikely to seek help from medical professionals, as it is ineffective from their perspective (Thomas et al., 2015).

The Kuwaiti community is principally collectivistic as family members are adjacent to each other in daily tasks and resemble a working unit. They make shared decisions, so no individual decisions are made; thus, when they face mental health problems, they consult their family members (Scull et al., 2014). Indeed, a study conducted on Arabic people showed and confirmed that they highly rely on family members in mental crises, as 22% of participating Arabs preferred to seek help from their relatives, while 11% chose to visit specialised therapists (Aloud, 2004). Consequently, Kuwaiti patients are known for being accompanied by their relatives when they see a psychiatric health clinic, and their relatives become part of their treatment plan (El-Islam, 2008). Moreover, on some occasions, the patient's relatives consult the psychiatrists asking for help for their sick relatives instead of the patient. It is crucial to highlight that Arabic families are often extended families where family members are expected to be involved in finding solutions to the problems that face any member of the family (Al-kernawi and Graham, 2000).

Since Islam is the predominant religion in Kuwait, daily life missions are achieved through the guidance of Islam. According to Scull et al. (2014), the people in Kuwait find in Islam, through

their strong faith and daily prayers, the solution and the ways to cope with the stressors of life and lessen the symptoms of mental disorders.

Islam is a monotheistic and Abrahamic religion based on the divine disclosure to the Prophet Muhammad 1400 years ago, which were recorded in the Holy Qur'an; the Qur'an provides a holistic guide to the followers to handle all aspect of life such as relationships, finances, family, and healthcare (Sabry and Vohra, 2013). The Arabic word Islam means absolute submission to Allah (the creator of the whole universe), which indicates the central theme of Islam, which is the submission to the will of God (Ahmad and Khan, 2015). Because of this solid belief among Muslims that God is omnipotent, their lives are wholly centred on God's will. Thus, diseases tend to be viewed as under the control of the will of God (Ypinazar and Margolis, 2006). For example, a qualitative study done among American Muslims highlighted that most participants interpreted diseases as a test of faith or punishments of God and believed that God had the primary role in health (Scull et al., 2014).

Muslims generally view illness or any catastrophic events that occur as a punishment for their sins and malevolent mistakes that could have happened at any time of their life. This fact is illustrated and mentioned by sayings from Prophet Muhammad as he said, "No fatigue, no disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he receives from a thorn, but Allah expiates some of his sins for that." (Al-Shari and Al-Khenaizan, 2005).

It is worth mentioning that in Islam, it is compulsory to attain proper treatment for illnesses. Indeed, Islamic teachings encourage accessing health services for medical help and medication adherence. Muslims believe in the importance of medications as Prophet Muhammed has taught them that Allah didn't send a disease unless a treatment remedy has been sent down for it (Ateeq et al., 2014). Therefore, Islam promotes enhancing the range of knowledge about treatment remedies. Obvious evidence of the higher perception and positive attitude of Muslims towards mental treatment is that the first psychiatric hospital in the world was established during the golden era of Islamic civilisation in Baghdad, Iraq, in 705CE by Al-Razi, who is one of the most outstanding Islamic physicians (Sabry and Vohra, 2013). Al-Razi interpreted psychiatric disorders as physiological problems and introduced and discussed ideas such as the definition of mental illness and its symptoms as well as psychotherapy methods. Moreover, Ibn

Sina, known as Avicenna in the West and one of the most excellent Islamic physicians, rejected the idea that possessing Jinn would cause mental illness (Sabry and Vohra, 2013). But Islamic scholars at that time didn't contradict the concept of religious counselling by faith healers.

## **2.8 The Challenges Between Policy and Practice of Faith Healing**

The mental health policies in Kuwait are designed to support Western medicine. Giving total power to the biomedical side leaves faith healers without official recognition or support. Although faith healing practices are eminently accessible in Islamic and Arabic societies as a mental health care provider, the policy makers and authorities in Kuwait have always relied on allopathic medicine and ignored faith healing practices when they plan and formulate the national health care strategies and policies. An extensive review of published literature revealed no discussion of the practice of faith healers in Kuwait and underscored the previous lack of attention to this issue. But what might be the reasons for this exclusion, and what impact might there be of drawing faith healers into the discussion of mental healthcare in Kuwait? Indeed, the only source of information and data about faith healing in Kuwait were some articles in some Kuwaiti newspapers discussing reasons behind banning faith healing practices in Kuwait. For instance, an article in a Kuwaiti electronic newspaper called *Eremnews* pointed out that Ministry of Islamic Affairs in Kuwait announced that faith healing is illegal due to several malpractice incidences in several areas of the country (Eremnews, 2017). Furthermore, other articles mentioned that faith healing practices in Kuwait are lucrative jobs where faith healers are not well-qualified both scientifically and in Islamic teachings, causing healthcare accidents with severe and fatal complications (Alsalmah 2017; Alsanea 2010).

The other challenge is that faith healers are not recognised as legal healthcare providers in Kuwait, and their healing centres are not officially organised and regulated. Thus, it would be challenging to establish a collaboration with an unauthorized practice. A further dilemma that might hamper initiating the first contact with faith healers and make it difficult is that there is no association in Kuwait that represents the faith healers. In addition, a mutual mistrust and disdain is inherited by some psychiatrists and faith healers in Kuwait that could make each side hesitant to cooperate with the counterpart.



## 2.9 Rationale of the Research

In November 2015, Dr Khalid Al-Sahlawi, the Undersecretary of the Ministry of Health of Kuwait, declared that about one-third of Kuwaitis are diagnosed with psychiatric conditions (Abdelmaaboud, 2015). In addition, a study done in one of the primary healthcare facilities in Kuwait revealed that 42% of Kuwaiti patients who were regularly attending that primary healthcare centre complained of mental morbidities (Al-khadhari et al., 2016). In fact, according to the WHO, mental health conditions are causing 20% of the disease burden in Kuwait (WHO, 2011). Nevertheless, despite the high prevalence of mental disorders among people in Kuwait, they commonly avoid accessing mental health services. Thus, mental health services tend to be inadequately approached (Almazeedi and Alsuwaidan, 2014).

Although the government of Kuwait has allocated a substantial proportion of its budget to improving the health system that has ensured the accessibility of advanced mental health services with abundant psychiatric medications, and also with free of charge access to these services for all the people living in Kuwait, the utilisation of mental health services is relatively low. This is because of various obstacles that hinder mental health services, such as low mental health awareness, stigma attached to psychiatric settings, and approaching faith healers to seek mental care. Thus, decisions-makers and key stakeholders in Kuwait are urged to enhance the utilisation of mental healthcare services to ultimately reduce the mortalities and morbidities of mental disorders in Kuwait. The main reason behind the low utilisation rate of mental health services in Kuwait is related to the stigma attached to psychiatric settings (Almazeedi and Alsuwaidan, 2014; Scull et al., 2014). Indeed, stigmatisation made mental treatment a challenging task in Kuwait and the Middle East in general since psychiatric patients and their relatives commonly refuse to be referred to mental health services (Scull et al., 2014). Indeed, a study by Alansari et al. (1990) showed that only 0.3% of Kuwaiti patients accepted the referral to mental healthcare facilities. The delay in obtaining prompt mental healthcare and therapeutic medicine is closely related to the poor prognosis of psychiatric diseases. Indeed, the outcome and the consequences of such delay could be harmful and destructive in terms of having high relapse rates, unsuccessful treatments, and deterioration in cases (Burns and Tomita, 2014). Thus, the chief action to alleviate mental health problems' adverse and harmful outcomes is rapid detection and early medical intervention. As a result, the identified hindrances of approaching and utilising mental health services in Kuwait must be mitigated.

As Islam is the religion of the vast majority in Kuwait, many mental disorders sufferers rely on their Islamic teaching and religious beliefs when they face mental health problems (Scull et al., 2014). Indeed, a study done in Kuwait claimed that faith healing centres are important mental health care providers in Kuwait as people tend to avoid psychiatric settings due to stigma (El-Islam, 2008). Therefore, the attempts to enhance the utilisation of mental health services should consider establishing collaboration with faith healers. The vital role played by traditional and faith healers in decreasing the mental treatment gap has been recognised by WHO since the mental health action plan 2013–2020 recommended the inclusion of faith healers in mental healthcare delivery (WHO, 2013). Indeed, many countries, particularly in Africa, have successfully formed the collaboration between allopathic medical practitioners and faith healers (Musyimi et al., 2016). This could be helpful and beneficial as psychiatry sometimes fails in providing culturally competent treatments, while faith healers utilise appropriate and applicable methods to the patient’s cultural background (Shore et al., 2005). That is to say, the collaboration between the two sides is appropriate to obtain a more holistic healthcare treatment. The advantages of establishing the partnership are various such as regulating the faith healing practices, so maltreatments will be prevented in their centres and allowing the psychiatrists to adapt and provide a potential treatment that matches the patient’s cultural background (Thomas et al., 2015).

## **2.10 Conclusion**

This chapter was conducted to give a clear picture of the situation in Kuwait. Indeed, a general background of Kuwait was presented, the health system of Kuwait was illustrated, the faith healing practices in Kuwait were explained, the challenges between policy and practice of faith healing were identified, and the rationale of this study was clarified. Given the current contradiction between recognising faith and faith healing as integral to Kuwaiti explanations and attributions of mental health problems and separating this from the formal organisation of mental healthcare, this study’s aim to explore the opportunities for faith healers and mental health professionals to collaborate appears both vital and timely.

## **Chapter 3**

### **Literature Review**

#### **3.1 Introduction**

Mental health conditions are projected to affect 25% of the world population, as WHO (2013) indicated. Similarly, in November 2015, Dr Khalid Al-Sahlawi, the Undersecretary of the Ministry of Health of Kuwait, declared that about one-third of Kuwaitis are diagnosed with psychiatric conditions (Abdelmaaboud, 2015). Nevertheless, despite the high prevalence of mental disorders among Kuwaiti people, they commonly avoid accessing mental health services because of the stigma attached to psychiatric settings (Scull et al., 2014). Traditional and faith healing practices are popular alternative sources of treatment that continue to be utilised throughout the entire world from ancient times to the present. Despite abundant effective modern health services, people continue to approach traditional or faith healers to receive help for physical or psychiatric disorders. Many patients access allopathic health practitioners and traditional and faith healers simultaneously, believing they can receive comprehensive treatment by combining the two. Consequently, forming and establishing collaboration between the two mental health providers is necessary. This literature review aims to examine and map the existing literature discussing the partnership between faith healers and health professionals.

#### **3.2 Background**

##### **3.2.1 Introduction**

This section will identify the significance of this topic and the rationale behind analysing such a problem. Furthermore, the important definitions related to the subject and the objectives of this literature review will be presented.

##### **3.2.2 Mental Health and Mental Illness**

The WHO (2005) has defined mental health as a state of well-being when a person can manage his daily tasks efficiently and positively discover and utilise his abilities. This definition emphasises the vital role of having a stable mental condition in living a normal life (Prince et al., 2007). In contrast, mental illness is considered a medical condition affecting people's temper, emotional states, behaviour, and judgments in a negative way (Duckworth,

2013). Conditions categorised as mental disorders include personality disorder, bipolar disorder, depression, panic disorder, schizophrenia, eating disorder, obsessive-compulsive disorder, and addictive behaviours (Almutairi, 2015).

### **3.2.3 Burden of Mental Illness Globally**

Mental health conditions are projected to affect 25% of the world population, as the WHO (2013) indicated. Furthermore, around 37% of all healthy life lost years are contributed by mental health conditions. Thus, they are one of the critical causes of disabilities worldwide (Jack-Ide and Uys, 2013). The burden of psychiatric disorders is estimated to increase steadily as unipolar depression is expected to be the third most common contributing factor to disease burden globally by 2030 (Mathers and Loncar, 2006). Although mental illness represents a considerable disease burden, many countries disregard it in their national health policies. In many countries, less than 1% of the total health expenditure has been assigned to mental illness (WHO, 2008). Indeed, even in some developed countries, mental illness patients are frequently neglected and are not receiving prompt and adequate medical treatments (Wang et al., 2007). The situation is much more difficult in developing countries as the treatment gap for mental health conditions is more than 85% (Musyimi et., 2016). This could be related to the various barriers hindering the access and utilisation of psychiatric health facilities in low- and middle-income countries, such as accessibility constraints, reliance on traditional or faith healing practices, and stigma towards mental health services (Ghanizadeh et al., 2008; Kessler, 2000).

### **3.2.4 The Significant Role of Traditional Healing Practices**

Traditional healing practices are popular alternative sources of treatment that continue to be utilised throughout the entire world from ancient times to the present. Despite abundant modern health services, people approach traditional healers to receive help for physical or psychiatric disorders. Indeed, studies showed that the prevalence of utilising traditional medicine in Turkey, Malaysia, and Australia was 61%, 61%, and 51%, respectively (Mohammad et al., 2015). Some patients use only traditional medicine as a sole source of treatment. Others combined it with medical treatments. The rate of traditional medicine utilisation is increasing in the United States. Its rate increased from 33.8% to 42.1% between 1993 and 1997 (Bahceci et al., 2013). Indeed, in the last decade, the crucial role played by traditional medicine has been recognised globally in both developed and developing

countries. The WHO declared that 80% of African people depend on traditional medicine and indigenous knowledge to encounter health problems (Agbor and Naidoo 2011). There is consensus by numerous studies that traditional healing practices provide effective health treatment and support for those who suffer from mental problems in many developing countries (Al Riyami et al., 2009; Sorketti et al., 2011; Sorsdahl et al., 2010). For instance, a systemic review study discovered that about 50% of African psychiatric patients have initially accessed traditional or religious healers before contacting formal medical care services (Burns and Tomita, 2014).

### **3.2.5 Definition of Traditional Healing Practices**

The words “traditional” and “modern” are usually used misleadingly. “Traditional” is often used to refer to unscientific and irrational views, while “modern” is often assumed to be scientific and rational (Dein et al., 2008). Generalising the terms in one meaning doesn’t reflect reality because when the societies developed in stages, the traditional practices improved in a revolutionary process to become modern, so the modern is a continuation of the tradition, and tradition accepts modernity (Dein et al., 2008). Therefore, it is incorrect to assume traditional knowledge is irrational. Having said that, traditional medicine can be understood as a combination of various knowledge, skills, and practices derived from different beliefs and experiences specific to certain cultures that are used to promote health and treat physical and mental problems (Abbo, 2011). Indeed, traditional healing is a broad term used to label all healthcare approaches or techniques that are not integrated within the official health system. Accordingly, the traditional healer is a person who gained a reputation in the community by their ability to treat people through unorthodox methods of healing. Their practices are primarily based on inherited family experience or religious power.

### **3.2.6 Faith Healing Practices as One of the Traditional Medical Methods**

In religious communities, faith healing practices, as one of the traditional medical methods, have a much broader function and influence than other traditional approaches. Indeed, many traditional medicine practices in Islamic communities, such as in Saudi Arabia, are done by faith healers in spiritual-based methods (Alosaimi et al., 2014). According to the Oxford dictionary, faith healing is a healing manoeuvre done by religious beliefs and practices rather than scientific medical therapies (Stevenson, 2010). It can also be defined as an alternative treatment method based on the assumption that illness can be managed and cured by faith

alone through prayers or other religious rituals. Regarding Islamic spiritual healing, as the illness is generally predicted to occur under the will of Allah, so the faith healing focuses on religious practices that enhance the adherence to Allah to stimulate and induce the power and existence of God towards treating disease and disabilities (Bathla et al., 2011; Ateeq et al., 2014). A faith healer is defined as an individual who mitigates patients' psychological and physical problems using religious means of treatment. In the Islamic and Arabic world, those faith healers have different names, such as Mutawa, Mulla, or Shiekh. Those healers do not necessarily have a formal qualification in Islamic spiritual healing, where they gained their recognition position within the community by reputation. Nevertheless, some faith healers may pursue higher academic teaching in some high-standard Islamic universities (Thomas et al., 2015).

### **3.2.7 Islamic Perspective on Mental illness**

The Islamic clarification of mental disorders is that it begins when doubt and dissociation surround the person leading to an interpersonal conflict of thoughts that develop the symptoms of psychiatric illness (Farooqi, 2006). In addition, it is recognised within Islamic teachings that a weak and inadequate attachment to God is associated with poor mental health. This is because the insufficient connection with God will subsequently cause a feeling of loneliness, and low satisfaction in life, eventually leading to anxiety and even depression (Ghobor et al. (2013). On the other hand, Muslim believers worldwide, based on their Islamic faith and teachings, frequently have alternative interpretations of mental illness. Many Muslims believe in supernatural forces or spirits called Jinn (El-Islam, 2008). These beliefs of the existence of such miraculous powers are inherited from one generation to another within the Muslim community. They are usually accompanied by fear, as the Jinn is stated in Qur'an on several occasions (Al-Habeeb, 2003). According to Islamic belief, Jinn is an invisible creature that can be male or female, a believer or unbeliever of God, live with human beings in the same universe, interfere with the life of human beings, and might harm them by various satanic methods (Al-Habeeb, 2003). Indeed, Islamic belief reveals that Jinn has the power to affect humans physically or mentally through possession. Some Muslims believe that jinn can make people speak loudly, hear strange voices, or do repetitive and aggressive movements (Scull et al., 2014). Other Muslims may also attribute mental disorders to a supernatural force called the "evil eye." The Holy Qur'an mentions that the evil eye can harm human health. The evil eye belief is a popular concept among Muslims. It refers to

encountering bad luck or misfortune due to harbouring envious feelings toward coveted objects or their owners. (Scull et al., 2014; Saged et al., 2018).

### **3.2.8 The Origin of Islamic Faith Healing Practice**

To understand the origin of Islamic faith healing, a method used by most Islamic faith healers, “Ruqyah,” must be clarified. Ruqyah refers to reciting various verses from the holy Qur’an and is sometimes accompanied by sayings from the Prophet Muhammad. It is performed mainly on those presumed to have mental disorders (Md. Sa’ad et al., 2017). During Ruqyah practice, some faith healers might use Zamzam water found only in Mecca in Saudi Arabia. Indeed, numerous studies found that the religious psychotherapy Ruqyah was effective for Muslim patients in alleviating their distress from anxiety and depression conditions (Sabry and Vohra, 2013). Ruqyah in Islam is an ancient practice that has been performed since the beginning of Islam (Md. Sa’ad et al., 2017). Indeed, various reliable narrations reveal that the Prophet Muhammad had performed Ruqyah practices on several occasions during his life, and he had explained the accurate way of Ruqyah to his companions. For example, “Bukhari” and “Muslim,” the most reliable narrators among Muslims, narrated that Prophet Muhammad recited verses from the Holy Qur’an on a companion whom a scorpion bit. In addition, it was told that Prophet Muhammad used to recite specific verses from the Qur’an when he faced fatal illnesses, then breathe on his hands and rub his body with them (Md. Sa’ad et al., 2017). Recent studies discovered that the waves of sounds which carry meaningful and unique ideas could awaken positive human feelings, imagination, and memories, thus affecting people positively. Therefore, relieving psychological stress by Ruqyah and the positive influence of reciting the Qur’an on people applies the same theory (Saged et al., 2018).

### **3.2.9 The Inevitable Collaboration Between Faith Healers and Health Professionals**

Many patients access allopathic health practitioners and traditional and faith healers simultaneously since, from their perspective, they can receive the proper and comprehensive treatment through this technique. Consequently, forming and establishing collaboration between the two mental health providers is necessary. The WHO has emphasised the importance of integrating traditional or faith healers’ practices in the national health system since 1978. Unfortunately, only a few countries have initiated strategies to promote cooperation between the two sectors and include traditional and faith healers within their

official health systems. Indeed, successful collaborative results have been achieved mainly in preventing and treating HIV/AIDS, while little progress was noticed in mental healthcare (van der Watt et al., 2017). Traditional and faith healing practices are often derived from the culture, and it has been found that in every culture, there are often rigid and fixed knowledge and beliefs about mental illness meanings, its causative factors, ways of diagnosis, and methods of treatments (Rashid et al., 2012). Hence, the substantial use of traditional and spiritual healing, particularly in developing countries, is closely related to the indigenous explanatory model of illness held by people living there (Campbell-Hall et al., 2010). The explanatory model of illness, which illustrates how a person understands and comprehend their illness, asserts the influence of cultural and social beliefs (Chilale et al., 2017). Thus, applying the biomedical model of mental health to treat patients holding a cultural view about their mental illness is likely to seem unreasonable and impractical. Accordingly, it looks more operative to find an integrative approach that considers the indigenous cultural beliefs of patients (Thomas et al., 2015). This dual approach fits with Kleinman as he illustrated a difference between disease and illness as the disease is a biological fact that could be investigated and treated. In contrast, illness is the cultural domain of that fact. Therefore, social and cultural perspectives must be integrated to obtain effective healing practices (Campbell-Hall et al., 2010). Indeed, each field has its unique medications and methods of treatment which are mainly based on the training and expertise of the providers of each area, and patients might approach both areas concurrently for the same problem; therefore, a collaboration between the two areas is essential to obtain enhanced outcomes of care and satisfaction (Akol et al., 2018).

### **3.2.10 Mental Healthcare in Kuwait**

In November 2015, Dr Khalid Al-Sahlawi, the Undersecretary of the Ministry of Health of Kuwait, declared that about one-third of Kuwaitis are diagnosed with psychiatric conditions (Abdelmaaboud, 2015). In addition, a study done in one of the primary healthcare facilities in Kuwait revealed that 42% of Kuwaiti patients who were regularly attending that primary healthcare centre complained of mental morbidities (Al-ghadhari et al., 2016). In fact, according to WHO (2011), mental conditions are causing 20% of the disease burden in Kuwait. Nevertheless, despite the high prevalence of mental disorders among Kuwaiti people, people in Kuwait commonly avoid accessing mental health services. Thus, mental health services tend to be inadequately approached (Almazeedi and Alsuwaidan, 2014). The main



reason behind the low utilisation rate of mental health services in Kuwait is related to the stigma attached to psychiatric settings (Almazeedi and Alsuwaidan, 2014; Scull et al., 2014). Indeed, stigmatisation made mental treatment a challenging task in Kuwait and the Middle East since psychiatric patients and their relatives commonly refuse to be referred to mental health services (Scull et al., 2014). Indeed, a study by Alansari et al. (1990) showed that only 0.3% of Kuwaiti patients accepted the referral to mental healthcare facilities. As Islam is the religion of the vast majority in Kuwait, many mental disorders sufferers rely on their Islamic teaching and religious beliefs when they face mental health problems (Scull et al., 2014). Indeed, a study done in Kuwait claimed that faith healing centres are important mental health care providers in Kuwait as people tend to avoid psychiatric settings due to stigma (El-Islam, 2008). Regrettably, there are no publications discussing the faith healing practices in Kuwait so no data is available about their numbers and the extent of their utilisation in Kuwait, which is probably related to the lack of the official endorsement of their practices. Indeed, the local authorities in Kuwait consider the faith healing practices as illegal practices. In fact, the Kuwaiti government represented by the Ministry of Health rely only on the biomedical model and the scientific epistemology for illustrating and treating the psychiatric illnesses. This is because the Ministry of Health of Kuwait needs a scientific evidence to embrace and include any further complimentary treatment approaches. This also could be related to the overall vision of the Kuwaiti government to adapt a secular regime in governing and regulating all aspects and ministries of the country. The hostility towards faith healing by the local authorities in Kuwait is manifested in several ways. For example, the faith healing is excluded to be part of the formal health care system and labelled as informal and unofficial practice. Indeed, the Ministry of Interior in Kuwait has launched several campaigns to close all the detected faith healing centres (Al-Dhafiri, 2011). The other way of hostility is the concerns of malpractices that occurred within the faith healing centres. Indeed, the authorities are regularly questioning and doubting the legitimacy of faith healing in Kuwait due to several malpractice incidences that occurred in several areas in Kuwait (Eremnews, 2017). Another picture of the hostility towards faith healing in Kuwait is the inherited disrespected. Indeed, the authorities in Kuwait view the faith healing practices in Kuwait are conducted occasionally for lucrative jobs where faith healers are not well-qualified both scientifically and in Islamic teachings, which caused many cases to deteriorate with severe and fatal complications (Alsalmah 2017; Alsanea 2010).

Consequently, this literature review aims to examine and map the existing literature discussing the collaboration between faith healers and health professionals. The objectives are **1)** to determine a rationale for establishing collaboration between faith healers and health professionals to provide mental healthcare, **2)** to identify and summarise previous research findings which have examined the relationship and interactions between faith healers and health professionals, and **3)** to identify the research gaps in the existing literature about the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait.

### **3.3 Literature Review Approach**

A scoping review was performed by following the methodology illustrated by Arskey and O'Malley (2005). Scoping reviews are becoming a popular and common approach when researching a topic with limited literature (Peters et al., 2015). Indeed, scoping reviews can be carried out to address broad research questions, whereas systemic reviews can only target specific and restricted research problems. Furthermore, the scoping reviews approach can create opportunities for future research by identifying literature gaps about a particular topic after examining the literature extensively (Hanneke et al., 2017). Another advantage of scoping review is that the selected studies can be included within the pool of the research analysis regardless of the paper quality, as no theoretical appraisal of selected articles is needed (Peters et al., 2015). Therefore, I conducted a scoping review as my aim was to examine and map the existing literature discussing the collaboration between faith healers and health professionals. This review shall employ the five steps strategy used by Arksey and O'Malley (2005), which includes (1) identifying the research question, (2) identifying relevant literature, (3) selecting studies, (4) charting the data, and (5) collating and summarising the data.

#### **3.3.1 Identifying the Research Questions**

During Alma Ata International Conference on Primary Healthcare in 1978 and again in 2002, the WHO recommended the formal recognition of traditional medicine and asserted the importance of including traditional healing practices within the formal national health programmes (Ae-Ngibise et al., 2010). Moreover, the WHO mental health Global Action Programme Intervention Guide (mhGA P-IG) recognised traditional practices as a crucial

element in reducing the mental treatment gap, which reached more than 85% in low- and middle-income countries (Musyimi et al., 2016). Additionally, the WHO mental health action plan 2013–2020 stated the formal integration of traditional medicine practices within health systems as one of its objectives (WHO, 2013). This indicates how crucial it is to raise our research question, which is: What are the opportunities for faith healers and health professionals to collaborate to provide mental healthcare in the context of Kuwait?

It is essential to consider which aspects of the research question are fundamental and illustrate and demonstrate the study population, interventions, and outcomes. According to our research question, the study population is the faith healers and the health professionals, the intervention is establishing collaboration between the two sides, and the outcome is the provision of mental healthcare. Three further subquestions need to be addressed in this scoping review: 1) What are Kuwait's current mental health policies concerning faith healing practices? 2) What barriers could hamper the collaboration between the two healing systems? 3) Which mechanisms could be appropriate for cooperation between faith healers and biomedical practitioners?

### **3.3.2 Identifying Relevant Literature**

The author conducted the literature search on April 2019 to elaborate all relevant published and grey literature about the topic. According to Arksey and O'Malley (2005), it is highly recommended to formulate broad keywords and search terms to be used in the literature research to obtain all potential and relevant literature on the topic. Search terms were chosen and developed according to the three essential elements of the research question: 'faith healer', 'collaboration', and 'mental health'. In fact, during the research process, many keywords for this review were selected, such as: faith heal\*- collaboration\*-mental health-service\*- healthcare- mental illness\*- treat\*- barrier\*- religion\*- Kuwait- Middle East-psychiatr\*. Indeed, numerous keywords were employed to cover all the different angles of the study. Moreover, the truncations (\*) and synonyms were employed to obtain all potential and relevant literature. Afterwards, Boolean operators "and/or" were used to combine the initial broad literature search results and filter them to attain the final selected studies. The primary databases to obtain peer-reviewed studies were PsychINFO, PubMed, MEDLINE, Scopus, and Web of Science. Studies were accessed via the University of York Library. These databases were selected as they are recognised in international health, Medicine and

psychology and contain many peer-reviewed articles. Thus they were accessed to obtain potential and relevant literature. Moreover, the websites of WHO, Kuwait Ministry of Health (MOH), United States Agency for International Development (USAID), World Bank, African Development Bank (AFDB), and Asian Development Bank (ADB) were approached since mental health is an essential aspect of their work. Other grey literature was obtained by consulting search engines such as Google Scholar and Google. Lastly, snow-balling the accepted references from the above sources created and produced other helpful literature. Table 3.1 shows how 475 articles were obtained from PubMed databases after following the previously illustrated approach of using various combinations of truncated key terms. The other databases followed the same technique to collect additional studies.

**Table 3.1 Sample database search result**

	Search Terms	Number of hits
		PubMed
1	collab* or integrat* or cooperat* or partner*	77,457
2	heal*or treat* or praction*	164,808
3	faith or religio* or tradition*	7,781
4	Mental* or psychiatr* or medic*	581,267
6	#1 and #2 and #3	4,103
7	#1 and #2 and #3 and #4	457

### 3.3.3 Selecting Studies

Initially, the article title and abstract were scrutinised to select the relevant articles. Then, papers were sorted according to inclusion or exclusion criteria (illustrated below).

#### Inclusion and Exclusion Criteria

- Only English and Arabic publications were included.
- Only articles available via public or by the University of York Library and free to be accessed were included.
- Only relevant literature focused on the relationship and the interaction between faith healers and health professionals in the mental health area were included. Studies

focused on collaboration between the two sides in other health disorders such as HIV, tuberculosis, and other diseases were excluded.

- Any literature that discusses only the reasons behind accessing faith healers was excluded. Articles that only examined the characteristics of faith healers' visitors were excluded too. Moreover, studies focusing only on the type of interventions and treatment methods used by faith healers were also excluded.
- Only publications after 1990 were included as mental health only gained global attention and consideration in the last two decades.
- All articles were considered regardless of the location of the study, so studies conducted in both developing and developed countries were included.

Eligible studies were identified after rigorous reading of the whole text of these studies. Indeed, the obtained studies were selected and considered suitable for our scoping review after satisfying the inclusion criteria. After accomplishing the literature research, 19 articles were selected for this scoping review. Figure 1 shows how the study was carried out to choose the 19 relevant articles for this scoping review, and additional grey literature was included.

### **3.3.4 Charting the Data**

By following the methodological framework of Arksey and O'Malley' (2005), data from the relevant articles that fulfil the inclusion criteria were extracted and charted according to the following headings: author, year of publication, study location, the aim of the study, study design, participant population, intervention or topic, and main findings. Appendix 1 shows the complete process of charting the data of the 19 selected articles for this scoping review.

## **3.4 Results**

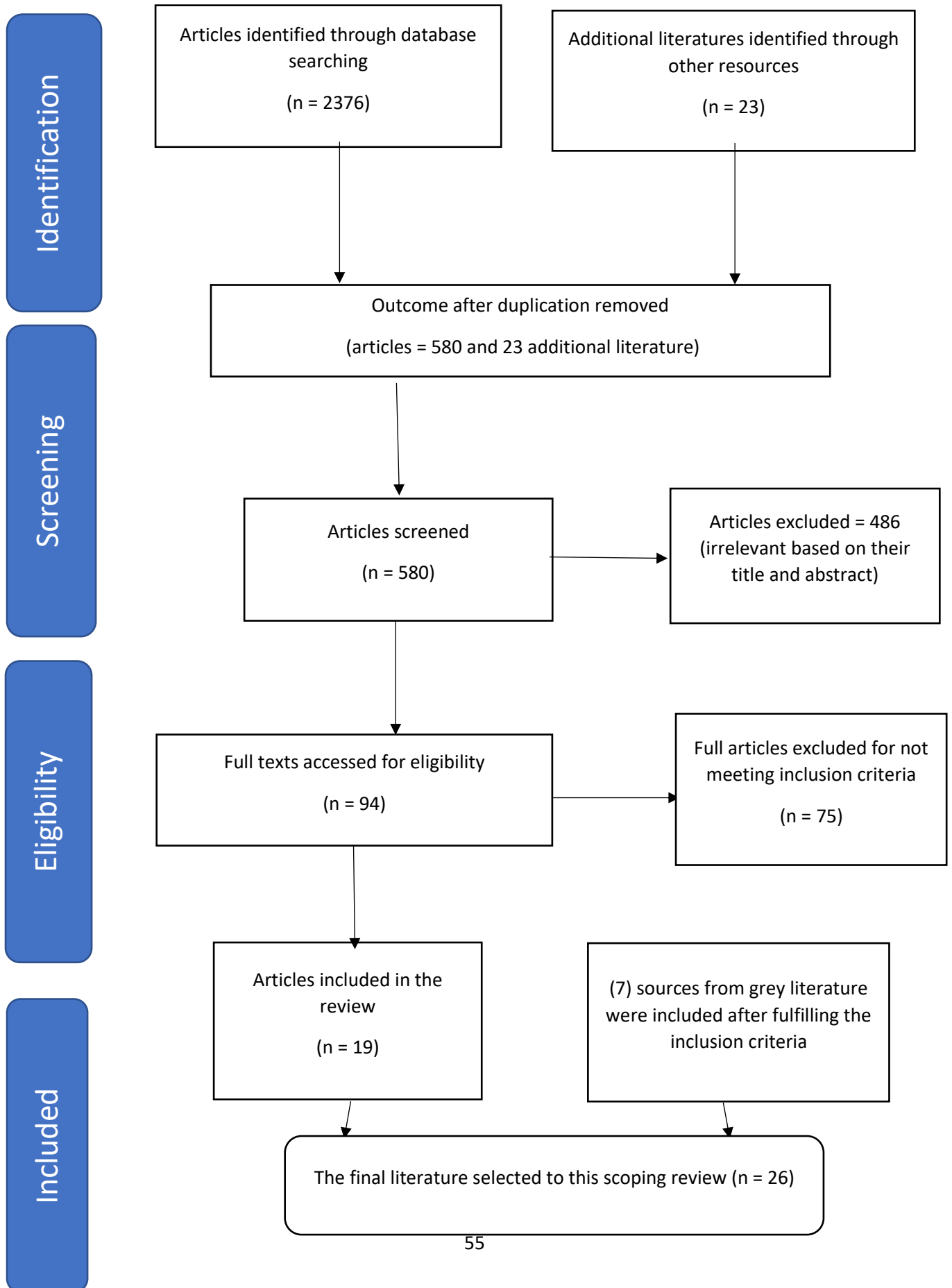
Nineteen articles were selected for this scoping review as they reported findings related to the interaction between faith healing practices and the biomedical field in managing mental disorders. Table 2 shows the relevant conclusions of each article included in this scoping review. The studies were conducted in (11) different countries: Ghana (4), South Africa (5), Uganda (2), Kenya (1), the UK (1), the UAE (1), India (1), Zimbabwe (1), Cameroon (1), Egypt (1), and one additional study done in three Sub-Saharan African countries: Ghana, Kenya, and Nigeria. The publication of the selected studies spanned a period from 2007 to

2018. In addition, searching the grey literature added further complementary knowledge mainly related to the mental health policies concerning faith healing practices in Kuwait. Thus, seven additional sources were included in this scoping review. The sources of the included grey literature were the Kuwait Ministry of Health, WHO, and three different Kuwaiti newspapers. Therefore, the total number of the selected literature becomes 26 various literature sources.

Figure 3.1 shows how the research was conducted to select the 26 relevant literature for this scoping review. Also, a thematic analysis of the 26 papers' main findings was performed, which yielded the exploration of three main themes:

1. The current mental health policies in Kuwait concerning faith healing practices
2. Barriers preventing collaboration between the two mental health providers healing systems (faith healers and health professionals)
3. Mechanisms or methods can be adapted to foster cooperation between faith healers and mental health services.

**Figure 3.1: Prisma flow chart showing literature selection**



### **3.5 Discussion**

The answers to this research question and sub-questions will be identified and analysed in this section of my scoping review. My scoping review question was: What are the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait? The sub-questions were: 1) What are the current health policies in Kuwait regarding faith healing practices? 2) What barriers prevent collaboration between the two mental health providers healing systems (faith healers and health professionals)? 3) What mechanisms or methods can be adapted to foster collaboration between faith healers and mental health professionals?

#### **3.5.1 Mental Health Policies Concerning Faith Healing Practices in Kuwait**

Establishing the collaboration between faith healers and psychiatrists in Kuwait is crucial and essential to recognise the power represented by the two sides. In Kuwait, a mental health policy was formulated in 1975. Various components were included within the Kuwaiti mental health policy, such as promotion, prevention, advocacy, and rehabilitation (WHO, 2006). Kuwait is considered a high-income country with a gross domestic product (GDP) of nearly US\$ 180 billion and a per capita income of approximately US\$ 182,000 (WHO, 2014a). This high-income rank has assisted and aided the Kuwaiti government in establishing high-quality healthcare where significant financial funding and support (total health expenditure per person= \$1,507) was assigned by the government of Kuwait to the health sector (WHO, 2014b). Indeed, the urbanisation and modern development that currently exist in Kuwait directly reflect on the health sector as modern health services are abundant and easily accessible free of charge to all Kuwaiti people. In Kuwait, there is one psychiatric hospital as the country is considered a small country with an area of approximately 18,000 km<sup>2</sup> and a population of 3,050,744. This psychiatric hospital is the only place in Kuwait that offers psychiatric inpatient treatments with the availability of about 900 beds (MOH, 2013). Also, outpatient clinics and rehabilitation services are available in this hospital.

Further psychiatric clinics existed in the five general hospitals of Kuwait, which only provide outpatients services. Moreover, psychiatric clinics are available in prisons and private schools (WHO, 2006). It is also worth mentioning that mental health has been integrated within the primary health centres. Thus, eight psychiatric clinics have recently been introduced in some



primary healthcare facilities (MOH, 2013). Also, numerous private psychiatric outpatients' clinics currently exist in Kuwait. The mental health policies in Kuwait are designed to support Western medicine, therefore giving total power to the biomedical side, leaving faith healers without official recognition or support. Although faith healing practices are eminently accessible in Islamic and Arabic societies as a mental health care provider, the policy makers and authorities in Kuwait have always relied on allopathic medicine and ignored faith healing practices when they plan and formulate the national health care strategies and policies.

An extensive scoping review of published literature in PsychINFO, PubMed, MEDLINE, Scopus, and Web of Science revealed no discussion of the practice of faith healers in Kuwait. It underscored the previous lack of attention to this issue. But what might be the reasons for this exclusion, and what impact might there be of drawing faith healers into the discussion of mental healthcare in Kuwait? Indeed, the only source of information and data about faith healing in Kuwait were some articles in some Kuwaiti newspapers discussing the reasons behind banning faith healing practices in Kuwait. For instance, an article in a Kuwaiti electronic newspaper called Eremnews pointed out that the Ministry of Islamic affairs in Kuwait announced that faith healing is illegal in Kuwait due to several malpractice incidences that occurred in several areas in Kuwait (Eremnews, 2017). Furthermore, other articles mentioned that faith healing practices in Kuwait are lucrative jobs where faith healers are not well-qualified both scientifically and in Islamic teachings, which caused many cases to deteriorate with severe and fatal complications (Alsalmah 2017; Alsanea 2010).

### **3.5.2 Barriers Preventing Collaboration Between Faith Healers and Mental Health Professionals**

Indeed, several obstacles hindering the formation of the collaboration were identified, such as the shortage of medical health workers, geographic constraints, and limited financial support (van der Watt et al., 2017). However, in the context of Kuwait, these barriers are not applicable. As mentioned earlier that accessible advanced mental health services with adequate medical health workers exist in Kuwait. Nevertheless, further barriers were identified and presented in the following sections.

## **The Inherited Disrespect and Mistrust Between the Two Healing Systems**

van der Watt et al. (2017) conducted a study in three sub-Saharan African countries exploring the views of traditional or faith healers and mental health workers about the viability of establishing a partnership and the barriers and facilitators to such collaboration. They found that one of the main barriers is rivalry and feelings of superiority. Each side considers their practice and knowledge superior to the other, thus creating distrust and disrespect. They found that medical practitioners viewed the treatment approaches used by traditional and faith healers as an illicit way of treatment, and they also considered such practices as regressive and backward. Indeed, biomedical care providers in this study mainly relied on physical interventions to diagnose and manage physical and mental disorders. They can't trust non-biomedical approaches as there is no evidence of their efficacy.

Furthermore, they illustrated that each sector's solid belief and a firm reliance on the effectiveness of its methods of treatment and diagnosis had created conflict and inferior perspective towards the other sector, which in turn impedes collaboration. Similarly, a study done in Ghana exploring the reasons behind the widespread utilisation of traditional or faith healers and identifying what obstacles or aiding factors may exist for creating bi-sectoral partnerships discovered that scepticism around possible collaboration is a potential obstacle as many biomedical workers failed to respect and accept the significant role of faith healers (Ae-Ngibise et al., 2010). Further studies revealed similar findings: faith healers and biomedical practitioners refuse to refer patients to each other, and mistrust hampers the establishment of effective partnerships (Musyimi et al., 2016; Wamba and Groleau, 2012). At the same time, faith healers also claimed that healthcare workers are unaware of religious or spiritual aspects related to mental health (Osafu, 2016). A study exploring the relationships between faith healers and health professionals in Ghana illustrated that Muslim faith healers considered their treatment methods more effective than biomedical ones because their work is based on the wills of Allah and his prophet. They were unwilling to work with biomedical practitioners since they believed that the two approaches function completely differently (Kpobi and Swartz, 2018). Moreover, the same study pointed out that faith healers' unwillingness to integrate their practices within the health system is due to their fear that allopathic physicians might dominate the integration. Thus, they lose their opportunity to continue practising their work. The same result was reached by a study conducted in Uganda to explore traditional or faith healers' views on their collaboration with biomedical health

systems, where traditional or faith healers viewed themselves as being more capable than psychiatrists in treating mental disorders because they indicated that biomedical practitioners have no understandings of the religious and spiritual aspects related to mental health (Akol et al., 2018). It was found that the main reason for lack of mutual trust and unwillingness to collaborate among traditional or faith healers is the belief that biomedical clinicians showed no respect for their work and usually accused them of the death of some patients.

Additionally, traditional or faith healers reported that the referral to biomedical health care is only a temporary action in rare occasions as they don't believe in the efficacy of Western methods of treatment, thereby causing severe and critical complications because of the delay of receiving the appropriate medical treatments (Sorsdahl et al., 2010).

This deep sense of disrespect can be rooted in the negative influence of colonisation and the introduction of Western medicine in the developing world, which led to demeaning the indigenous and traditional practices and labelling them as harmful and regressive practices, thereby giving almost unlimited power and high reputation to Western medical practices (Ae-Ngibise et al., 2010; van der Watt et al., 2017). The tension between religion and science has more historical roots, dating back to as far as the predynastic period in Egypt (before 3100 BCE), followed by the great conflict in 1000–1300 CE when the first medical school opened in the West to start teaching biomedical doctors based on scientific knowledge thus separating them from all other healers. The separation has widened with time, and hostile relationships started when Johann Blumhardt in Germany, for example, was harmed in 1846 by medical doctors to stop his religious or spiritual treatments for patients and forced him to transfer his patients to physicians (Osafo, 2016).

On the other hand, a study done to examine the perspective of faith healers and biomedical staff towards creating potential intersectoral partnerships discovered that biomedical providers had an interest in working with faith healers as they consider that an opportunity to reform and control the faith healing centres and prayer camps (Arias et al., 2016). Similarly, a study conducted in UAE revealed that faith healers were enthusiastic and keen to integrate their work within the medical healthcare system (Thomas et al., 2015). Similar findings were obtained from a study among Muslim psychiatrists in South Africa. Most participants claimed that they were willing to collaborate with faith healers since their conceptualisation of mental illness is influenced by their religion and culture (Bulbulia and Laher, 2013). Moreover, faith healers in Zimbabwe were motivated and willing to cooperate with mental

health workers for several reasons. First, they believed that such collaboration would increase referrals towards them from psychiatrists. Second, they mentioned that collaboration might allow them to receive material resources, funding, and training in medical technology (January and Sodi, 2006). According to Allay and Laher (2007), all the Muslim faith healers who participated in their study showed encouraging desire and motivation towards collaborating with allopathic physicians precisely because they understood the different elements of illness such as medical, psychological, and spiritual.

### **Malpractices Incidences of Traditional or Faith Healing Practices**

Ae-Ngibise et al. (2010) found that one of the main barriers hampering effective cooperation between psychiatric healthcare providers and traditional or faith healers was concerns about safety issues and human rights abuses that could happen in faith healing practices. Many participants of their study expressed their concerns about the malpractice incidences occurring in some traditional or faith healers, such as physical abuses that might result in death, compulsory fasting, chaining disturbed patients, and mandatory incarceration. Many decision makers and psychiatrists are hesitant about collaboration because they are uncertain about the safety and efficiency of traditional or faith healing treatment methods. Similarly, a review study investigating the evidence supporting collaboration between psychiatric healthcare providers and traditional or faith healers indicated that the recurrent reported cases of human rights abuses and even fatalities in traditional or faith healing treatments delay any possibility of collaboration (Robertson, 2006). Furthermore, many studies have shown the harmful effects of the non-standard provision of traditional or faith healing treatments. For example, several cases of acute poisoning occurred after the provision of traditional or faith medicines, which led to fatal outcomes (Sorsdahl et al., 2010). On the other hand, faith healers indicated that malpractice abuses could also occur within the biomedical field as psychiatrists sometimes use unwarranted isolation and incarceration with unhygienic conditions (Ae-Ngibise et al., 2010).

### **Concerns of Faith Healers About the Threat to Regulate Their Practices**

It has been found that faith healers have a low interest in collaborating with mental health professionals because they are concerned that collaboration might threaten their works. For instance, traditional or faith healers in Ghana were very reluctant to work with biomedical practitioners as they were unwilling to be subject to regulations and had concerns regarding

applying scientific standards to their methods of treatment; thus, they refused to give their information to mental health workers (Ae-Ngibise et al., 2010). According to Robertson 2006, it may be mandatory for the medications used by traditional or faith healers to fulfil the scientific prerequisites of the Medicines Control Council, and more knowledge and information are required to understand and promote how traditional or faith healers practice their work.

### **Biomedical Ethical Rules Constraints**

The high refusal rate among biomedical practitioners to work with faith healers can be understood through the biomedical ethical rules that forbid healthcare workers to cooperate and engage with traditional or faith healers (Wamba and Groleau, 2012). Indeed, tensions can develop because of the ethical codes that biomedical practitioners must follow. Health professionals have received medical education and training for many years, and their career is structured thoroughly around such ethics. Healthcare workers are supposed to work with these ethical rules. Thus, they often feel unwilling to work and cooperate with faith healers since that might be against their biomedical ethics. In addition to that, many faith healers didn't receive any form of teaching about mental illness, which could worsen and reduce the ability of mental health workers to engage with them (Osafo, 2016).

### **3.5.3 Mechanisms of Establishing collaboration between faith healers and mental health workers**

Launching a partnership between the two healing approaches could be challenging as several barriers have been identified. However, many studies included in this scoping review have identified and recognised different successful mechanisms.

### **Building Mutual Respect and Trust Between the Two Healing Systems**

Building mutual respect between the two sides is a prerequisite to establishing the collaboration process. To construct such mutual trust and respect, it is crucial and essential that allopathic physicians expand their explanations of mental illness to include diverse cultural descriptions of disease along with their biomedical knowledge and scientific basis (Campbell-Hall et al., 2010). Indeed, mental health workers need to appreciate and respect the numerous explanatory theories of mental illness that people embrace and work accordingly to increase mental health literacy (Sorsdahl et al., 2010). One of the best ways to establish collaboration is by recognising the complementary role played by each sector and

appreciating the difference in their beliefs, thus enhancing their trust and respect (Akol et al., 2018). Indeed, openness, understanding, and acceptance of each other's practices and beliefs are essential. Without mutual respect, collaboration can't be achieved (Ae-Ngibise et al., 2010; van der Watt et al., 2017).

### **Educating Faith Healers and Health Professionals About Each Other's Approaches**

Educating faith healers and health professionals about each other's treatment methods and diagnoses can promote and accelerate the collaboration process. Education will help bring the two philosophies closer (van der Watt et al., 2017). The interaction between the two sectors is closely related to the education level of both sides since a high level of education could build mutual trust and enhance the interaction consequently (Osafo, 2016). Indeed, it is evident that traditional or faith healers need to receive training and education about mental illness, as this would improve their skills and enhance their knowledge about mental illness. As a result, the well-trained and highly educated faith/traditional healers could be a significant healthcare provider and potential referral resource for patients with psychiatric conditions (Sorsdahl et al., 2010). In this regard, conducting training courses and teaching faith healers about psychiatric disorders is urgently required as it was found that proper training was vital to bridge the gap and increase the possibility of collaboration (Musyimi et al., 2016; Osafo, 2016). On the other hand, mental healthcare workers must receive training in spirituality in healthcare. There is a vital need to expand the medical curriculum to include exercise in spiritual assessment (Osafo, 2016). According to Uvais (2018), who conducted his study on Muslim doctors in India to explore their views regarding Jinn and psychiatry, the academic curriculum in medical schools must be improved and adjusted to include knowledge and teaching sessions about the significant role of culture and religion in dealing with psychiatric conditions. Similarly, a review study that examined the role of Islam in managing different mental disorders to find an appropriate psychiatric therapeutic method that fits and harmonises with the Islamic principles found that beneficial outcomes and enhanced drug adherence among Muslim patients resulted from incorporating Islamic principles into biomedical therapeutic techniques (Sabry and Vohra, 2008).

### **Official Governmental Recognition of Faith Healing Practices**

The government recognition of faith healing practices is considered a vehicle for better collaboration. Indeed, it is recommended to have official governmental visits to faith healing

centres regularly, as that could legitimise the faith healing practices and develop a secure environment to cooperate without fear of exploitation (van der Watt et al., 2017). A study done in South Africa to explore methods in which collaboration could be enhanced in the provision of mental healthcare claimed that locating the two healing approaches at the same level and getting the same power would facilitate cooperation between them (Campbell-Hall et al., 2010). Indeed, the faith or traditional healers who participated in the same previous study pointed out that professionalisation of their practices and official recognition of their works was a possible mechanism of collaborating with health professionals. Indeed, power and legitimacy could be vital in partnership formation (Kpobi and Swartz, 2018). Official recognition not only promotes and facilitates the collaboration process, but it could also be an opportunity to scrutinise the faith healing practices, improve hygiene, and prevent malpractices in their settings (Akol et al., 2018). Indeed, with such official legitimisation of the collaboration, even healthcare professionals' practices could be scrutinised to ensure effective bi-sectoral partnership, especially because several studies indicated an unwillingness to cooperate among healthcare professionals.

### **Establishing a Multisectoral Mental Health Advisory Group**

According to Campbell-Hall et al. (2010), establishing a multisectoral mental advisory group, in which representatives of faith healers and mental health workers are included, could be an optimum method to form a collaboration between the two sectors. This kind of advisory group could work on the strengths and weaknesses of each field to plan a scheme for the collaboration process. The regular supervisory visits to faith health settings by the advisory group would help encourage mutual respect and enhance the referral networks between the two sides, which ultimately strengthens the integration between the two systems (Arias et al., 2016).

### **Task Shifting or Sharing**

The WHO recommends task shifting to support the inadequate medical workforce in low-income countries. It is considered an effective public health intervention to overcome the shortage of trained health workers, especially when newly recruited staff who are less qualified and received less training replace the experienced and well-qualified ones in a planned manner so by this replacement they obtain proper training and solve the shortage problem (Osafu, 2016). The task shifting method effectively impacted the supervision of

WHO on several occasions, such as HIV/AIDs treatments and maternal and newborn health interventions (Osafo, 2016). According to Ae-Ngibise et al. (2010), when the task shifting approach has been used by making psychiatric nurses work with faith/traditional healers, teaching them psychosocial support, many healers are encouraged to refer their patients to medical doctors to receive biomedical treatments. In fact, the WHO encouraged and supported the active inclusion of informal mental health care providers, (including faith healers within the formal health care settings), as one of the objectives of the WHO mental health action plan 2013–2020. The plan recommends the formal integration of all kinds of traditional medicine practices, including families, as well as religious leaders, faith healers, traditional healers, school teachers, police officers and local nongovernmental organizations within the health care systems (WHO, 2013; WHO, 2021). Thus, the task shifting can be applied to the mental health care services by moving faith healers to work collaboratively within the psychiatric settings to assess and treat the patients. This collaborative initiative will help in building trustful and positive relationships between the two sides as each field will value the merits of the counterparts after working together closely. Subsequently, this will encourage the bi-directional referral between the two fields as they would have a prior interaction and collaboration through task shifting. It is important before starting the actual task shifting is that faith healers receive brief training and educational support in psychiatry to enable them to comprehend the biomedical approach, and thus contribute to delivering a comprehensive mental health care (Osafo, 2016).

### **Developing a Therapeutic Referral System Between the Two Healing Systems**

Another way of cooperation between the two healing systems is via the referral of patients (Wamba and Groleau, 2012). To develop an effective referral system between the two sectors, it is obligatory first to build mutual respect and license faith healers' work.

### **Forming Regular Dialogue Sessions Between the Different Mental Health Providers**

It is fundamental and crucial to form a cooperative dialogue regularly between faith healers and psychiatrists as these could help develop an environment of dynamic exchange and an opportunity for knowledge sharing, which would help in understanding and appreciating each other's practice, and each sector will value the input of the other sector (Teuton et al., 2007; Wamba and Groleau, 2012). It has been found that frank discussions of knowledge, concerns,



and goals could facilitate partnerships between faith healers and biomedical practitioners (Arias et al., 2016). In addition, a cooperative discussion between biomedical workers and traditional or faith healers could enhance the skills and confidence of faith healers, more transparency of their job, and timely referral of their patients (Musyimi et al., 2016).

### **3.6 Conclusion**

This literature review was conducted to examine and map the existing literature discussing the collaboration between faith healers and health professionals. Three main themes were identified after conducting this scoping review and analysing the current literature: the current mental health policies concerning faith healing practices, barriers hindering collaboration, and mechanisms that can be adapted to form such cooperation. The findings of this scoping review revealed a lack of accurate data regarding faith healing practices in Kuwait, indicating the urgent need for future research that focuses on the faith healer's role as a mental health provider. In addition, the findings of this review suggested several effective interventions or methods to achieve collaboration. On the other hand, the findings of our scoping review indicated and highlighted various obstacles that might hamper forming the collaboration between the two sectors. Thus, to overcome these difficulties, multisectoral support is required to ensure developing political will, financial aid, and governmental acceptance and approval.

## **Chapter 4**

### **Research Methodology and Methods**

#### **4.1 Introduction**

This study was conducted to explore and examine the views of faith healers and mental health professionals about collaboration in providing mental healthcare in the context of Kuwait. Moreover, the objectives of this study are 1) to describe and analyse the role of faith healers in delivering mental healthcare in Kuwait, 2) to critically examine the significance of professional and faith-based mental health services in Kuwait, and 3) to discover and describe the appropriate mechanisms that can establish collaborations. The main question of this study is, “What are the opportunities for faith healers and health professionals to collaborate to provide mental healthcare in the context of Kuwait?” This chapter will explain how the research aim and questions have a role in shaping the study methodology, and further will justify the reason behind selecting a qualitative approach using phenomenology. The methodology is the philosophy that forms the fundamental bases guiding research and its design. At the same time, methods are the tools and techniques that are specifically selected to collect the data. This chapter will present the justification behind choosing this study's methodological framework and the reasons for considering other methodologies but not using them for this research.

#### **4.2 Justification of a Qualitative Approach**

This study will use a qualitative methodological framework to answer the research question. Qualitative methodology is the most suitable as this research explores the participants' beliefs to understand their perspectives. This is because qualitative research seeks to find clarifications of social phenomena (Noble and Smith, 2013). Qualitative research focuses on understanding people's behaviour from social perspectives (Hancock et al., 2007). Qualitative studies allow inductive reasoning to interpret the collected data's meanings. It is appropriate for this study since the focus is to gain an interpretive understanding of the faith healing practices phenomena in Kuwait. Indeed, qualitative research tends to be humanistic as it focuses on examining the personal, subjective aspects of particular knowledge or practice. It

is often holistic since it encapsulates meanings of a given behaviour from various directions to rationally comprehend it within a given context (Kielmann et al., 2011). Therefore, if a study aims to explore the perspectives of people and how they behave towards a particular phenomenon or examine a new practice that has never been explained before, qualitative methods will be the best way to conduct such research (Al-Busaidi, 2008). It would be challenging to apply quantitative methods to studies in the social sciences, such as psychology, anthropology, and sociology, where subjects focus on explaining human behaviours (Hancock et al., 2007). In this study, where the aim is to explore the faith healing practices in Kuwait and the opportunity to merge them within the health system, qualitative research methods will help provide detailed descriptions of this phenomena and gain interpretive understandings of such practices.

### **4.3 Ontological and Epistemological Standpoint**

The research paradigm can be defined as a crucial set of beliefs that guide how the problem is perceived, comprehended, and addressed (Crotty, 1998). The research paradigm can be understood by its three main domains: ontology, epistemology, and methodology (Crotty, 1998). Ontology is how the nature of reality is understood, while epistemology is a framework of knowledge (Orlikowski and Baroudi, 1991). Indeed, epistemology is the theory of knowledge. It constructs ideas regarding how we understand the world and identifies the basis and the validity of that knowledge. Therefore, the epistemological position will directly correlate and impact the selected methods to conduct the research and the ways of interpreting and validating the gathered data. It is vital to be explicit and transparent during the study regarding what was achieved. There are key epistemological positions, such as positivism, realism, critical realism, and interpretivism.

Ontology deals with what is real and what exists, while epistemology is about how what is real can be known and comprehended (Hughes and Sharrock, 2007). There are two central ontological positions: constructionism and objectivism. The ontology of positivists claims that there is only one single reality (Bryman, 1988). The positivist position primarily relies on deductive theorising with practical validation and proof (Babbie, 2005). The epistemology of positivists indicates that by applying observed and experimental measurements the reality can be reached and understood. Thus, they often apply quantitative methods to determine the truth. Using quantitative measurements requires a considerable amount of data, and social phenomena are approached objectively (Hughes and Sharrock, 1997).

In contrast with the ontology of positivists, the interpretivist paradigm suggests that several realities exist. These different realities are derived from people's perspectives and are based on many contributory elements, such as social and cultural norms and beliefs (Houghton et al., 2012). Indeed, interpretivism is concerned with having multiple realities, which are vulnerable to change with time and with different circumstances such as location, compared with positivism, which adheres to a single reality that is recordable (McEvoy and Richards, 2003). In a qualitative framework, the interpretivism paradigm must adapt non-numerical narrative tools (Jack and Raturi, 2006). That is opposed to positivism which makes interpretivism criticised the positivist ideology (Jack and Raturi, 2006). Indeed, the perspective of interpretivism depends on the individuals' interpretations of their social world, so interpretivism view reality as a subjective projection of human beings' experiences and interactions in the social world and how they interpret these interactions (Jack and Raturi, 2006). Therefore, the interpretivist position is primarily based on inductive reasoning and built on people's experiences. Indeed, the epistemological paradigm of interpretivism considers that reality can't be measured or obtained by empirical verification. Although the certainty of a deductive argument is often maintained, interpretivists follow approaches of reasoning that provide sufficient evidence of truth and convincing conclusions without broader generalisation. Indeed, interpreting the various factors of the social world could reveal better understanding and reach more general principles (Babbie, 2005).

The constructionist ontological approach was selected to be the underlying approach of this research as this study investigates a social phenomenon constructed by a continuous interaction of several social actors. Constructionism is an approach to the interpretivism paradigm. It involves making the meaning of social entities by connecting the various social elements to build the social phenomenon (Bryman, 2004, p.16). These concepts that formulate the constructionist ontological approach correlate correctly with the underlying philosophy of this research and with conducted fieldwork and the findings of this study. Constructionist position believes that individuals or communities construct reality through social relationships and by the influence of the social settings and atmosphere, so knowledge is socially created (Kivunja and Kuyini, 2017). Therefore, we can have several correct realities that are socially constructed. The epistemological assumption of the constructive paradigm assumes that the obtained findings are reached through the interactions between the participants and the researcher so all of them participate in creating the findings (Kivunja and Kuyini, 2017). Applying these concepts in this study, the exchange is necessary to discover

meanings and gain an in-depth understanding of the relationship between faith healing practices and the formal health system in Kuwait.

Indeed, this study fits with the philosophy of constructivism and social constructionism. This is because the researcher of this study believes that reality and knowledge are formed and created socially through the experience of people and their shared meanings. The researcher thinks that even though each person has their explanation and interpretation of the social world, some beliefs are socially created. Similarly, Warmoth (2000) clarified that constructionism as a philosophical position doesn't eliminate people's ideas. It means people's ideas come from shared meanings based on their social settings and background. Yet, the researcher believes that is not eradicating people's capability to construct their own beliefs. Likewise, in the mental health sector, the healthcare providers from both sides have their own opinions about the causes of mental health disorders and their treatment methods. These beliefs were built not only based on education and training but also socially constructed.

#### **4.4 Rationale for Choosing Phenomenology Approach**

The research aim and questions are the chief determinants for selecting the appropriate methodological framework of any study, as each research approach is designed to answer specific research questions (Gelling 2015). For instance, the research questions of qualitative studies are apparently different from quantitative ones. The questions in quantitative research typically are more specific, while the questions in qualitative studies are more open-ended. However, quantitative and qualitative research questions focus on finding answers about the nature of social reality (Bryman 2012). Quantitative research questions look for answers to why and how a particular experience happens (Miller 2010). Qualitative research questions often aim to explore meanings and understand a situation by applying questions like how and what (Gelling 2015).

The methodological framework was formulated to achieve the study aim. According to Lacey (2015), the most crucial step in conducting the research is to select the appropriate research methodology as this will affect the study's progress and the remaining stages of the investigation, from data collection and data analysis to findings interpretation and knowledge formation. The quantitative and qualitative methodological frameworks have been formulated and established in different historical periods and backgrounds and adapted completely

different philosophical traditions (Lacey 2015). It is crucial to understand that after selecting an appropriate methodological approach, it will convey certain assumptions to the study, ultimately affecting the outcome of the research (Creswell 2013). Indeed, various qualitative methodological approaches have been created for many years, providing a variety of choices to research workers (Creswell 2013). Although these methodological approaches seem to have similar corresponding assumptions, they are different in their techniques and involvement in literature expansion (Gerrish and Lacey 2006). The widely applied qualitative approaches in healthcare studies are phenomenology and grounded theory (Creswell 2013; Parahoo 2014). Both methods have a high value and reliability in the field of study. Nevertheless, they are principally different. Grounded theory attempts to generate an approach from the obtained data, while phenomenology has the target of finding a meaning of the essence of the experience. It is worth mentioning that different approaches have been adopted in the field of research, such as case studies and ethnography (Creswell 2013).

As illustrated earlier, determining and selecting the most suitable qualitative approach for conducting this study was based on several elements. These involved considering the aim and the research questions, assessing and evaluating the different qualitative methodological approaches, and receiving guidance from the researcher's supervisors. The objective of this study is to explore the opportunity of establishing collaboration between mental health professionals to obtain a profound understanding of the phenomenon of bringing the two sides together and finding a practical way to reach a mutual agreement and collaborate. Once thriving, this study will obtain new knowledge to contribute to clinical practice. Thus, the phenomenological approach was chosen as the most appropriate to fulfil the study aim and answer the questions of this research. Indeed, this research explores a phenomenon occurring in Kuwait about the concurrent access to two mental health providers: faith healers and mental health professionals. Thus, in this study, the phenomenological approach will be followed.

In contrast to grounded theory, phenomenology aims to explore and discover how people perceive and observe their experiences to obtain an explanation of the world surrounding them (Bryman 2012). Phenomenological approach was founded as a unique philosophical research approach in the early 20th century by Edmund Husserl, who is considered the chief founder of phenomenology (Holloway and Todres 2006). Phenomenological research approach has offered meaningful reasons behind analysing individuals' experiences from

their perspectives. Phenomenologists reveal the results of their research by combing the mutual themes of a specific social phenomenon (Todres 2005).

The other reason behind choosing the phenomenology design is that it is used when the researcher attempts to explore and investigate a phenomenon by interpreting how people understand and respond to it (Creswell et al., 2007). Phenomenology is suitable for studies with research questions about the essence of people's experience of a phenomenon (Lewis, 2015). In the phenomenological approach, the researchers gather data from people with prior experience with the phenomena and create an extensive description of the essence of the experience for all people (Creswell et al., 2007). Phenomenology is not only a descriptive approach but also an interpretive process where the research will interpret and clarify the meanings people bring about from their lived experiences.

Other methodological approaches were fully considered to be used in this study. For instance, grounded theory was considered but not selected in this study as this qualitative research design is suitable to develop a general clarification (a theory) of a process, action, or interaction involving many individuals (Creswell et al., 2007). In other words, grounded theory is used when there is no existing theory or the current theories are insufficient. Grounded theory is particularly used to study a phenomenon through understanding the social process of human behaviour and experience towards that phenomenon (Thorne 2000). For example, if the target of this study was to explore people's experience of healing or even providing healing, the grounded theory would be a suitable approach. But, in this research, the focus is to achieve a better understanding of the essence of a phenomenon that existed in the Kuwaiti context, which is contacting two different health approaches to investigate some of the fundamental bases or essence of that phenomenon through the extensive scrutinising of individual cases so that the phenomenology approach is used.

## **4.5 Research Methods**

The following methods were employed to gather information from the participants in Kuwait:

### **1. Scoping Review**

A scoping review was conducted to examine and map the existing literature discussing the collaboration between faith healers and health professionals. The findings of this scoping review revealed that there is lack of accurate data regarding faith healing practices in Kuwait which indicate the urgent need for future research that focus on the

faith healer's role as a mental health provider in Kuwait. When the chapters of this PhD study are formulated, this scoping review will be updated and included as the literature review chapter.

## 2. **Semi-structured Interviews**

Since the phenomenological approach has been selected for this study, individual interviews will be the suitable method to conduct this study. This is because interviewing is recommended to reach the unique construction and experience of any given phenomena. Indeed, interviews are appropriate to understand how people think and feel toward a particular topic and how they behave according to their understandings. Interview methods can be defined as *“A professional conversation to get a participant to talk about their experiences and perspectives, and to capture their language and concepts, about a topic that you have determined”* (Braun and Clarke, 2013, p.77). Thus, semi-structured interviews will be utilised in this study. From its name, the semi-structured interviews are composed of a combination of closed-ended and open-ended questions to cover the investigated topic's different elements. Indeed, in qualitative healthcare research, semi-structured interviews are regularly employed (Al-Busaidi, 2008). This is because this kind of interview allows the researcher to acquire a detailed description and better understanding of the investigated topic by obtaining abundant information through a flexible way of interviews (Kielmann et al., 2011). It is worth mentioning that prompts can be utilised during the interviews to obtain richer knowledge and to elicit more profound interpretations, but without leading and guiding the interviews to a specific direction and control (Francis et al., 2010). Also, it is crucial to design a guide for the interviews before conducting them to have a more organised and systematic scheme of interviews (Al-Busaidi, 2008). The interview guide (see Appendix 2) was generated after understanding the topic from the literature review. It is necessary to have such a guide which outlines the themes, to facilitate the conversations and ensure covering all aspects of the topic to be explored. This technique was followed to allow the participants to articulate their point of view on their terms without interfering with the interviewers' agenda, to obtain a profound response and reflective feedback from the participants and open and transparent participation.



### **3. Autoethnography**

Initially, non-participant observation was the third chosen method. However, because of the situation of COVID-19 in Kuwait and the impact of the related restrictions and precautions, the researcher of this study discussed with his supervisors at York University and his supervisor at Kuwait University the possibility of carrying out his fieldwork. They agreed that the interview part of the research could be carried-out through Video conferencing platforms. However, the observation part of the research has been dropped. Instead of the observations, the researcher has decided to examine his personal and professional experiences with psychiatrists and faith healers in the past as an autoethnographic exercise (supported by Ellis, 2002; Maréchal, 2010). The researcher will only be examining his own experiences and will not engage anyone beyond the psychiatrists and faith healers as per the approved ethics application. It is worthy of reflecting on the autoethnographic approach and of exerting further attention as O'Connell Davidson and Layder (1994) noted that during carrying out an ethnographic study, there is a high tendency that the researchers will analyse the obtained results based on their cultural beliefs and social norms, thus biased results would be the outcome of the conducted study because of the imposed assumptions from the researcher.

#### **4.6 Ethical Consideration**

No ethical approval was obtained before conducting the scoping review, as it is based on only literature available to the public and did not include the participation of human individuals. The researcher of this study did receive ethical approval from the Health Sciences Research Governance Committee from the University of York for the interview methods of this study in February 2020 (HSRGC/2020/373/A) (see Appendix 3). Moreover, the researcher also received ethical approval for this study from the Kuwait Ministry of Health ethics committee (see Appendix 4). All this was completed before starting the fieldwork. No ethical approval was required for the autoethnographic part as it is only based on the researcher's personal and professional experience.

## **4.7 Study Area**

Kuwait is considered a wholly urbanised country as most of the population (97%) live in urban areas (WHO, 2006). This study was conducted in all six administrative governorates of Kuwait: Asimah, Hawalli, Farwaniyah, Jahra, Ahmadi, and Mubarak Al-Kabeer. According to the World Bank (2016), Kuwait is a high-income developing country. It has an area of approximately 18,000 km<sup>2</sup> with a population of 3.7 million, among which Kuwaitis are 1.2 million and 2.5 million are expatriates (Kuwait Central Statistical Bureau, 2014). Unfortunately, there is no published data regarding the faith healing practices in Kuwait. However, the researcher of this study believes that based on his identity as a Kuwait citizen and on his experience of living his entire life in his country (Kuwait), faith healers are scattered throughout all the governorates in a significant number. Furthermore, the scoping review that was conducted earlier found some grey literature sources discussing faith healing practices in Kuwait, which confirms their existence in the Kuwaiti context.

## **4.8 Study Population**

The study population of this study are the faith healers from all the governorates of Kuwait and psychiatrists working in the psychiatric hospital in Kuwait.

### **Faith Healers**

Faith healers with at least two years of experience in faith healing practices and a respected status and reputation within the community were selected to contribute to this study. Faith healers from all nationalities (Kuwaiti and non-Kuwaiti) were included in the sample since expatriates are the majority within the total population of Kuwait, so they are part of the faith healers' population. Faith healers from both genders can participate in this study. However, it might be challenging to reach female faith healers as they are scarce in Kuwait, and there is a high tendency among female faith healers to refuse participation due to cultural reasons.

### **Psychiatrists**

In Kuwait, psychiatrists are the only ones who are entitled to make a treatment plan for psychiatric patients, so they are the ones who can refer these patients to other healthcare providers if needed. Therefore, in this study, only psychiatrists were included. Other healthcare workers working in the psychiatric hospital were excluded. Psychiatrists with at least two years

of working experience were involved in the study sample as those with less experience might not be able to provide sufficient informative input to the study. Kuwaiti, as well as non-Kuwaiti psychiatrists, were included. Similarly, female and male psychiatrists were included. Nevertheless, only Muslim psychiatrists were chosen because faith healing practices in Kuwait are only based on Islam, so non-Muslim psychiatrists will not be able to understand the role of Islam in managing mental problems, so their contribution to this study might cause unintentional bias.

## **4.9 Recruitment Method**

### **Faith Healers**

#### *A. Identifying Participants*

There is no central directory of FH or FH organisations, so recruitment relied on a convenience sampling strategy.

Two types of FHs were recruited:

- i) FHs who are also Imams at mosques were contacted by an in-person meeting.
- ii) FHs operating independently were contacted by responding to advertisements in written or electronic media, as they usually put their mobile numbers there for contact.

#### *B. Recruitment Process*

- i) All FHs were provided information about the study (using the Information Sheet in Appendix 5) and invited for an interview. The date and time will be agreed upon for no less than two days to allow the FH to reflect and consider the offer of consent.
- ii) The researcher arranged with the faith healers who agreed to participate at the appropriate time to conduct the interviews. The interviews with the faith healers were conducted virtually because of COVID-19 outbreak precautions. The consent form (see Appendix 6) was signed and received electronically before the interview commenced.

## **Psychiatrists**

### *A. Identifying Participants*

Since psychiatrists in Kuwait operate from one psychiatric hospital, a convenience sampling strategy was utilised to recruit participants from this institution.

### *B. Recruitment Process*

i) A meeting with the hospital's head of psychiatry was arranged. During the meeting, the study was explained, information was provided, and permission to distribute the information sheets was asked.

ii) Information sheets were distributed to all hospital psychiatrists, with an invitation to participate.

iii) Psychiatrists were then provided information about the study (using the Information Sheet in Appendix 7) and invited for an interview. Interviews were scheduled for no less than two days before to allow the psychiatrists to reflect and consider the offer of consent.

iv) The researcher contacted the psychiatrists and arranged the appropriate time to conduct the interviews. The interviews were conducted virtually because of COVID-19 outbreak precautions and restrictions. The consent form (see Appendix 6) was signed and received electronically before the interviews commenced.

## **4.10 Study Size**

In qualitative studies, relatively small sample size is required, and this is because one of the advantages of qualitative research is the ability to gain a rich contribution and adequate information from each participant (Kielmann et al., 2011). The interviews will be conducted until themes become repetitive and saturation is met. This means a sufficient sample will be reached after obtaining theoretical saturation when every new participant's input becomes minimal. No additional contribution occurs to developing the emerging theory (Hancock et al., 2007). Indeed, this study achieved saturation after conducting 19 interviews (10 psychiatrists and nine faith healers).

## **4.11 Sampling Technique**

### **Faith Healers**

In this study, a purposive convenience sampling technique will be followed in selecting the participants. Purposive sampling was applied because participants with specific characteristics will be chosen intentionally. In contrast, convenience sampling was used because the participants, particularly the faith healers, were approached through personal communications or by looking for advertisements in written or electronic media (usually their mobile numbers for contact). Indeed, various faith healers were found after typing in Arabic the common local names of faith healers such as Sheikh or Mutawa in the internet search. Moreover, snowballing sampling technique was used and has yielded a considerable number of further faith healers. The previous technique was done by asking each participating faith healer about the contact numbers of other faith healers, as they tend to know each other and often share some work.

### **Psychiatrists**

Similarly, purposive convenience sampling was used to select the informants among the psychiatrists in the psychiatric hospital in Kuwait.

## **4.12 Data Collection Method**

Semi-structured interviews were the chosen method to collect the data in this study. This data collection method was selected because it is a flexible method that allows for open discussions, allowing the participants to provide answers and flexibly express their thoughts. Thus, it encourages the participants to give more details of their experience and knowledge. The flexibility of the interviews can be manifested by adapting the appropriate style of discussion that matches the participant's anticipation to ensure obtaining rich information. Initially, an interview guide will be developed based on the conducted literature review's understandings to help guide the discussion and grasp more profound data. Indeed, the semi-structured approach ensures flexible and open debate, which produces different insights and perceptions. The interviews were recorded using a digital recording device and informants were allowed to review or amend their transcriptions if requested. A semi-structured interview guide (see Appendix 2) was formulated to structure the discussion to gather the required data. The interview guides will be written in English, translated into Arabic, and

tested before the interviews are conducted. The interview guide was piloted to check for any tricky questions and to look for gaps or defects in its ability to obtain adequate information that should contribute to answering the research questions. Consequently, the interview guide has been adjusted based on the outcome.

### **Construction of the Interview Guide**

The interview guide was developed to answer the research questions. It was organised into three key areas, which were developed through an extensive review of the literature. These areas were as follows:

- Views on mental healthcare in Kuwait
- Views on the relationship between faith healers and psychiatrists
- Views on opportunities for the collaboration process

Prior preparation for the interviews was carried out so all participants would be invited in advance by phone to determine their interest in the study and to arrange a suitable time for the interviews. The interviews were conducted virtually, the information sheet and consent forms were sent electronically, and consent was received verbally before starting each discussion. The interviews were conducted after obtaining informed consent from the informants who agreed voluntarily to participate. The interviews were recorded using a digital audio recorder and transcribed. The approximate time for each interview is 45 minutes, of which various open-ended questions were involved in allowing the participants to express their ideas and views without any restrictions, but also closed queries were raised during the discussions to elicit particular pieces of information. The interviews were continuously conducted until themes became repetitive and saturation was achieved. Indeed, the interviews lasted between 45 min to one hour. The time was determined based on the respondents' interactions and willingness to contribute. Occasionally, prompts were employed to obtain additional and deep input and details. Each interview ended by informing the participant to ask questions freely and mention any comments they might have. The researcher also thanked the participants for their time and efforts. Lastly, all the participants have been aware that they are allowed to view their transcriptions, and they could ask for any amendments to be made if required.

It is crucial to mention that the researcher of this study has kept a brief diary after each interview about his experience and feelings during the conducted interview, only to eliminate any probability that his assumptions might impact the outcome of the interview. Furthermore, the researcher added some notes before and after conducting each interview. Indeed, the researcher constantly tried to think reflexively during the interview process by maintaining his way of thinking and feeling when engaged in performing the interviews. Certainly, this has been achieved by recognising the researcher's beliefs and predictions about the topic and by realising the impact that might acquire on the results of the study by holding previous expectations of the results. Each reflexive diary is saved from being used and combined with reflexive notes of the upcoming interview to establish a continuous and collective development of reflexivity. These reflexive diary notes were inspirational and beneficial since the researcher was able by their contributions to progress in comprehending the response of the participants meaningfully.

#### **4.13 Data Analysis Plan**

Thematic analysis was applied in this study to analyse the acquired data to produce meaningful findings. The thematic analysis has the advantage of its flexibility to make many emerging themes, but then it will selectively choose the relevant ones. Indeed, the thematic analysis was applied in this study because of its flexibility, and it suits the adapted interpretive epistemology and the methodological approach of this study. In fact, the primary cause of selecting the thematic analysis technique is its correlation with the constructivist approach (Braun and Clark, 2006). Braun and Clark (2006) describe thematic analysis as an analytical research tool characterised by its ample freedom to provide a sufficiently informative and multidimensional account of data. Moreover, it can generate a meaningful analysis that would yield adequate answers for the investigated research questions, as illustrated by Braun and Clark (2006). There are typical steps to perform the thematic analysis: first, familiarise yourself with the data, produce initial codes, classify the themes, formulate thematic structure by integrating the pieces, and lastly, interpret the outcome. Following Braun and Clark's (2006) description, the thematic analysis process was employed and illustrated in the following sections.

## **Transcription of Data**

The data obtained from the interviews were first translated and then transcribed into written documents for deeper analysis. Transcribing the data is the cornerstone of the process as it is the first step in the thematic analysis of data. It is an interpretive process as it allowed the researcher to acquire a prior knowledge of the data before commencing the analysis. The researcher transcribed all the interviews by himself, and that was intentionally done to form a connection with the data, immerse within the data, and understand the data properly before conducting the analysis. It has been claimed that data transcription is perceived as the most crucial step in the analysis (Bird, 2005). It is worth mentioning that all names were anonymised during the transcription process.

The field notes were organised as follows:

- Summary (participants' background and summary information)

This will include information about the work experience of the participants in terms of the number of years since they have started their work, location of their work, the characteristics of the patients who access them.

- Interview arguments
- Reflection on developed themes
- Additional information

## **Familiarisation With the Data**

Braun and Clark (2006) illustrated that familiarisation with the data is achieved by immersing yourself in it to the degree of becoming familiar with every detail of the content. Indeed, the researcher of this study completed that from the beginning during data collection and transcription. Nevertheless, to obtain extensive familiarisation, the researcher followed several steps, including reading the transcribed data of the interviews several times, relistening to the records, and revising the filed notes that have been collected during the interviews. The researcher has always considered his reflexive notes, while the process of relistening and rereading allowed him to form some initial codes. The repetitive process of listening and rereading helped extensively in immersing the researcher within the collected data and promoting his thinking in extracting meanings from the transcribed data, ultimately



helping generate initial themes. It is essential to mention that the researcher has started listening to the recorded interviews and reading the transcripts immediately after each interview so that the recall the researcher had can help in overcoming the issues that could occur from any problems related to the recordings and any mishearing errors. In the end, the researcher could remember the transcripts and details and who had mentioned what by himself without searching who said that.

### **Coding and Sorting Data From the Transcripts**

The second step is to work on coding the collected materials. Every transcribed document is coded line by line. Coding is a process of highlighting the significant elements of the material with labels so that these highlighted elements can contribute to providing answers to the research questions (Noble and Smith, 2013). Coding involves sorting the whole data and organising it into a set of codes that will be later examined to extract meanings from the participants' responses.

The coding process is continuous, where codes are constantly generated, reviewed, and divided, so other new codes are produced. Indeed, the process of coding will create new codes by continuously dividing and combining the existing ones. Eventually, as the analysis progressed, the coding could no longer produce any other codes, which occurred in the last four transcripts as only a single code was generated, achieving saturation. The researcher was moving back and forth between the transcripts several times, questioning his decisions about the end of the coding process. Indeed, the researcher sometimes created additional emerging codes by furthermore profound readings, thinking, and understanding of the transcripts. Finally, the researcher was convinced with the outcomes from the achieved saturation of data.

### **Searching for Themes**

The next step is to organise the generated codes so that the relevant codes will be grouped in one category (Braun and Clarke, 2006). Consequently, the grouped codes will be merged to produce themes which are broader forms of meaning. After that, the generated articles are reviewed and examined to form a meaningful data or evidence contributing to answering the research questions (Noble and Smith, 2013). The last step is to check the generated theme to formulate conceptualisations of the studied topic. Furthermore, subthemes and sub-subthemes will be spontaneously generated from the themes' refinements, which means the themes have

been analysed comprehensively. Indeed, it is an organised process of converting and reducing the whole text into more understandable information that demonstrates the content's significance (Kielmann et al., 2011). The more repetitive themes will acquire higher codes. Generating the themes will continue until they become repetitive and saturation is accomplished. Table 4.1 shows some examples of the generated themes from the obtained responses of the participants of this research.

**Table 4.1 Examples of the generated themes**

Participants' Responses	Generated theme
<p><i>Islam views science, especially medicine, with a respectful eye, and does not deny their role in treating diseases, so they must be approached when needed. (Shaikh Ismaeel)</i></p> <p><i>In Islam, we believe there is no disease without cure in this life. Even if humans don't discover the cure, it still exists. So psychiatric medicine is true, and people should seek help from them when needed. (Shaikh Omar)</i></p> <p><i>Many patients have visited faith healers seeking for help before they decided to approach us. (Dr. Ihab)</i></p> <p><i>I am absolutely aware about the existence of faith healers in Kuwait and people sometimes prefer to access them because it is part of their cultural heritage. (Dr Mohammed)</i></p>	<p>Recognition and awareness of other mental healthcare services</p>
<p><i>Of course, we do not have any objections towards collaborating with mental health workers, and the opposite is true. We would like to collaborate with them and learn from them to enhance our knowledge. (Shaikh Rajab)</i></p> <p><i>I am strongly with the idea of forming collaborated atmosphere with psychiatrists as their medications is developed after doing experiments on them, so I think this idea is great. (Shaikh Omar)</i></p>	<p>Willingness towards collaboration between faith healing and psychiatry</p>

<p><i>People avoid going to the psychiatric hospital because they are afraid of the scandals and gossips that could happen if someone would notice them there. They would say that they are crazy. (Shaikh Othman)</i></p> <p><i>People feel shame and disgrace if they would see psychiatrists and this is a reason why they might prefer accessing us. (Shaikh Rajab)</i></p> <p><i>The patients are afraid to be labelled as crazy persons because they have visited the psychiatric hospital which could reduce their chance of getting married. (Shaikh Ismaeel)</i></p> <p><i>Of course, the stigma is preventing people to come to us, people are really afraid to access us because it is disgraceful and shameful in their culture. (Dr Amro)</i></p>	<p>Obstacles and facilitators to access psychiatric facilities or faith healers' centres</p>
<p><i>The optimum way to establish such collaboration is to have a multisectoral cooperation between the Ministry of Islamic affairs and the Ministry of Health. (Dr Salamah)</i></p> <p><i>We need frequent meetings with them to learn from each other and share knowledge, and we should launch workshops to educate each side about the others' treatment approaches. (Dr Salah)</i></p> <p><i>To establish the collaboration, we need the cooperation between various ministries such as ministry of health and ministry of Islamic affairs to formulate strategies of collaboration. (Shaikh Rashid)</i></p>	<p>Proposed ways of establishing the collaboration programme</p>

### **Extracting Meaning**

Meanings were extracted from the content by constantly splitting and combining the emerging codes and themes, comparing the obtained themes and attempting to find links between them. The next stage is establishing a broad structure of the participants' responses and the gained understanding and insights of their contributions. The three headline topics of

mental healthcare in Kuwait, the relationship between the two fields, and the collaboration process were created to spread the themes around them, thus providing more controllable linked data to scrutinise and analyse. As the analysis progressed, the researcher continuously searched the data again and again. Finally, the outcome will be created through several reports containing all the analytical extracted data. A conclusion will be derived from these data that contribute to answering the research questions (Bradley et al., 2007).

#### **4.14 Validity, Reliability, and Research Rigor**

Enhancing the rigour of the research is a critical component of the research design (Shenton, 2004). The research's accuracy and reliability play a crucial part in determining the research's worth (Lincoln and Guba, 1985). Therefore, methodological rigour and vigilance were constantly maintained in this research to ensure the validity and reliability of this study. This is crucial in qualitative studies as it is vulnerable to the researcher's subjective input. Since it was relatively uncommon to conduct qualitative research, some leading researchers have suggested and formulated a new technique to ensure and retain the reliability and validity of qualitative approaches (Lincoln and Guba, 1985; Leininger, 1994; Warren, 2002). For instance, Guba (1981) has established a robust framework for maintaining and determining the reliability and validity of qualitative research and labelled both with the term trustworthiness.

Validity is the extent of reaching the goal of investigating and obtaining what is needed and supposed to be received and investigated (Robson, 2002, p. 553). Qualitative studies have been regularly criticised for lacking the standardised statistical measurements that enable measuring the results, so they are regarded as less scientific than quantitative studies. This has been tackled by reflecting on the researcher's beliefs and positions during the research process to convey an accurate account and representation of the data. Moreover, the researcher was obliged to enhance the willingness of the participants to engage in an open discussion that allowed their ideas and predictions to be stated. This is one of the main challenges to the validity of qualitative research (Silverman, 2011). As a result, reflectiveness is essential in studies that adapt constructivist phenomenology methodology since the researcher shares with the participants constructing the meanings. According to Huberman and Miles (1998), the researcher in qualitative research needs to be reflectively involved with their study by providing continuous reflective thought on all the contributory factors that

influenced their decisions throughout the research process. This helps establish the validity and reliability of the research. The researcher must realise that they are part of the research tools and contribute to generating theories from the obtained data (Hammersley and Atkinson, 1983). Ultimately, validity in qualitative research act as a judgment to determine if the research has explained and measured what was intended to be defined and measured (Mason, 2002). Detailed reflective processes are explored in Chapter 9.

To increase the accuracy and trustworthiness of the data, reflexivity was employed as a continuous process throughout the research. The researcher of this study critically evaluated and assessed his role and possible biases and impact on the participants, data collection, and analysis. This was done to establish evidence based on findings and merely form the data, not from the researcher's beliefs and values, and not influenced by his desires, interests and expectations. Moreover, contradictory data has been interpreted and involved in the analysis and not neglected because it didn't match the researcher's ideas and beliefs. In addition, the methods employed in this study tolerated open and accessible discussions, where the participants were freely engaged in transparent discussions without any boundaries or restrictions. This remarkable room of openness has enhanced the validity of the respondents' inputs. Also, the researcher attempted in the interviews to ask the same questions and repeated them in different ways to ensure the consistency of the answers. Numerous steps were employed in the data collection phase (as illustrated in the data collection section) to facilitate having open discussions with the participants that aid in sharing their thoughts with them quickly and the broader aim of building the proper validity of this study.

Reliability of the research is related to the accuracy of the methods used in the study and the followed technique (Mason, 2002). Also, the reliability of the study is achieved with the consistency of the results (Guba, 1981). Reliability in qualitative research is judged by evaluating the decision trail, which is understood as the justification and clarification of any decision during the research process (Sandelowski, 1986). This study was done through the supervision of two experienced tutors. Further measures were taken to assess the analysis of the obtained findings by taking advice from the researcher's supervisors when the relevant contribution was needed. Decision trails and all the reflexive steps carried out during the entire process of completing this study from the introduction to the conclusion are described and explained to aid in maintaining the validity and reliability of this research. Analyst and theory perspective triangulation can be accomplished by peer review (Barbour, 2001). The

researcher of this study worked closely with his supervisors to conduct an analyst triangulation during the research process by reviewing the transcripts and the generated codes and themes. Indeed, complete transcripts of two participants (psychiatrist and faith healer) were examined by supervisors, and independent coding was undertaken. All names and identifying details were unrevealed further to protect the participants' identities for confidential purposes. This technique saved the research from bias and added broader perceptions and deeper understandings to the themes (Andrews et al., 1996).

Furthermore, there are other potential ways to fulfil the reliability of the research, such as providing a transparent and precise description of the data analysis process, ensuring the steps applied in the analysis are accurately and extensively recoded and clarified throughout the analysis process, and reporting the findings in a transparent and informative manner (Gasson, 2004). Indeed, the researcher of this study believes relying on himself in recording, translating, and later transcribing the conducted interviews has satisfied the reliability requirements. The outcome was presented by reports which show and demonstrate the extracted meanings from the findings and are supported by evidence (Lewis and Ritchie, 2003). Diary field notes have added strength to the reliability of this study, as discussed earlier. Moreover, the association between the interpretation of the results and the supporting evidence must be clearly stated, further adding the referenced quotations from participants (Mays and Pope, 1995). This has been applied in presenting the findings of this study.

#### **4.15 Limitations of This Study**

It might be healthier if we first recognise the study's strengths before identifying its limitations. This study is one of the first to explore mental illness among a population of faith healers and psychiatrists in Kuwait. Indeed, this study offers a valuable count to the literature development, particularly with the scarcity of published studies about Muslim faith healers in Kuwait. Certainly, with the difficulties of employing and interviewing the participants involved in this study (faith healers in particular), it is essential to perceive the obtained findings of this study as a chief primary step in enhancing the literature in this field of research. Indeed, the obtained findings in this study succeeded to develop the initial and the introductory knowledge on the factors which hinder mental health services utilisation in Kuwait from the perspectives of two primary mental healthcare providers, which is a significant strength of this study. The qualitative design of this study managed to capture a rich picture which emerged from the views of faith healers and psychiatrists on mental illness

and the collaboration between the two sectors. A further strength of this study is achieved by using a purposive sample of psychiatrists and faith healers with at least two years of experience, which yields more trustworthy views. Therefore, it is plausible to generalise these views to all psychiatrists and faith healers in Kuwait, presuming that the health care system and faith healing setting is uniform throughout the whole country. Concerning data analysis, steps were taken to ensure a rigorous examination. For example, the researcher did incorporate additional validity checks such as supervisors reviewing full transcripts, and independent coding has been undertaken. Ongoing discussion or interaction with data or supervisors' findings may have added to the study's rigour. That was like data triangulation and involved checking provisional findings with participants. The themes generated in this study have potential practical implications for promoting the mental health status in Kuwait and future research. Findings from the current research have revealed the necessity for establishing the collaboration between psychiatrists and faith healers.

On the other hand, it is essential and trustworthy to mention that there are several limitations of this study which should be illuminated in order to be contemplated when interpreting the findings. Indeed, it is crucial to perceive and understand the limits of this study as the study has several limitations, such as:

- Patients who suffer from mental health problems, who are one of the chief determinants in shaping the mental health care pathway and in making the decision of whom health care service will be utilised, were excluded from the sample due to ethical concerns as they were regarded ineligible to provide reliable and valid consent.
- Although the interview guide was developed based on relevant literature and tested before apply, it cannot be considered a valid tool that negatively impacts the study findings' validity.
- The small sample size of this study restricted the capability and the potential to defend and advocate the generalisability of the study results. Indeed, this research was restricted by small sample size and cannot be viewed as representative of the Muslim population. The obtained data could be inadequate to explore the attitudes and relationships among faith healers and psychiatrists. Larger sample size would have facilitated the researchers to gain a more comprehensive view of Kuwait's psychiatrists and faith healers. But it is believed that this dilemma was overcome by following and adapting purposive sampling, so respondents of particular

characteristics have been deliberately chosen, yielding an informative participant with at least two years of experience. Moreover, while qualitative researches do not aim to resemble the quantitative approaches to attain the generalisation, purely quantitative researches obscure the complex nature of the social world and can't reach the profound internal meanings of our social world (Kirmayer and Ban, 2013). In addition, the qualitative method of this research provides a rich picture of the investigated area felt essential to this sample.

- Although faith healers from both genders were eligible to be included in the study sample and can participate in this study, only male faith healers were included. This is because it was difficult to reach female faith healers through personal communications due to cultural constraints. Also, it was challenging to find female faith healers because they are scarce in Kuwait. Moreover, the snowballing sampling technique that was used in this study has yielded only male faith healers, this might be due to cultural and religious reasons that prevent male faith healers to collaborate with female faith healers. Therefore, our results cannot be generalised to the entire faith healing practices in Kuwait as no female faith healers included in the study sample.
- The participating psychiatrists were recruited in collaboration with the Head of the Psychiatrists' Unit at the Psychiatric Hospital. As a result, it is crucial to highlight that there is a risk of some selection bias since the recruitment was under the control of the head psychiatrist.
- Interviewer was medical and public health doctor, so participants may have been inclined to report more favourable responses to medical practices. Moreover, several faith healers believe that health professionals degrade their jobs, so they might prefer non-medical interviewer to express their thoughts more frankly.
- Because translation was done by medical doctor (the author himself) and not trained professional interpreters, the integrity of the conducted translations of the interview guide from English to Arabic is questionable, as the unskilled translator sometimes interpreted and presented the topics in more subjective ways. Furthermore, translating back the transcripts of the interviews from Arabic to English before being involved in data analysis could have resulted in what Marcos (1979) refers to as errors of omission, substitution and condensation.
- Because we don't have data on faith healers in Kuwait, and there is no central directory of faith healers or faith healers' organisations, recruitment relied on a



convenience sampling because the participated faith healers were approached through personal communications or by looking for advertisements in written or electronic media (they usually put their mobile numbers for contact). Further, snowballing sampling was applied intensively in this study, which yielded many participants. This approach may inadvertently cause our participating faith healers to work in a relatively particular geographic area and share similar perspectives, so the sample might not have adequate variation in the type of healers, and our results may not be generalisable to the entire faith healing practices of Kuwait. Future studies that involve a more random selection of various areas may help address this bias because that would ensure the diverse make-up of the selected participants and prevent any criticism making this claim.

- Many psychiatrists gave concise and brief answers to the interview questions because they assumed that the author, as a medical doctor, should know the answers and not need to go into detail. Also, psychiatrists may be reluctant to admit to consulting a faith healer to a researcher who is perceived as representing Western medicine.
- The study relied on faith healers' recall of treatment of the past six months as the interviews were conducted in August 2020, and the curfew and the lockdown in Kuwait started in February 2020, when all the faith healing centres were closed.
- Interviewing healers who claimed to have supernatural powers would be exceptional opportunity to add further insights to the research focus which might provide implications for future research.
- Using an interviewing method to explore attitudes and relationships between the two healing approaches, the researcher of this study found that faith healers showed more desire and willingness to participate in this study. That willingness has benefited by obtaining sufficient data from their contributions to the study. However, it has also drawbacks. This is because, in qualitative studies, the research process and the social context could directly influence the obtained findings and its analysis. Therefore, reflexivity, the capability of the researcher to isolate their prior expectations and beliefs away from influencing the obtained results and its analysis, were considered during the research process. The researcher used strategies such as interviews, reflective notes or diaries to reappraise and determine the explicit factors that influenced the interpretation of the data.

- It is predictable that some faith healers were inclined to provide and favour the medical knowledges and privileging the western theories, just to appear more educated and not to be considered ‘ignorant’. Moreover, they may provide brief responses as they expect the researcher who is from their culture is aware of what they believe.
- In fear of being exposed, some faith healers declined the offer of an interview. Others mistrusted the motives of the research because they assumed that a study done by a medical doctor studying in a foreign university in the UK would aim to show their practices negatively and simply against their work. As a result, some of the potential participants could be missed. The researcher used different methods to dispel this mistrust, and the researcher managed to convince some of the hesitant faith healers by explaining the actual aim and objectives of the study and ensuring them that this study was not designed against their job and that the author was utterly neutral not against or with any side of the research. Fortunately, some of them changed their mind and decided to participate.

Despite these limitations mentioned above, as illustrated, this data is the first to describe the use of faith healing for mental healthcare in a sample in Kuwait. Future research in this area should compare some of the generated themes in the current study. For instance, future research should compare the obtained findings in this study with participants from other religions. It may also be helpful to consider the impact of other demographic factors, such as age, gender, and nationality. It is projected that the new generations could be more open and inclined to the Western culture and its dominating media and accordingly they might more knowledgeable about the Western medicine and reject the faith healings practices. Another option may be to explore the views of patients who have accessed services by examining if the patients have utilised both treatments (the faith and the medical treatments) simultaneously which would be fruitful choice for future research. Also, it is crucial to highlight that researchers interested in conducting similar researches should focus on targeting one single psychiatric disease to attain more profound exploration and understanding and to allow more rich comparison between the two different treatment modalities.

Despite the limitations, faith healing appears to contribute significantly to health care provision in the Kuwaiti context, providing a beneficial complementary help to biomedical health care services. With recognising the contributions, they can offer, a call is consequently required for faith healers to cooperate with medical healthcare providers. To gain a deeper understanding of how faith healers may conceptualise mental illness in Kuwait, there may be a need to carry out more qualitative studies. Moreover, we did not have data on faith healing practices in Kuwait, so more information on this would help us understand their treatment methods.

#### **4.16 Conclusion**

This chapter presents the research methods and methodological approach used in this study. This study will use a qualitative design following the phenomenological approach to answer the research questions and address the research aim of exploring the opportunity to collaborate between faith healers and psychiatrists in Kuwait in providing mental healthcare. This chapter has outlined the justification for choosing the qualitative research approach and following the phenomenology approach. Indeed, this chapter provided a rationale for why the phenomenological approach was adopted in this study. Moreover, the chapter illustrated the methods used in this study to gather the information from the participants. The plans were selected to fit with the phenomenological approach. The next chapter will present the findings obtained after conducting the fieldwork of this study.

# Chapter 5

## Findings

### 5.1 Introduction

This research was conducted to achieve the aim of exploring and examining the views of faith healers and mental health professionals to collaborate in providing mental health care in the context of Kuwait. As illustrated in the methodology chapter, this study used a qualitative methodological framework to answer the research question. Individual interviews were the suitable method to conduct this study, and the notes taken from the interviews were thematically analysed. In addition, the experiences and observations of the researcher as a Kuwaiti national, medical doctor, and a user of faith healing were used to substantiate the field data through reflections. In this chapter, the findings of the interviews, that have been undertaken and completed previously, will be presented and analysed. Consequently, the themes that will be generated from the analysis will help to answer the research questions and sub-questions. The research questions of this study are:

Main Question:

What are the opportunities for faith healers and health professionals to collaborate to provide mental healthcare in the context of Kuwait?

Sub-questions:

- 1) What constitutes faith healing?
- 2) What is the role of faith healers in providing mental healthcare?
- 3) What is the role of professional mental health services?
- 4) What are the commonalities and differences between faith healing and professional mental healthcare?
- 5) What are the mechanisms to establish collaborations between official mental health services and faith healers?

### 5.2 Background

The researcher conducted 19 interviews with 10 psychiatrists and nine faith healers. The number of the interviews was 19 because after conducting nine interviews with faith healers,

the theoretical saturation was achieved as the last three interviews with faith healers did not add further information and no new themes emerged. For example, all the nine participating faith healers showed a willingness to collaborate with mental health professionals, thus no new information was added regarding this question and no further theme could be generated from the repeated answers. Whereas in the psychiatrists' interviews, the point of data saturation was achieved after conducting 10 interviews. In the case of psychiatrists, three female psychiatrists and six male psychiatrists participated in this study after accepting the invitations and showing a willingness to participate. They were included in this study after fulfilling the inclusion criteria of having at least two years of experience, as those with less experience might not give informative input to the study. All psychiatrists who participated in this study worked at the psychiatric hospital in Kuwait as this hospital is the only place in Kuwait that provides mental healthcare. After obtaining a permission paper from the Kuwait Ministry of Health to conduct this study, I visited the hospital and met the head of the psychiatrists' unit at the psychiatric hospital. After explaining the study to him, I provided him with copies of the information sheet and copies of the consent form for this study. After three days, the head psychiatrist sent me a list of psychiatrists' names and telephone numbers who were willing to participate. It is crucial to highlight that there is a risk of selection bias since recruitment was under the control of the head psychiatrist. The researcher contacted the psychiatrists and arranged the appropriate time to conduct the interviews. The interviews were conducted virtually because of the precautions and restrictions related to the COVID-19 outbreak.

The faith healers who participated in this study were all male faith healers. It is worth mentioning that male faith healers in Kuwait practice at their houses or mosques. On the other hand, female faith healers practice in their homes only and male patients are prohibited from accessing female faith healers due to religious and cultural reasons. Moreover, there is no organisation in Kuwait for the faith healers that can be accessed to facilitate conducting the interviews for this study. Thus, I relied mainly on my personal communications and relationships to reach the faith healers who participated in this study. A purposive convenience sampling was used to select the informants; purposive sampling because the respondents of particular characteristics were deliberately chosen, and convenience sampling because the study participants were identified through various means of personal communications or by searching in the widely used internet engines, such as Google and Yahoo. The reason for not including female faith healers is that the researcher could not reach

the houses where female faith healers practice because of the COVID-19 outbreak. Second, female faith healers are scarce and refuse to be accessed by men due to religious reasons. Through my personal connections, I could reach only male faith healers. Lastly, I used snowball sampling to obtain additional participants from the previously identified ones. This yielded only male faith healers, as male and female faith healers in Kuwait do not work closely due to religious and cultural reasons. It is important to explain that the faith healing practices are derived from the same sources which are the Holy Qur'an and the prophet Mohammed sayings. Therefore, from theoretical point of view the faith healing practice is identical among male and female faith healers so that the findings obtained from male faith healers can be applicable to female faith healers. But, from clinical and practical perspective, the former assumption needs experimental testing to be rationally confirmed and proven. Thus, it remains uncertain and doubtful that the findings of this study can be generalizable to both genders. Lastly, three of the 12 contacted faith healers declined to participate because they lacked trust in Western research. I arranged with the faith healers, who agreed to participate at the appropriate time to conduct the interviews. The interviews were conducted virtually because of COVID-19 precautions.

The two tables below (Tables 5.1 and 5.2) illustrate the details of the participants of this study. The names of the participants are pseudonyms to maintain and ensure the confidentiality of the participants' data. The faith healers in this study were selected from diverse cities in the six governorates of Kuwait: Kuwait City (the Capital), Hawalli, Ahmadi, Jahra, Farwaniya, and Mubarak AlKabeer. As mentioned, faith healers in Kuwait practice in mosques or at their houses. The group of faith healers shown in Table 1 were selected because they have a high reputation in faith healing, and their practices have exceeded two years. Faith healers with less experience were excluded because they may still have little to contribute to this study. Therefore, it is understandable that all the faith healers who participated in this study were above 45 years. They had sufficient years of work and have built a reputation that enhances their likelihood of being consulted by people with mental health problems. These faith healers have different names in the Islamic and Arabic world: Mutawa, Mulla, or Shaikh. These healers do not necessarily have a formal qualification in Islamic spiritual healing. They gained their recognised position within the community only by reputation. The word Shaikh means leader or ruler in Arabic. In Kuwait and most GCC countries, faith healers are called Shaikh.

According to Al-Habeeb (2003), a faith healer is a religious person who practices the Islamic healing method to treat mainly mental health problems. A faith healer mitigates patients' psychological and physical problems using religious means of treatment. In Islamic spiritual healing, an illness is generally predicted to occur under the will of Allah, so faith healing focuses on religious practices that enhance the adherence to Allah to stimulate and induce the power and existence of God towards treating diseases and disabilities (Bathla et al., 2011; Ateeq et al., 2014).

It is crucial to elucidate the primary method used by most faith healers in Kuwait, "Ruqyah". Ruqyah simply refers to reciting various verses from the holy Qur'an and sometimes accompanied by sayings from Prophet Muhammad. It is performed mainly on those presumed to have mental disorders (Md. Sa'ad et al., 2017). During Ruqyah practice, some faith healers might use Zamzam water, found only in Mecca in Saudi Arabia. Ruqyah has been performed since the beginning of Islam.

**Table 5.1: Details of the faith healers who participated in this study**

Pseudonym	Age	Work Experience	Place of Work	Gender
Shaikh Hassan	49	Above 2 years	Mosque	Male
Shaikh Rajab	53	Above 2 years	Mosque	Male
Shaikh Ismaeel	46	Above 2 years	Mosque	Male
Shaikh Mohammed	62	Above 2 years	Mosque & House	Male
Shaikh Rashid	51	Above 2 years	Mosque & House	Male
Shaikh Othman	43	Above 2 years	Mosque	Male
Shaikh Ahmed	57	Above 2 years	Mosque	Male
Shaikh Omar	50	Above 2 years	Mosque & House	Male
Shaikh Yousef	46	Above 2 years	Mosque	Male

The Psychiatric Hospital in Kuwait is the only hospital in the country that provides psychiatric inpatient healthcare services, with about 900 beds for admission (MOH, 2013). Moreover, rehabilitation services, as well as outpatient clinics, are available at the psychiatric hospital. In addition to the psychiatric hospital, psychiatric healthcare services are available in the (five) general hospitals of Kuwait, and in some prisons and private schools (WHO, 2006). But their clinics have restricted schedule by working two days only per week with outpatients' services

only, and the psychiatrists in fact, come to these clinics from the psychiatric hospital itself since they are employed there (Al-ansari et al., 1990). Thus, all the participated psychiatrists in this study were selected from the psychiatric hospital. In Kuwait, the healthcare workers are mainly the expatriates since around 80% of the mental healthcare workforce in the psychiatric hospital are non-Kuwaitis, predominantly from Egypt (WHO, 2006). The psychiatric hospital has 48 psychiatrists, 17 psychologists, eight social workers, 294 psychiatric nurses and 182 non-medical staff (MOH, 2013). Most of the medical staff (60%) in Kuwait have graduated from universities in the Arab region, where psychiatry doesn't get sufficient attention and care, so undergraduate psychiatric education is negligible (Alansari et al., 1990).

**Table 5.2 Details of the psychiatrists who participated in this study**

Pseudonym	Age	Work experience	Place of Work	Gender
Dr. Ihab	43	Above 2 years	The psychiatric Hospital	Male
Dr. Mohammed	52	Above 2 years	The psychiatric Hospital	Male
Dr. Salah	38	Above 2 years	The psychiatric Hospital	Male
Dr. Salamah	57	Above 2 years	The psychiatric Hospital	Male
Dr. Abeer	40	Above 2 years	The psychiatric Hospital	Female
Dr. Mona	48	Above 2 years	The psychiatric Hospital	Female
Dr. Amro	51	Above 2 years	The psychiatric Hospital	Male
Dr. Fuad	50	Above 2 years	The psychiatric Hospital	Male
Dr. Sumayah	43	Above 2 years	The psychiatric Hospital	Female
Dr. Hazem	61	Above 2 years	The psychiatric Hospital	Male

### 5.3 Thematic Analysis: Faith Healers Interviews

Below are the themes generated from conducting the thematic analysis for interviews of the faith healers.

#### Definition of Faith Healing

There is consensus among all the participants regarding the definition of faith healing. The participants (nine faith healers) defined their faith healing work as a process of reciting various verses from the Qur'an and sayings from Prophet Muhammad with the purpose of soliciting



Allah's help to cure the illness of their patients. They named their work Ruqyah and they mentioned that it was performed by the prophet himself and his companions as in the Qur'an it is mentioned that the Qur'an was sent down in which it is a *healing* and a mercy to those who believe.

*Faith healing is simply reading verses from the Qur'an and sayings of the Prophet Muhammad. By reading them, we are asking God for a cure and healing. (Shaikh Rajab)*

*Faith healing was endorsed by the Prophet Muhammad when his companions performed it in Islam. It is permitted to perform Ruqyah and has existed in Islam's history. (Shaikh Hassan)*

*Ruqyah is mentioned in the history books about the life of Prophet Muhammad, and his companions also did it because the Qur'an's words are considered a cure in Islam. (Shaikh Mohammed)*

Faith healers consider it crucial to have a firm belief about the value and the usefulness of Ruqyah for it to be effective and to obtain beneficial outcomes.

*The faith healer and the patient must have certitude and confidence in Ruqyah to obtain sufficient cures and treatment. (Shaikh Ismaeel)*

### **Methods of Learning Faith healing Practices**

As mentioned by the participants, faith healing could be learned by reading several books that taught the Ruqyah, including the history of Prophet Muhammed, as there are many narratives reporting the practice of Ruqyah done by Prophet Muhammad to himself and his wives when they became ill.

*Faith healing practices are described in many books, and they can be easily learned from these books, particularly the reliable sources and narrators such as Al-Bukhari and Muslim. In some of these books, you can find stories about how Prophet Muhammad performed Ruqyah. (Shaikh Rashid)*

Furthermore, faith healers pointed out that faith healing practices can be learned from well-known faith healers who are trustworthy and honest and considered a reliable source of learning faith healing. They said that the learning process should be practical. They must physically meet and observe him while practising the Ruqyah to learn.

*Faith healing practices can be learned from well-known faith healers by sitting beside them while practising Ruqyah. (Shaikh Hassan)*

*Faith healing can be learned from a faith healer who has a good reputation and is considered a reliable source when numerous faith healers testify his honesty. (Shaikh Ismaeel)*

### **Motivation or Reasons for Becoming a Faith Healer**

As stated by several healers, the motivation to become a faith healer is to help people and let happiness enter their lives to gain blessings from God and be rewarded for good deeds.

*The motivation behind being a faith healer is to gain blessings from Allah because we are helping sick people who seek help, and by that, we feel happy and pleased after doing such good deeds. (Shaikh Rajab)*

*The best action in Islam is to make your brothers in Islam and sisters in Islam happy and to prevent unpleasant and evil things from occurring to them because in Islam, God tells us, "If anyone saved a life, it would be as if he saved the life of the whole humanity." (Shaikh Ahmed)*

The faith healers also mentioned that it is acceptable for faith healing to be a lucrative vocation. This is supported by a well-known story that occurred during the time of the Prophet Muhammad. This story was mentioned by four of the faith healers who participated in this study. The story happened to some companions of the Prophet Muhammad who were travelling back to Mecca. On their way, while having a short rest in one of the Arab tribes' lands, the leader of that tribe became ill and asked for help. The companions practised Ruqyah on him,

and the man got cured. The leader rewarded the companions with a herd of sheep to show gratitude. When the companions arrived at Mecca and told the Prophet Muhammad about the incident, he endorsed their actions and did not object to receiving rewards. Therefore, many faith healers, and six out of the nine who participated in this study, mentioned that there is no deterrent to requesting money from patients or their relatives in exchange for healing.

### **Forms of Treatments and the Practical Side of Faith Healing**

The faith healers usually start by reassuring the patient and telling him that Allah is very merciful because he did not send any ailment without sending its cures with it, as stated by the Prophet Muhammad:

*We start with psychological relief by informing the patient that his problem is not severe since God can cure every disease. (Shaikh Rashid)*

Second, the faith healer will attempt to build trust by taking history and giving the patient the opportunity to explain his problem thoroughly.

*I ask the visitors about the symptoms and give them enough time to clarify their problems. (Shaikh Mohammed)*

Two faith healers asserted that they request the patient to access medical doctors and do all the required medical tests to confirm that he has no diagnosed medical problem before starting the faith healing.

*I personally ask my patients first to be examined by medical doctors to ensure they don't have any medical problems. If they did all the medical tests and are medically fine, I would start with my treatment methods on them. (Shaikh Mohammed)*

According to the participants, this is how the Ruqyah takes place. The faith healer will be seated close to the patient and put his hand on the patient's head. If the patient is female, he won't put his hand. Then, he will start reciting verses from the Qur'an, such as Al-Fateha or Al-Baqarah and the sayings of Prophet Muhammad. Furthermore, the faith healer will recite verses from

the Qur'an, then breathe on his hands and rub the patient's body with his hands. Indeed, all participants explained the former approach of faith healing.

However, there are other forms of faith healing practices. One of these involves reciting Qur'an verses over a cup or bottle of water and asking the patient to drink from the water regularly for a particular period that might last for days to months. Six out of nine faith healers in this study mentioned this approach. A similar manoeuvre can be applied to honey called Al-Sader honey, found mainly in the Arabic peninsula, especially in Yemen. The faith healer also recites over a cup or bottle of Al-Sader honey and asks the patient to eat from it regularly. Four faith healers in this study mentioned this approach. Also, Zamzam water, only found in Mecca, is used for treating patients, as stated by two participants. Another form of faith healing practice involves the use of olive oil. Since it is believed to be sacramental in Islam, olive oil is rubbed over the body, as stated by three participants of this study. It is worth mentioning that two faith healers declared that faith healing practices could be learned and performed by patients or their relatives. It is not mandatory to be performed by a faith healer, but people usually prefer approaching faith healers because they believe in their power and vital link to God.

*Anyone can learn faith healing, and the patient can perform Ruqyah on themselves, so it is not exclusive to faith healers only. (Shaikh Ahmed)*

### **Causes of Mental Problems**

According to faith healers, one of the leading causes of mental problems is the weak and inadequate attachment to God, which makes the person unable to cope with life stressors, eventually leading to distress and sadness. Thus, those with a solid and adequate connection with God will maintain stable mental health. In contrast, others with an improper attachment will be depressed if they face difficulties, such as losing children, getting divorced, losing jobs, and facing financial struggles.

*Muslims, if they lost their connection with God, would suffer in life and be more vulnerable to mental problems. (Shaikh Omar)*

*The causes of mental problems are various, but one of the leading causes is being far from God. Eventually, they will ignore the daily rituals and prayers, and in the end, they won't be able to have a normal life without mental problems. (Shaikh Othman)*

The other main reason for mental problems is Jinn possession. The faith healers said that Jinn could interfere with human beings' lives, causing them harm. Indeed, all the faith healers who participated in this study believed in the existence of Jinn as a creature of God because it is mentioned in the Qur'an in various verses.

*I personally witnessed many cases of Jinn possession. When I read Qur'an on a patient that a Jinn possesses, the whole body of the patient starts shaking, his eyes turn white, screaming and threatening me to stop reading Qur'an. (Shaikh Rajab)*

*Jinn possession is one of the causes of mental issues among many patients. There is a faith healer who is a friend of mine. He married a woman, and then a Jinn possessed her. (Shaikh Rashid)*

The evil eye can also cause mental illness. As mentioned in the Qur'an, it can affect people causing harmful influences on their lives due to envious and jealous feelings from other persons. Seven faith healers mentioned the evil eye as a cause of mental illness.

*The evil eye is mentioned in the Qur'an and is one of the main causes of psychological diseases. (Shaikh Yousef)*

*I consider the evil eye as the main cause of mental health problems as some people stare at others with a powerful desire to obtain what they have, thus causing harm to them. (Shaikh Rashid)*

Lastly, sorcery is another cause mentioned by six faith healers. Although it is rare in Kuwait, it still exists, as clarified by the faith healers.

*Sorcery is another reason why some patients suffer from mental problems; this practice is done by witches who deal with evil spirits. (Shaikh Ismaeel)*

Sorcery is different from the evil eye, which occurs through a look from a person who carries envious feelings directed to others, which could inflict injury to them. In contrast, sorcery is the use of magic and witchcraft by a person who gained power from the assistance and aid of evil spirits.

### **Recognition and Awareness of Other Mental Healthcare Services**

All nine participating faith healers pointed out that there is another way to receive mental healthcare and support in Kuwait: psychiatric healthcare centres. They stated that they are not against accessing medical care services since the Prophet Muhammad encouraged Muslims to seek help and receive proper treatment from medicine if available and effective.

*Islam views science, especially medicine, with respect and does not deny its role in treating diseases, so they must be approached when needed. (Shaikh Ismaeel)*

*In Islam, we believe there is no disease without a cure in this life. Even if human beings haven't discovered the cure yet, it already exists. So psychiatric medicine is true, and people should seek help from them when needed. (Shaikh Omar)*

*Yes, of course, I am aware that there is another way to receive mental care and support in Kuwait: psychiatric healthcare centres. (Shaikh Yousef)*

Therefore, seven faith healers who participated in this study do not oppose the desire of some patients to access healthcare services to receive care in parallel with obtaining their treatments.

### **Obstacles and Facilitators to Access Psychiatric Facilities or Faith Healers' Centres**

Seven faith healers believed that people avoid approaching psychiatric health services because of the stigma attached to them. They said there is a shared sense of embarrassment and disgrace towards accessing mental health services. They pointed out that if people decided to approach mental healthcare centres and been noticed and recognised by others, that would probably

affect their status and label them as abnormal people, which eventually might affect their life in different manners, such as the inability to get married.

*People avoid going to the psychiatric hospital because they fear it might cause a scandal and gossip about them and their reputation. If someone noticed them there, they would say they were crazy. (Shaikh Othman)*

*People feel shame and disgrace if they see psychiatrists, which is why they might prefer accessing us. (Shaikh Rajab)*

*The patients are afraid of being labelled as crazy because they have visited the psychiatric hospital, which could reduce their chance of getting married. (Shaikh Ismaeel)*

One faith healer mentioned that the high cost of psychiatric medications could be a barrier to accessing mental healthcare centres, mainly because patients will be dependent on these medications for their entire life, so they will spend a considerable amount of their income on them. Moreover, two faith healers stated that not seeking help from psychiatrists could be due to a lack of knowledge and low education.

*One of the main constraints preventing people from visiting psychiatrists is the patients' ignorance about psychiatry and its role in managing mental illnesses. (Shaikh Omar)*

On the other hand, people are motivated to access faith healers because of their excellent reputation and the effectiveness of their treatment methods, as clarified by three participants.

*Patients prefer to visit us because they believe in our capabilities and effectiveness since they hear about our good reputation from their families and friends. (Shaikh Hassan)*

However, some might avoid accessing faith healers and disregard their high reputation because of the impact of Western culture. They believe that faith healing practices are archaic and inefficient.

*People might think of our ways of treatment as something ineffective and useless. This is especially obvious among people who lived abroad in Western countries for a while for studying or any other reason. (Shaikh Hassan)*

*Indeed, secularism and liberalism are spreading in the world these days and affecting even the Arabic world, causing people to forget their culture and heritage so they won't access faith healers anymore as they will view it as something backward and outdated as stated by. (Shaikh Rajab)*

The other reason that might prevent people from accessing faith healers is the paucity of female faith healers, which will prevent female patients from visiting the faith healing centres because of the cultural obstacle and embarrassment.

*Some people do not accept and allow their female relatives to be examined by male faith healers; the problem is that we do not have enough female faith healers. (Shaikh Hassan)*

Also, the malpractice incidences by some faith healers affected the reputation of the whole faith healing community, thus preventing some people from accessing them, as mentioned by three faith healers.

*What prevents people from visiting the faith healing centres is the malpractice incidences, including deception and dishonesty from some faith healers, leading to lower esteem of the community of faith healers. (Shaikh Ismaeel)*

To sum up, stigma, low education level, and high cost of psychiatric medications are key barriers faith healers suggest preventing people from accessing psychiatric facilities. While faith healers view the impact of Western culture, the paucity of female faith healers, and malpractice incidences are the main obstacles that inhibit some patients from visiting faith healing centres.

### **Compatibility Between Faith Healing and Psychiatry**

All the participants (nine faith healers) declared that they have never used psychiatric medications or any medical treatments to treat their patients as they think this would be an



incorrect decision to be made by faith healers who do not specialise in the medical field. They believed each field has its background and unique treatment, and they cannot rely on other ways of treatment.

*We are not physicians, so we do not have experience with the medications. They might harm the patients inadvertently if we use them because some medications might increase the blood pressure or glucose level, causing severe adverse consequences for the patients. (Shaikh Hassan)*

*We must not prescribe any medical medications as it is not our work. We should only perform the faith healing approaches that we know. (Shaikh Ismaeel)*

All the nine faith healers stated that they do not have any previous communications or interactions with psychiatrists or mental health professionals, but that does not mean they disrespect their work. Faith healers view psychiatry as a complementary field and have no objection to referring their patients to psychiatrists.

*As a faith healer, I view psychiatry as superior to my work, so when the patient visits me for the first time, I ask him to see a psychiatrist first to rule out any psychiatric problems. (Shaikh Ahmed)*

*Psychiatric treatment must be the first option, so people must seek help from a psychiatrist first and then they could approach us if medical medications fail to treat their problem. (Shaikh Yousef)*

Most participants (seven faith healers) mentioned that they had advised some patients to access psychiatrists as they think psychiatrists should manage some particular cases to receive better treatment. Indeed, the participants stated that if they experienced difficulties handling any case, they would advise the patient and their relatives to contact a psychiatrist because they believe he would receive better treatment in hospitals.

*On several occasions, I advised some patients to see a psychiatrist as I thought their cases would receive better treatment by physicians. (Shaikh Hassan)*

*Yes, I advised many of my patients to visit the psychiatric hospital even though I personally do not have any previous communications with a psychiatrist. (Shaikh Mohammed)*

Nevertheless, two faith healers mentioned that they would refer their patients to another faith healer who has more experience if they experienced difficulties. They would not refer their patients to psychiatrists because they believe that psychiatric medicines are harmful.

*I would refer my patients to another faith healer rather than a physician if I failed in treating any case because psychiatric medications have side effects on the kidneys and liver, and patients might commit suicide from the side effects. (Shaikh Othman)*

Talking about the inherited disrespect and distrust among psychiatrists towards faith healing, the participants admitted it is true that some psychiatrists viewed faith healing in a derogatory and demeaning way. Despite this, they mentioned that some psychiatrists respect faith healing because they have some religious knowledge and are conservative. One of the participating faith healers stated that medical doctors are one of their clients who visit them to receive treatment by Ruqyah.

The participants mentioned various obstacles to establishing the collaboration between the faith healers and psychiatrists. Indeed, one of the barriers that the five faith healers mentioned is the lack of trust among faith healers and mental health professionals, so they probably will not be motivated to accept such collaboration.

*Each side looks at the other side with superiority and thinks his approach is more effective, so they are not convinced of the other side's effectiveness. (Shaikh Othman)*

According to two of the participants, the obstacles could be the endorsement by the government as faith healing practices are still considered illegal here in Kuwait.

*How can such collaboration happen if the faith healing practices are still not officially recognised and the government has not authorised our job? (Shaikh Mohammed)*

One faith healer pointed out that countries worldwide tend to adapt secular regimes, and that perspective does not fit with the idea of collaborating with religious methods.

*I do not think such collaboration could be formed here in Kuwait because the influence of secularism is noticeable here, and Kuwaiti people are becoming more liberal. Such collaboration might be possible with countries that have conservative Islamic regimes, such as Saudi Arabia and Iran. (Shaikh Rajab)*

Moreover, one faith healer stated that obstacles to forming the collaboration could be due to not having a clear job description of each side.

*If we did not divide the work, the tasks would be mixed, and conflicts could occur between the two sides because each side would interfere with the other side's work. (Shaikh Hassan)*

### **Willingness Towards Collaboration Between Faith Healing and Psychiatry**

Even though two faith healers expressed concerns over the safety of psychiatric medications, all the nine participating faith healers showed a willingness to collaborate with mental health professionals as they thought that would be an ideal opportunity for them to learn a new aspect or a new way of treating the patients and the additional learned knowledge will be complementary to their original practice.

*Of course, we do not have any objection to collaborating with mental health workers, and the opposite is true. We want to collaborate and learn from them to enhance our knowledge. (Shaikh Rajab)*

*I am firm with forming a collaborative atmosphere with psychiatrists as their medications are developed after experiments, so I think this idea is great. (Shaikh Omar)*

Some participants said such collaboration would benefit them by helping them obtain official recognition of their work so they might receive financial support from the government.

*Faith healers will be very motivated by the idea of collaboration because, with such collaboration, they will probably receive an official certificate from practising their job and earning money. (Shaikh Mohammed)*

Also, faith healers were motivated to receive medical training to be eligible to work with psychiatrists.

*It will be wonderful to receive medical training. I have no problem with that. (Shaikh Rashid)*

### **Proposed Ways of Establishing the Collaboration Programme**

The participants mentioned various ideas. For example, four faith healers suggested that the collaboration must be established under the supervision of a multi-sectorial official authorities' partnership between the Ministry of Health and the Ministry of Islamic Affairs.

*To establish the collaboration, we need the cooperation between various ministries such as the Ministry of Health and the Ministry of Islamic Affairs to formulate collaboration strategies. (Shaikh Rashid)*

They emphasised that the collaboration should be a step-by-step process by forming a plan, selecting the proper place and time, accepting each other, and not being dominant in the collaboration. They also stressed being cautious when selecting the proper faith healers.

*Some faith healers are not well-qualified to work closely with psychiatrists because they are not educated enough to understand the mentality of psychiatrists. The psychiatrists themselves will face difficulty dealing with such faith healers. (Shaikh Hassan)*

Thus, a committee of well-known faith healers should be formed to select proper faith healers who have received appropriate religious teachings. Another task of the committee is to qualify cadres from young faith healers.

*Not every faith healer can work closely with the medical field. We should choose the trusted ones to be elected to represent the faith healers by a committee from the most well-known faith healers who obtained high-ranking Islamic teachings and have high-level reputations. (Shaikh Yousef)*

Moreover, five faith healers recommended launching workshops to be attended by both faith healers and psychiatrists to learn from each other and share knowledge.

*My recommendations and suggestions are to have mutual training workshops so each side can learn from the other. (Shaikh Omar)*

There must be regular joint meetings to discuss each other's treatment methods and share experiences. Lastly, forums and conferences must be held to show their treatment methods and persuade each other.

*There should be cooperative meetings to share experiences; each side will be familiar with the other approaches and learn from them. (Shaikh Mohammed)*

### **Expected Outcome on Patients From Such Collaboration**

All the participated faith healers clarified that the outcome of such collaboration would be positive for patients as they will receive two different treatment methods, so they will get more integrated and cohesive solutions. Although some faith healers identified some obstacles, as explained earlier, they were optimistic about obtaining positive results if the challenges were overcome.

*The collaboration will have a positive impact because those patients who are more convinced with either medical treatments or faith healing will get answers to their complaints from both sides. (Shaikh Rashid)*

In addition, they mentioned that the collaboration could further benefit on patients by reducing their doses of psychiatric medications as they now receive complementary treatment by faith healing approaches.

#### **5.4. Summary of Findings From Thematic Analysis – Faith Healers**

The faith healers defined their faith healing work as a process of reciting various verses from the Holy Qur'an and sayings from Prophet Muhammad to solicit Allah to help cure their patients' illnesses. They named their work Ruqyah, and the prophet and his companions performed the practice of Ruqyah for treatment. Ruqyah is the primary method of faith healing, but there are other ways of faith healing practices, such as reciting the Qur'an versus over a cup/bottle of water or honey and asking patients to have them. Learning faith healing practice could be achieved by reading books describing the Ruqyah. The motivation to become a faith healer is to help God reward people for doing good deeds, but it is acceptable for their job to be lucrative.

According to faith healers, one of the leading causes of mental problems is a weak and inadequate attachment to God which makes a person vulnerable to psychological problems. Moreover, Jinn possession, the evil eye, and sorcery are other causes of mental issues.

Faith healers know that there is another way to receive mental care and support in Kuwait: psychiatric healthcare centres. The faith healers pointed out that there is no hindrance to accessing medical care services in Islam since the Prophet Muhammad encouraged Muslims to seek help and receive proper medical treatment if available and effective. Faith healers reported that they do not have any previous communications or interactions with psychiatrists or mental health professionals, but that does not mean they disrespect their job. Faith healers view psychiatry as a complementary field and have no objection to referring their patients to psychiatrists. Faith healers have advised some of their patients to access psychiatrists. Faith healers were willing to collaborate with mental health professionals as they thought it would be an ideal opportunity to learn new knowledge that would complement their original practice. Nevertheless, some obstacles and barriers to establishing the collaboration between faith healers and psychiatrists were identified, such as the illegal recognition of their work, inherited disrespect, and distrust among mental health professionals.

However, the faith healers identified various ideas for collaboration. For instance, they suggested that the cooperation must be established under the supervision of multi-sectorial

official authorities' partnership, such as between the Ministry of Health and the Ministry of Islamic Affairs.

They emphasised that the collaboration should be step-by-step by forming a plan, selecting the proper place and time, accepting each other, and not being dominant in the partnership. They also stressed that there must be regular joint meetings to discuss each other's treatment methods and share experiences. Finally, the faith healers expected the outcome of such collaboration would be positive for patients as they would receive two complementary treatment methods to get more integrated and cohesive solutions.

## **5.5. Thematic Analysis – Psychiatrists Interviews**

The themes generated from conducting the thematic analysis for interviews of the psychiatrists are as follows.

### **Work Description and Motivations to Become a Psychiatrist**

As clarified before, ten psychiatrists participated in this study. This study's participants described their work as a humanitarian job that helps very neglected people, people with psychological disorders such as anxiety disorders, cognitive disorders, and affective disorders, thus dealing with the whole spectrum of psychiatry, including psychoses, neurosis, and personality disorders.

*I think most psychiatrists generally have a high sense of humanity and have chosen psychiatry as a specialisation to treat neglected people. (Dr Ihab)*

They precisely clarified their job by identifying their obliged tasks such as receiving psychologically ill people, whether outpatients or inpatients, examining them thoroughly, making necessary investigations for diagnosis, prescribing treatment, following them up and adapting treatments according to their conditions and sometimes referring the patient to other medical specialists if needed. Some psychiatrists work mainly with older patients treating them for various conditions related to older people, such as Alzheimer's, dementia due to various

causes like Parkinson's disease, and other conditions. In contrast, others work in the childhood and adolescent unit treating patients under 16. On the other hand, some psychiatrists describe their job as challenging and stressful since they deal with a unique kind of patient who might be unable to explain their condition to them adequately, with some of them being forced by their relatives and being sceptical to psychiatry.

*Although I am enjoying doing my work as a psychiatrist, I cannot deny it is a challenging and stressful job because we are often dealing with complex cases. Most psychiatric patients do not listen to us, so we need more effort and time to convince them of our treatments. (Dr Abeer)*

According to some of the participants, humanitarianism is one of the main reasons behind choosing psychiatry as a specialisation.

*I believe that most psychiatrists have chosen psychiatry as a profession because they have a high sense of humanity and compassion. They deal with people who usually suffer silently, so no one feels their pain. (Dr Ihab)*

Indeed, psychiatrists pointed out that they selected psychiatry as a profession to make a difference in the current situation where stigma surrounds the whole psychiatry setting and to have the chance to change that and help people with mental illness in a significant way and allow them to live a normal life.

*Stigma is still surrounding psychiatric settings, so to have the chance to change that and to help people in a significant way is why I have chosen to be a psychiatrist. (Dr Mona)*

Other psychiatrists indicated the influence of their tutors at the university, who taught them psychiatry subjects and explained them in a very stimulating way. Hence, their tutors inspired them to be fascinated and admire the discipline, which ultimately convinced them to be psychiatrists.



*Indeed, as a medical student, I was entertained by the lectures discussing the new era of psychiatry that explained the biological aspect of mental disorders by neurotransmitters imbalance. Thus, I have decided to specialise in psychiatry. (Dr Salah)*

Some psychiatrists mentioned that they have decided to become psychiatrists because only a few newly graduated doctors choose to enrol in psychiatry, which led to a shortage of psychiatric staff globally and will stratify them as rare professions so there will be high demands on them so better future work opportunities.

### **Treatment Methods Used by Psychiatrists**

*We follow here the biopsychosocial approach for treating psychological illnesses, like medications and other biological interventions such as electroconvulsive therapy (ECT), and psychological ways of treatment, such as psychotherapy. Lastly, we also take care of social aspects through social therapy. (Dr Salamah)*

All psychiatrists agreed that they use the biopsychosocial approach. The psychiatrists described how they look at the patients with a broad scope that encapsulate various components affecting the patient directly and indirectly. The biological part of their treatment involves the pharmacological aspect, simply prescribing medications, which is considered the primary treatment method. In contrast, psychological management includes psychotherapy, which has been proven to positively impact many psychological disorders, such as anxiety and obsessive-compulsive disorders (OCD). Lastly, the psychiatrists described social therapy that addresses the family, friends, and the environment affecting the patients. The choice of treatment method depends on the severity of the disease, type of disorder, compliance of the patients, the findings of evidence-based research, and other factors as clarified by the participants.

### **Causes of Mental Disorders**

Several psychiatrists mentioned that in Kuwait, they believed that genetic factors play a significant role in developing mental disorders. The consanguinity is high among Kuwaiti families, so some psychological disorders frequently run in some families.

*Genetic factors play a significant role in the appearance of mental disorders, so depression runs commonly in some families and OCD disorders are common in other families and so on. (Dr Mohammed)*

Psychiatrists clarified that life stressors are the main causative factors for the non-Kuwaiti people who live in Kuwait, as most of them stay alone in Kuwait, leaving their families back home and working for long hours.

*The stress is high on the foreigners here in Kuwait, leading to mental problems among them. (Dr Sumayah)*

Psychiatrists stated it is multifactorial, so many factors include genetic, biological, social, and environmental factors.

*It is multifactorial. In my opinion, it isn't just one thing. Maybe genetics play a role in the development of disorders more often because of consanguinity. Still, I think it is genetic and biological, social, and psychological factors. (Dr Mona)*

Psychiatrists viewed that social factors can be weak family bonds or introverts being more prone to depression. Meanwhile, environmental factors could be childhood abuse, life stressors, and drug addiction, which has been popular among youths recently. Moreover, the participants emphasised that the leading causes of mental disorders in Kuwait are the same as the main cause elsewhere.

*The causes of mental disorders are almost the same globally. (Dr Amro)*

### **Mental Healthcare in Kuwait**

Psychiatrists stressed that the rate of psychiatric disorders in Kuwait is equivalent to the global rate as psychiatric disorders tend to occur at a similar rate in every country.

*I think the rate of psychiatric diseases here is comparable with the rest of the world. Like 1% of the Kuwaiti population suffers from schizophrenia, and 10–15% suffer from depression. (Dr Mohammed)*

*Mental problems exist worldwide at approximately the same rate, so the schizophrenia rate in the USA is equal to the schizophrenia rate in Kuwait, Egypt, and anywhere, which is approximately 1% of the population. (Dr Ihab)*

However, it is noticeable that Kuwait and other Arabic countries have a low suicide rate compared to other regions of the world, which could be related to cultural and religious factors, as stated by one of the participants. After that, most psychiatrists (eight out of ten) expressed their non-satisfaction with the mental healthcare system in Kuwait. They mentioned a shortage of psychiatric staff, and the mental health system is chiefly centralised around a single psychological hospital that offers in-patient and emergency mental healthcare services. They also complained about the government's postponed endorsement of the mental health act.

*There is a large shortage of mental health staff. We have 4 million people living in Kuwait, and the mental health staff is very few. (Dr Salamah)*

*Yes, there is a significant shortage in mental health staff. The number of psychiatrists is minimal compared to the total population. Even the facilities are few as we have only one psychiatric hospital in Kuwait. (Dr Abeer)*

Nevertheless, two psychiatrists stated that people in Kuwait receive adequate mental healthcare, with primary centres filtering all sorts of illnesses. Inpatient and outpatient psychiatric care in Kuwait's general hospitals, highly professional addiction centres, and various social and psychological help institutions are available. Thus, they stated that mental healthcare in Kuwait is equivalent in quality to other developed countries such as the United States and European countries.

*I am very content with mental healthcare in Kuwait as there is no difference between the mental health services provided here and mental healthcare in America and Europe. (Dr Salah)*

## **Recognition and Awareness of Other Mental Healthcare Services**

All the psychiatrists who participated in this study said that they are aware of other mental care services available in Kuwait, such as faith healers. Also, they admitted that many of their patients have access to faith healers before visiting them.

*Many patients had visited faith healers seeking help before they decided to approach us.*  
(Dr Ihab)

*I am aware of the existence of faith healers in Kuwait, and people sometimes prefer to access them because it is part of their cultural heritage.* (Dr Mohammed)

One of the psychiatrists labelled the faith healing practices as para-psychiatric services and heritage in the Arab world since they have a more ancient history than the new psychiatry itself.

*In the Arab world, para-psychiatry like faith healers has existed for a long time, and they treat mental problems before the psychiatry science itself.* (Dr Salah)

Others (four psychiatrists) considered accessing faith healers as a barrier preventing patients from receiving prompt treatment. They also think that accessing faith healers put patients at risk of abuse as no one knows what is happening there.

## **Obstacles and Facilitators to Accessing Psychiatric Facilities or Faith Healers' Centres**

Seven psychiatrists emphasised that stigma is one of the main barriers hindering accessing their hospital. Indeed, stigma is a serious issue here in Kuwait and most Arabic countries, as pointed out by many participants.

*Of course, the stigma is preventing people from coming to us. People are terrified to access us because it is disgraceful in their culture.* (Dr Amro)

The cultural and traditional belief of shame and disgrace toward visiting psychiatrists is high in Kuwait. People avoid accessing psychiatrists because they are afraid of being identified by others, mainly because Kuwait is such a small country, and usually, people are interconnected. Unfortunately, the stigma exists even within the medical field since physicians in other disciplines look at psychiatry degradingly, as mentioned by one of the participants. This degrading view could be related to their underestimation of the quality of care provided in the psychiatric hospital. Therefore, media campaigns are required to raise awareness among Kuwaitis to change all the misconceptions about psychiatry.

The other main reason is the low education level among some people. As clarified by six psychiatrists, less educated people prefer to utilise the faith healing approaches. Patients might choose faith healing approaches because of the high reputation of their effectiveness. But this could be misleading, as the participants explained:

*It is misleading to believe in the effectiveness of faith healing since many visitors of the faith healers are only complaining of minor psychological symptoms such as the feeling of sadness or unhappiness with their current situation, so they do not fit in the scientific criteria of psychological illnesses. Their conditions could be revealed by themselves with time or with some social support from family or friends. (Dr Ihab)*

Psychiatrists reported that people who believe in Jinn possession, the influence of the evil eye, and sorcery as the cause of their distress tend to prefer to access faith healers.

*There is a cultural legacy imposing the belief of Jinn possession, the influence of the evil eye, and sorcery. Thus people do not believe in our role. (Dr Mohammed)*

So, there seems to be a coherence between illness belief or attribution and help or treatment sought. Thus, if the patient thinks the problem stems from jinn, they would go and see a faith healer, not a psychiatrist. The same concept was revealed in faith healers' interviews. The participating faith healer believed that patients who believe in Jinn possession, the influence of the evil eye, and sorcery tend to visit them.

## **Role of Islam in Understanding Psychiatric Illness**

Five psychiatrists mentioned that Islamic culture influences their understanding of psychiatry as Islam gives keys to establishing stable mental health.

*Indeed, Islamic values are a helpful tool that can assist in treating some patients: offering support, consolation, cognitive correction, and behavioural change. Islamic values immunise patients against suicide. (Dr Hazem)*

*For example, praying five times in a mosque strengthens the link with God and walking to the mosque, even for short distances, is good for mental health. Gathering with people in the mosque will help to create social bonds. (Dr Salah)*

Four psychiatrists described that religion could play a role in psychotherapy since the spiritual approach can sometimes be used as a supportive therapy. Two psychiatrists stated that religion plays a significant role in the rehabilitation stage of the treatment scheme for the addiction.

*The spiritual approach is an excellent psychotherapy choice in treating the addicted patient, particularly at the rehabilitation stages. (Dr Amro)*

Nevertheless, psychiatrists stressed that they would not impose religious treatment on their patients. Still, if patients already said that they are utilising religious therapy, we usually accept and do not object to that but within safe boundaries:

*We recommend not to go to a healer for Jinn possession. Still, we usually say that our treatment does not contradict them reading the Qur'an and doing Ruqyah for themselves as long as they are not harming themselves. However, they should also receive medical treatments, which go hand in hand. (Dr Mona)*

The psychiatrist here feels they have the power to be the arbiter of the decision because of how she stated her view – i.e., “we recommend” and “within safe limits...”. However, her view showed a possible opportunity for collaboration, where a patient might be referred for religious counselling/treatment to accompany psychiatric treatment.

In addition, all the participated psychiatrists do not believe there is a correlation between Jinn possession and mental health problems, although they believe as Muslims of the existence of Jinn. They usually view patients who think that jinn possessed them as patients suffering from a delusion which should be treated if they fit with the psychological disorders' criteria.

*I am entirely against the concept of Jinn possession. I do not believe that it is accurate and possible to happen. (Dr Mohammed)*

*I do not believe there is a correlation between Jinn possession and psychiatric diseases since there is no scientific evidence of Jinn possession, and those who think that Jinn possessed them are suffering from delusions and should be treated. (Dr Amro)*

### **Correlation Between Faith Healing and Psychiatry**

Psychiatrists said that there are no similarities between psychiatric treatment and faith healing since faith healers are dominant in their treatment as they are the ones who do Ruqyah and give orders to the patient. Hence, the patient's role in the treatment is passive, while in psychiatry, the patients interact with psychiatrists and decide with them on the suitable treatment method.

*Faith healers are authoritarian in their work as they do everything, and the patient is passive. At the same time, the situation is completely different in our work as the patient is active and has a role in their treatment. (Dr Mohammed)*

However, this may only be a subtle distinction because, as mentioned earlier by a psychiatrist when he pointed out the passivity of the patient's role during treatment, mentally ill patients cannot tell their problems, indicating a good deal of passivity.

Other psychiatrists mentioned that the two fields are not comparable in any perspective as their work is not based on evidence as no research has been conducted to prove their effectiveness. In contrast, psychiatry is based on evidence from scientific research.

All the participants stated that they have never communicated with faith healers, so they have no relationship with any faith healer in Kuwait.

*I have never communicated with them, and I do not recommend approaching them. (Dr Sumayah)*

Furthermore, they confirmed that they have never referred any of their patients to faith healers as this could be fatal as they do not know what could happen to them there. Therefore, whenever they experience difficulties handling cases, the psychiatrists said they would often consult their colleagues. In some mental disorders, it is expected to have relapses, and the prognosis of some psychological disorders is known.

*If I face difficulties in managing a case, I usually go to my supervisor and our consultants, so we work as a team. Hence, there is no issue with refereeing patients to our colleagues as others may have more experience. Still, I wouldn't refer my patients to a faith healer who has never communicated with them. (Dr Mona)*

*We know in psychiatry that some cases are resistant, and the prognosis is low. For instance, in schizophrenia, one-third of the patients will need chronic hospitalisation as we are afraid they would harm themselves and the people around them. (Dr Ihab)*

Nevertheless, several psychiatrists declared that they are receiving patients referred by faith healers.

*No, I have never referred any of my patients to faith healers to receive treatments from them, but the opposite is true. I have some patients who have been referred to me by faith healers. (Dr Salamah)*

On the other hand, few (two) psychiatrists viewed faith healing as different but complementary since psychiatric treatment concentrates on the proximal cause of the disorder, such as neurological cause. In contrast, faith healing has a broader perspective and deeper view, concentrating on spiritual reasons. This appears to be their philosophical view of what they believe about mental illness and spirituality rather than anything they can (or choose to) put



into practice in care because, as they declared previously, they never communicated with faith healers.

### **Willingness Towards Collaboration Between Faith Healing and Psychiatry**

Five psychiatrists hesitated towards the idea of collaborating with faith healers. However, psychiatrists admitted that many psychiatric patients are visiting faith healers. Psychiatrists emphasised that it is impossible to collaborate with faith healers to treat patients who have already been diagnosed with a mental health condition, such as schizophrenia. Still, it might be possible with particular conditions, such as dissociative disorder that can be treated with talk therapy.

*I am reluctant to collaborate with them, especially for patients diagnosed with a psychiatric condition such as schizophrenia. But sometimes, it is possible to negotiate the collaboration idea with the faith healers in cases such as dissociative disorders. (Dr Mohammed)*

Some participants put a condition to work with faith healers, which is to research their work to prove its effectiveness. Others welcomed the faith healer's contribution to their treatment with the rigorous supervision of psychiatrists.

*Before deciding to collaborate with them or not, we must first conduct scientific studies on their ways of treatment to ensure their effectiveness. (Dr Amro)*

### **Obstacles Preventing the Collaboration Between the Two Fields**

According to the interviewed psychiatrists, each side is attached to his method of treatment and believes in the effectiveness and superiority of his approach, so each side will try to dominate the collaboration leading to an unsuccessful partnership.

*Indeed, many health professionals are still resistant to permitting space to give room for faith healing to work with them in harmony with balanced tasks and roles. (Dr Hazem)*

Some psychiatrists feel they are dealing with people from an unknown field, so they cannot trust them. They are afraid of the abuses that could happen to their patients.

*We do not know what is happening there. Are they good people or bad? And how exactly are they treating people? We are ignorant about them, so I am worried if abuses could happen to our patients by them. (Dr Mohammed)*

As clarified by some participants, no previous interaction happened before, so they had no experience in how to formulate the strategy of the collaboration process. Five participants refused to learn faith healing practices which hinders forming such collaboration.

*I totally refuse the idea of learning the faith healing approaches. (Dr Sumayah)*

### **Proposed Ways of Establishing the Collaboration Programme**

The participants recommended multisectoral cooperation between the Ministry of Islamic affairs and the Ministry of Health to select qualified faith healers and qualified psychiatrists to launch the foundations of the collaboration project.

*The optimum way to establish such collaboration is to have multisectoral cooperation between the Ministry of Islamic affairs and the Ministry of Health. (Dr Salamah)*

Psychiatrists thought that joint meetings and conferences must be organised and conducted to learn from each other and share knowledge.

*We need frequent meetings with them to learn from each other and share knowledge, and we should launch workshops to educate each side about the others' treatment approaches. (Dr Salah)*

The participants recommended that collaboration is under thorough supervision with frequent meetings to ensure no harm to patients. According to psychiatrists, the partnership could be established by having faith healers in their hospital with obliged tasks. For example, patients

might prefer to receive faith healing in the hospital so the faith healer inside the hospital, under supervision, could see them and perform their work.

*The only possible way is to have faith healers in our hospital, so we have control over their work and perform their work under our medical supervision. (Dr Mohammed)*

Two participants mentioned that faith healers could collaborate with psychiatrists on particular tasks, such as offering an additional service in the rehabilitation stage of the treatment process of the addicted patients.

*If some patients ask for a faith healer to perform Ruqyah on them, we can provide this additional service as a psychotherapy intervention through a faith healer who works inside our hospital. (Dr Fuad)*

### **Expected Outcome on Patients from Such Collaboration**

Three psychiatrists thought that if the collaboration is established, the outcome probably will be positive as some patients will receive more convincing and preferable ways of treatment based on their culture. The faith healers would be educated after the collaboration so they will not diagnose their patients with Jinn possession, evil eye effect, and other common misconceptions. Patients will receive prompt medical treatment without excessive delay.

*The outcome is expected to be encouraging simply because faith healers, after being educated, will not diagnose their patients as possessed by Jinn or other misconceptions, ultimately treating their patients correctly. (Dr Sumayah)*

One of the participants said the consequences are unpredictable as there may be many hidden factors and unseen variables.

## **5.6. Summary of Thematic Analysis – Psychiatrists**

The participating psychiatrists have selected psychiatry as a profession to make a difference in the current situation where stigma surrounds psychiatry, help people with mental illness

significantly, and allow them to live a normal life. All psychiatrists agreed that they use the biopsychosocial approach. They look at the patients with a broad scope that encapsulate various components affecting the patient directly and indirectly. Indeed, psychiatrists believe that the cause of mental problems is multifactorial, so many genetic, biological, social, and environmental factors exist.

The psychiatrists expressed their non-satisfaction with the mental healthcare system in Kuwait as there is a shortage of psychiatric staff, and the mental health system is chiefly centralised around a single psychological hospital, the only place offering inpatient and emergency mental care services. Furthermore, the psychiatrists are aware of other sources of mental healthcare services in Kuwait, such as faith healers. Also, they admitted that many of their patients have access to faith healers before visiting them. Psychiatrists emphasised that stigma is one of the main barriers to accessing their hospital. The other main reason for the underutilisation of mental health services in Kuwait is the low education level among some people.

The psychiatrists have never communicated with faith healers, so they have no relationship with any faith healer in Kuwait. Furthermore, they have never referred any of their patients to the faith healers as this could have a severe negative consequence since the psychiatrists in this sample did not trust what could happen to the patients there. Indeed, psychiatrists believe that the two fields are not comparable. Faith healing practice, for them, is not based on evidence as no research has been conducted to prove its effectiveness. Nevertheless, psychiatrists declared that they are receiving patients referred from faith healers.

The psychiatrists were reluctant to collaborate with faith healers. The obstacles from their point of view could be because no previous interaction happened before, so they have no experience on how to formulate the strategy of the collaboration process. However, psychiatrists gave their recommendations and suggestions regarding the collaboration idea as they recommended having multisectoral cooperation between the Ministry of Islamic affairs and the Ministry of Health to select qualified faith healers and qualified psychiatrists to launch the foundations of the collaboration project. They also stressed that joint meetings and conferences must be organised and conducted to learn from each other and share knowledge. However, psychiatrists put some conditions to accept the idea of collaboration as they emphasised having faith healers in their hospital to collaborate with obliged tasks. The collaboration process should be under

thorough supervision. Finally, psychiatrists think that if the collaboration is established, the outcome probably will be positive as some patients will receive more convincing and preferable ways of treatment based on their culture.

## **5.7 Reflections on Faith Healing and Psychiatry**

As a person living in Kuwait, where stigma is attached to mental health problems, I witnessed how people suffer silently from mental health issues on various occasions. Realising the stigma toward psychiatric settings started early in my childhood. During my childhood, I understood from the community that people with mental illness were “abnormal,” and we should avoid them as they are dangerous. I received misleading messages from the community directly and indirectly. For example, several famous TV programmes and TV series in Kuwait portrayed the psychiatric hospital in Kuwait as a place where crazy people are detained. I always felt threatened by people with mental illness. In the nineties, when I was around 6 to 16 years old, it was common to find people in the street labelled as crazy because their relatives abandoned them to be homeless simply because they did not believe they could be healed. I experienced such a situation as a man in our neighbourhood with a mental health condition was living in our street, lying on the pavements with dirty clothes. His family lived on the same street, but they thought there was no treatment for him. We used to call that man crazy, but I felt sorry for him. At the same time, I cannot deny that I was afraid of him. Another man, one of our relatives, was almost experiencing the same situation. When I asked about his problem, the only answer I got was that he is crazy, there is no cure for his condition, and I should avoid him as he is a dangerous man. Therefore, the picture built in my mind about psychiatry in my childhood is that psychiatry is crazy, dangerous, and unsafe.

The other important thing related to psychiatry is the firm belief among the people who surround me about the existence of Jinn. They believe that Jinn possession is real and the cause of mental disorders. I remember it is common to hear stories about Jinn in some family gatherings, and some family members mention that they have seen a Jinn with their own eyes. Even the students at my schools usually discussed incidences among their family members regarding Jinn possession. I was frightened from hearing such stories. Moreover, there is a strong belief in the evil eye as I was informed since I was young that people might be envious of your belongings and your skills if they are exceptional and precious, which ultimately will

harm your health because of their evil eye. Therefore, I used to hide my valuable items and unique capabilities from others so I would be protected from their evil eyes.

I noticed during my childhood that if any member of my family had any mental illness, such as feeling depressed or unable to practice their life normally, the typical solution chosen by the sufferer or their relatives is to read Qur'an and perform Ruqyah. Furthermore, if the situation worsens, the following solution is accessing a faith healer to practice Ruqyah on the sufferer. From my observation, the process of approaching the faith healer by my family is usually started by attempting to choose the proper faith healer. Hence, they try to look for a faith healer with a good reputation. One of my cousins travelled with his father to Saudi Arabia as he was informed that there was a faith healer there who could help him with his mental health problem since he is an expert in practising Ruqyah. Also, it is worth mentioning that in our home and almost all the houses of our family, there will be water or oil purchased from a faith healer, and usually, a small quantity is reserved to be used when needed. Indeed, my mother used to give that water to me and my sisters and brothers, particularly during our exams when we were students because she was afraid of the evil eye as we always got high marks in school exams.

I had experienced accessing faith healers several times with my family when a member of our family faced mental health problems. As mentioned earlier, the first step is to choose the faith healer. This step can be achieved by asking relatives and friends with previous experience with similar mental health problems and have experience with faith healers to give their recommendations. After that, the second step will be contacting the faith healer to make the appointment, which is usually done by telephone. From my experience, most faith healers are very flexible with their appointments, and the appointment can sometimes be taken on the same day as the contact. Faith healers practice their religious ways of treatment in a regular house or a mosque. In the case of female faith healers, they practice their faith healing approaches only in homes and men are not allowed to enter the house, so they only treat female patients or children. From my experience, those who practice faith healing at regular dwellings will have a waiting room where patients and their relatives sometimes wait for a long time. In a mosque, it is more organised. There are appointments, so no aggregation of the patients and their relatives will occur inside the mosque. This is important because the mosque is mainly a place to perform prayers, so faith healers are eager not to disturb the prayers.

From my experience, the faith healer starts the process by initially taking the patient's history. They would usually reassure the patient and then start the faith healing treatment. Faith healing is performed by reciting particular verses from the Qur'an. Some faith healers put their hands on the head of the patient while reciting the Qur'an. This takes around 15 minutes and sometimes more depending on the patient's response since faith healers usually ask the patients if they felt some relief after reciting the Qur'an. If not, they continue until the patient is satisfied. In the end, the faith healer usually talks with the patient and their relatives, informs them about the patient's condition, and gives them the diagnosis, if possible, at the first faith healing session.

The diagnosis generally is either that the patient is suffering from Jinn possession, the impact of the evil eye, or sorcery. Furthermore, the faith healer typically gives their decision about the next appointment and the whole schedule of the treatment process, and often recommends purchasing water or oil from them and informs the patient when and how to use them. The faith healer typically does not ask for money for their consultation, but they put a donation box next to the exit door and explain to the visitors that the donation is not mandatory. This could be related to the unofficial recognition of their work, as they are afraid of any ramifications by law. They only request their visitors pay for the water and any purchased product. From my experience, most of the visitors' regular donation amount is roughly between £25 to £50. It is crucial to highlight that faith healers sometimes advise their patients to access mental health services when they think the patient's problem is unrelated to Jinn possession or sorcery. I witnessed such a case when one of our family members contacted a faith healer to help him with his problem. After performing the faith healing approaches, the healer informed his patient that his problem was not because of the evil eye or Jinn but because the patient was facing a difficult time in his life. He needs to be examined by a psychiatrist.

During my study at Kuwait University, where I obtained my bachelor's degree in medicine, there were various moments when I felt depressed and unable to study and enjoy my life. This could be because studying medicine generally is challenging and stressful, and medical students typically face difficulty in making studying medicine enjoyable and joyful. I remember having problems sleeping, particularly during exam week. I thought of taking sleeping pills. However, I always reject these thoughts in my mind and think of reading Qur'an and practising some Ruqyah. Deciding to choose the religious way might be related to the influence of my family and the community on me. Although I was a medical student aware of

the medical treatments, I still preferred the religious approaches. The religious way of healing to relieve the stress primarily positively impacted me. However, there was one occasion when I accessed the primary healthcare centres to visit the GP and take his advice regarding my difficulties with sleeping. I remember the GP reassured me that this is normal to occur to students and that I must not be worried about that, and he prescribed me some medications customarily used to treat allergies, but it could help in sleeping, as he said. Having mentioned that, there were always disputes in my mind regarding accessing the psychiatric facilities as I was afraid of the stigma attached to them. Thus, I used to prefer the religious way of treatment.

On the other hand, the situation changed significantly about psychiatry in the last decade in Kuwait. Mental health awareness campaigns were conducted in Kuwait to tackle the stigma toward psychiatric settings and to raise awareness about psychological illnesses. Furthermore, the Ministry of Health in Kuwait integrated the mental health services in the primary healthcare centres, which led to increased utilisation of mental healthcare services. Indeed, people have become more aware, particularly among the educated people who became more encouraged to talk about their mental health problems. My family members, and friends, particularly youths and those under 50 years old have become more open to psychological issues during the last decade. Indeed, there were various moments where a discussion happened in my family about the effectiveness of psychiatric medications and the scientific way of treating mental conditions. As a medical doctor, I have been contacted several times, especially in the last five years, by members of my family, my friends, as well as our neighbours to ask me about the effectiveness of psychiatric treatments, the side effects of psychiatric medications, and the possibility of being addicted to them. This indicates that people are more willing to access psychiatric care services and have accepted to utilise the mental health services.

Throughout the years, I had the chance to accompany some family members to psychiatrists. Because I am a medical doctor, they trust me and are more confident in accessing mental health services with me. Most of them prefer to choose private clinics to access a psychiatrist, which might indicate that stigma still exists, and it deters accessing the psychiatric hospital where the chance of being noticed is higher. Another observation is the high cost of the consultation in the private psychiatric clinics in Kuwait, which is around £250 for a single consultation that lasts 45 minutes. This amount of money is not affordable to all Kuwaiti citizens. It might prevent some of them from accessing psychiatric healthcare centres and encourage them to utilise other approaches like faith healing.



A private psychiatric clinic is generally a modern place with a well-organised appointment system; thus, the waiting time is relatively short. In the clinic, highly professional staff nurses initially take vital signs and measure weight. Afterwards, the assisting nurse staff invites the patient and their companions to the psychiatrist's room. The psychiatrist's room is usually very spacious with modern furniture. After welcoming the patient with kind and gentle words, the psychiatrist gives approximately 30 minutes for the patient to talk about their problem. The psychiatrist generally shows empathy when the patient expresses their sufferings. The last 15 minutes is for the psychiatrist, who will interpret the situation for the patient and give them their diagnosis if possible. Also, the psychiatrist might request some investigations to be done. Ultimately, the psychiatrist will negotiate with the patient the treatment plan. I notice that psychiatrists are flexible with their treatment plans. They give their patient the chance to discuss and express their worries about the treatment choices. After reaching a satisfactory solution, the psychiatrist will mention all the advice and precautions regarding the chosen treatment and give the patient a second appointment after four weeks, informing the patient that they can come at any time before the meeting if needed. I have noticed that some psychiatrists give their patients their personal telephone numbers to contact them directly in case of any side effects of medications or any other emergencies. I remember one of my relatives contacted his psychiatrist because of some side effects of recently prescribed medications. My relative called his psychiatrist through WhatsApp since he was on vacation and abroad, but the psychiatrist answered his call and helped him. Also, I notice that some psychiatrists do not recommend to their patients to utilise religious treatments, but they do not contradict it. For instance, I remember one patient that I accompanied during his consultation. He mentioned reading the Qur'an and performing Ruqyah to relieve his mental pain. The psychiatrist replied that it is acceptable to do that, and he is not against it as long as it has a positive impact, and the patient continues to receive medical treatment.

Talking about the public sector, I also have some experience accessing them to help some relatives with their mental health conditions. The psychiatric hospital is the only hospital in Kuwait that offers in-patient hospitalisation for psychiatric patients, and emergency mental healthcare is available only in it. The hospital is in the Alsabah health area, in the centre of Kuwait, to be accessible to all people. Nevertheless, the psychiatric hospital is not overcrowded, which could be related to stigma. Moreover, I noticed some patients wear black sunglasses so that they won't be recognised. Also, I saw some patients' relatives visit the

hospital to take their medications. Another observation is that those who access the private clinics generally take their drugs from the public sector as these medications are quite expensive in private pharmacies. The same medications are free of charge and available in the public sector. Therefore, the most crowded department in the hospital is the pharmacy. The waiting time to receive medication from the pharmacy sometimes extends to an hour. Talking about the service provided in the hospital from my observation, the hospital generally is a proper place, well-structured as recently refurbished and has spacious rooms for out-patient consultations. The appointments can be taken within weeks. The psychiatrists in the psychological hospital deal with their patients in a friendly way and plenty of time are given for consultations. The psychiatrists prescribe all the needed psychiatric medications to their patients as they are available in abundant quantities in the hospital pharmacies.

## **5.8 The Impact of the Collaboration on Stigma in Kuwait**

Firstly, it is crucial to recognize the high pervasiveness of stigma towards psychiatric settings in Kuwait. In fact, within Arabic communities, those who suffer from mental health problems are commonly stigmatised, disregarded, and ridiculed. The reason is that mental illness has been typically connected to evil forces, the evil eye, malevolent magic, violence, addiction, suicide, and sin (Pridmore and Pasha, 2004). This will lead to guilt and shame when family members are affected by a mental disorder, neglect the mental problem, and do not receive treatment (Farooqi, 2006). Indeed, mental health services in Kuwait and the Middle East are regularly stigmatised, and not only the patients are stigmatised from accessing the psychiatric settings, but also their families and the mental healthcare providers are stigmatised (Scull et al., 2014). This stigmatisation is a serious issue because it discourages people from accessing mental health services. Indeed, stigmatisation made mental treatment a challenging task in Kuwait and the Middle East since psychiatric patients, and their relatives commonly refuse to be referred to mental health services (Scull et al., 2014). A study by Alansari et al. (1990) showed that only 0.3% of Kuwaiti patients accepted the referral to mental healthcare facilities. The delay in obtaining prompt mental healthcare and therapeutic medicine is closely related to the poor prognosis of psychiatric diseases. Indeed, the outcome and the consequences of such delay could be harmful and destructive in terms of having high relapse rates, unsuccessful treatments, and deterioration in cases (Burns and Tomita, 2014).

The finding of this study correlate considerably with the significant impact of stigma on the Kuwait's mental health situation as the participated faith healers in this study believed that people avoid approaching psychiatric health services because of the stigma attached to them. They said there is a shared sense of embarrassment and disgrace towards accessing mental health services. They pointed out that if people decided to approach mental healthcare centres and been noticed and recognised by others, that would probably affect their status and label them as abnormal people, which eventually might affect their life in different manners, such as the inability to get married. Moreover, the participated psychiatrists agreed on the impact of stigma as they emphasised that stigma is one of the main barriers hindering accessing their hospital. They pointed out that stigma is a serious issue here in Kuwait and most Arabic countries since the cultural and traditional belief of shame and disgrace toward visiting psychiatrists is high in Kuwait. They elaborated that people avoid accessing psychiatrists because they are afraid of being identified by others, mainly because Kuwait is such a small country, and usually, people are interconnected.

This study developed a proposed mechanism of establishing the collaboration between the two side, and found out that one of the crucial advantages of having such a partnership is improving the utilisation of mental health services, as people commonly avoid approaching psychiatric services because of the attached stigma. Therefore, the collaboration would help bring mental health services to more culturally accepted settings by working closely with the faith healers who perform culturally constructed treatment methods. Indeed, biomedical treatments could be more acceptable, particularly among those firmly connected to faith healing practices as they consider allopathic medicine culturally foreign. That is to say, the positive outcome of establishing the collaboration is improving access to mental health services by reducing the stigma surrounding it. Indeed, a study conducted in India to investigate the role and the functions of religious and spiritual healing practices in managing mental illness found that religious and spiritual healing practices if integrated into the psychiatric settings, will not only provide complementary mental healthcare but also reduce the stigma attached to psychiatric settings (Ramakrishnan et al., 2014). The study has also recommended teaching the spiritual healing methods in the Indian medical teachings curriculum and establishing healthcare programmes within the hospitals that offer spiritual healthcare services to enhance the utilisation of mental healthcare services and overcome the

stigma issues. In fact, there are motivating and encouraging examples of collaboration processes between traditional or religious treating methods and biomedical approaches in different countries such as China and India, and the collaboration outcome showed a positive impact in improving the utilisation of mental health services and alleviating the stigma surrounding it (Thirthalli et al., 2016).

## **5.9. Conclusion**

This chapter on findings revealed and described the different methods of faith healing practices in Kuwait, particularly Ruqyah practice, which is considered the primary method of faith healing treatments, and psychiatric practices. Faith healers and psychiatrists showed similar perspectives in believing their work is humanitarian that helps people who are stigmatised because of their mental illness. The faith healers in Kuwait are motivated and willing to collaborate with mental health professionals as they think such collaboration will yield more comprehensive and convincing mental health services in Kuwait. However, they recognised the reality of barriers to establishing such a partnership, such as the unofficial recognition of faith healing practices, inherited disrespect, and mistrust among mental health professionals. In contrast, the psychiatrists were hesitant to collaborate with the faith healers because they only trust and believe in practices based on scientific evidence. However, psychiatrists admitted that many patients had prior access to faith healing centres.

Both sides suggested that the collaboration must be established under the supervision of multi-sectorial official authorities' partnerships, such as the Ministry of Health and the Ministry of Islamic affairs. The faith healers were more unrestricted towards collaboration. At the same time, psychiatrists could only accept the collaboration concept if they dominated the work and the mutual work became under thorough supervision from their side.

## **Chapter 6**

### **Theoretical Discussion**

#### **6.1 Introduction**

This research was conducted to explore and examine the views of faith healers and mental health professionals on collaborating to provide mental healthcare in the context of Kuwait. This discussion chapter aims to find interpretations of what this study's findings mean and why the findings matter. The discussion helps to reach a new understanding of the research problems being investigated. Basically, the focus of this chapter is to explain and evaluate what has been found and discovered and ultimately connect the obtained interpretations to what has been discussed in the introduction and the literature review to move the reader's understanding of the research argument forward and to help to answer the research questions. The research questions of this study are:

#### **Main Question**

What are the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait?

#### **Sub-questions**

What constitutes faith healing?

What is the role of faith healers in providing mental healthcare?

What is the role of professional mental health service providers?

What are the commonalities and differences between faith healing and professional mental healthcare?

What mechanisms establish collaborations between official mental health service providers and faith healers?

In this chapter, mental health in Kuwait will be examined thoroughly to help answer the research questions about the role of faith healers in providing mental healthcare and the other research question regarding the role of professional mental health service providers in delivering mental health healthcare. In addition, the understanding of mental health problems understood by faith healers and psychiatrists will be examined to comprehend what constitutes

faith healing and to recognise the role faith healers and psychiatrists play in providing mental healthcare. Also, by reviewing the understandings of mental health problems understood by faith healers and psychiatrists, the commonalities and differences in faith healing and professional mental healthcare can be recognised, thus helping to answer the research questions of this study. Lastly, in this chapter, the interactions between faith healers and psychiatry will be investigated to determine the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait.

## **6.2 Examining Mental Health in the Context of Kuwait**

As mentioned in Chapter 3, about one-third of Kuwaitis are diagnosed with psychiatric conditions, as declared in November 2015 by Dr Khalid Al-Sahlawi, the Undersecretary of the Ministry of Health of Kuwait (Abdelmaaboud, 2015). In addition, a study done in one of the primary healthcare facilities in Kuwait revealed that 42% of Kuwaiti patients who regularly attended that primary healthcare centre complained of mental morbidities (Al-ghadhari et al., 2016). In fact, according to WHO, mental conditions are causing 20% of the disease burden in Kuwait (WHO, 2011). The former statistics show how common mental illness is in Kuwait. Nevertheless, despite the high prevalence of mental disorders among Kuwaiti, people in Kuwait commonly avoid accessing mental health services. Thus, mental health services tend to be inadequately approached (Almazeedi and Alsuwaidan, 2014). The main reason behind the low utilisation rate of mental health services in Kuwait is related to the stigma attached to psychiatric settings (Almazeedi and Alsuwaidan, 2014; Scull et al., 2014). Indeed, stigmatisation made mental treatment a challenging task in Kuwait and the Middle East since psychiatric patients, and their relatives commonly refuse to be referred to mental health services (Scull et al., 2014). A study by Alansari et al. (1990) showed that only 0.3% of Kuwaiti patients accepted the referral to mental healthcare facilities. The delay in obtaining prompt mental healthcare and therapeutic medicine is closely related to the poor prognosis of psychiatric diseases. Indeed, the outcome and the consequences of such delay could be harmful and destructive in terms of having high relapse rates, unsuccessful treatments, and deterioration in cases (Burns and Tomita, 2014). Thus, the chief action to alleviate mental health problems' adverse and harmful outcomes is rapid detection and early medical intervention. As a result, the identified hindrances of approaching and utilising mental health services in Kuwait must be mitigated. Kuwait is a wealthy country and its high-

income status allowed the Kuwaiti government to establish a high-standard healthcare system where all citizens have free access to all health services. Indeed, Kuwait's government has spent a lot of its income on the health sector. Consequently, advanced accessible mental health services were developed in Kuwait. Nevertheless, faith healers remain a significant component but unofficial within the healthcare system of Kuwait in the provision of healthcare services. People habitually seek help from faith healers for conditions that are, from medical perspectives, recognised as psychiatric disorders.

Not only do people from developing countries use traditional treatments, but even in high-income and developed countries, a significant minority of the population frequently utilises traditional healing practices. Indeed, accessing traditional healers for mental help and services have been recognised among North American Indians, Chinese immigrants in Canada, Pakistanis in Britain, Bangladeshis in London, Turkish people in Germany, Hispanics in the United States, southeast Asian refugees in the United States, and Muslims in the United Kingdom (Nortje et al., 2016). Since many people in developing countries rarely approach formal mental healthcare facilities, traditional healers will remain an effective alternative to professional mental health service providers.

Although there is a current dispute about the legitimacy and validity of traditional healing practices, several countries have acknowledged the potential role that traditional healers could play. They have worked to integrate their practices within their official healthcare system. In Zimbabwe, a controlled study was conducted to compare the outcomes among traditional healing practices, primary healthcare services, and private general healthcare services, using a validated questionnaire at 1 and 12 months. Results revealed no significant difference between the three approaches to alleviating the symptoms of the common psychiatric diseases (Nortje et al., 2016). Although the study has shown no significant difference between the different approaches, people tend to perceive better improvement by visiting the traditional healers. Also, a controlled study was done in Puerto Rico on patients complaining of similar problems. Some have accessed faith healers, while others decided to receive psychotherapy to evaluate and assess the outcome of treatments of each group in terms of problem resolution or symptom alleviation. The study revealed that those who visited faith healers had a better effect than those who sought help from psychotherapists, which is mainly related to pre-existing expectations (Nortje et al., 2016). The previous two controlled studies have shown that traditional healers could play a possible role in assisting

healthcare services, particularly for psychosocial and neurotic complaints. Still, these results can't be generalised to all cultures (Nortje et al., 2016). There are several reasons why people might choose to access traditional practices, including dissatisfaction with biomedical treatments either because of their side effects or their ineffectiveness, the congruency of traditional medicine with people's beliefs and understandings of health, and the perceived relief after utilising the traditional medicine. The safety and the efficiency of traditional practices and methods are under scrutiny, and the biomedical standards assess them. Some traditional practices for specific health issues have provided safe and effective healthcare. For instance, St. John's wort for major depression, acupuncture for labour pain relief and for managing chronic low back pain, garlic for reducing hypercholesterolemia and other several traditional treatments are currently considered evidence-based treatments (Al-Rowais et al., 2010).

Living in Kuwait, I witness how people silently suffer from mental health issues on various occasions where stigma is attached to mental health problems. The realisation and the sense of stigma toward psychiatric settings started early in my childhood. During my childhood, I understood from society that people with mental illness are "abnormal" people, and we should avoid them as they are dangerous. I received misleading messages from society directly and indirectly. For example, several famous TV programmes and TV series in Kuwait showed the psychiatric hospital in Kuwait as a place where the "Majaneen" or crazy people are detained. I always felt threatened by the existence of people with mental illness. However, the situation changed significantly about psychiatry in the last decade in Kuwait. Mental health awareness campaigns were conducted in Kuwait to tackle the stigma toward psychiatric settings and to raise awareness about psychological illnesses. Furthermore, the Ministry of Health in Kuwait integrated the mental health services in the primary healthcare centres, which led to increased utilisation of mental healthcare services. People became more aware, particularly among the educated people, who became more encouraged to discuss their mental health problems. My family and friends, particularly youths and those under 50 years old, have become more open to psychological issues during the last decade. Indeed, there were various moments where a discussion happened in my family about the effectiveness of psychiatric medications and the scientific way of treating mental conditions.

The psychiatrists in this study described the mental health status in Kuwait as they defined their work: a humanitarian job that helps very neglected people. Psychiatrists pointed that



they selected psychiatry as a profession to make a difference in the current situation where stigma surrounds psychiatry and to have the chance to change that and help people with mental illness in a significant way and allow them to live a normal life.

It is crucial to highlight the historical root of traditional medicine within Kuwaiti society to understand its role in providing mental healthcare. Historically, the north part of Kuwait was considered a part of ancient Mesopotamia (Macmillan, 2016). During the Ubaid period (6500 BC), Kuwait was the central area of contact and communication between the people of Mesopotamia and Neolithic Eastern Arabia, located near Bahra in Subiya (Robert, 2002). The earliest evidence of human inhabitants in Kuwait dates back to 8000 B.C. when Mesolithic instruments were detected in Burgan. In 2000 B.C., the people of Mesopotamia first inhabited Failka, which is one of the Kuwaiti islands. Indeed, this island contains numerous buildings designed in a Mesopotamian architectural way like those located in Iraq since 2000.C. (Robert, 2011).

Mesopotamia, an ancient region in Southwest Asia, lasted for over ten thousand years and had been named the Cradle of Civilisation. This is because the people here lived in a productive and fertile environment in the Mesopotamian lands, enabling them to develop a system of writing and build the first cities of the world. During the fourth millennium BC, Sumer adopted their language in the region and created the first civilisation of human beings. The following great civilisation established in this region was the Babylonian civilisation with their well-known and eminent king of the old Babylonian dynasty, Hammurabi, who reigned from 1728–1686 BC. Hammurabi created a collection of laws called the Code, which contained 17 laws that regulated medical practices. These laws determined whether medical practitioners were rewarded or punished based on their treatment effects. Another ancient medical knowledge came from Nineveh around 700 BC. Several stomach health problems were identified, and various therapeutic medications were recommended.

The actual start of medicine is unclear and can't be precisely identified within history. However, archaeological evidence suggested and pointed out that ancient Mesopotamian medicine existed, and it was linked mainly with religion and magic. Three chief evil gods were considered accountable for the diseases: the demon of liver diseases, the demon of abortion and infant mortalities, and the demon of phthisis (tuberculosis). Healing approaches were mostly either religious-based treatments or sorcery. Indeed, during the Mesopotamian era, including the Sumerians, Amorites, Babylonians, and Assyrians, surgical operations were

done, wounds were cleansed and covered with bandages, and numerous remedies were utilised, from prunes to lizard droppings. Each remedy was used for a specific disease, and medical treatments were usually linked with chants and incantations (Sağlamer, 2013).

In Mesopotamia, various treatment methods ranged from formulations using materials from plants, animals, and minerals, to ritual practices or incantations for spirits or gods to obtain treatments and maintain good health. The therapeutic texts show that curative tools mainly consisted of magical and medical treatments. Moreover, the religious treatment was performed through prayers, recitation, and sacrifices to gods for cures. However, pharmacological drugs were used as part of the medical treatments. There were clay tablets which demonstrated different diseases, their identified symptoms, diagnosis, methods of treatment, and prognosis. In addition, the clay tablets also showed lists of medications and drugs and the proper way of taking them. Plants, animal elements, and minerals were used to produce the medical preparations. They were administered orally or applied as ointments, blown into orifices, inhaled as steam, and given as suppositories and enemas. The therapeutic agents were utilised based on religious ceremonies, the exact time of the day, and the positions of constellations (Sağlamer, 2013).

Having discussed the Mesopotamian history, which could represent one of the historical roots of medicine in Kuwait, it is crucial now to examine the Islamic influence on the traditional medicine of Kuwait since Islam is the religion of the vast majority in Kuwait. Many people in Kuwait with mental health conditions rely on their religious beliefs to cope (Scull et al., 2014). A study done in Kuwait posited that faith healers are a vital source of mental healthcare for many patients since stigma surrounds psychiatric settings (El-Islam, 2008). Islam plays a crucial part in assisting Muslim patients to overcome the stress of life challenges, which ultimately help prevent and treat depression (Sabry and Vohra, 2013). *“So, verily, with every difficulty, there is relief: Verily, with every difficulty there is relief” (Qur’an, 94: 5–6)*. Islam motivates Muslims to remain positive and optimistic, particularly when they face terrible problems and difficulties in life, since God’s mercy will support and protect them at all times. *“And never give up hope of Allah’s soothing Mercy: truly no one despairs of Allah’s soothing Mercy, except those who have no faith” (Qur’an, 12:87)*.

Like other religions, Islam provides its followers with several practices that act as coping tools against life stressors and adversities, thus alleviating anxiety and preventing their mental state from deteriorating. Some of these practices in Islam are praying five times a day,

fasting Ramadhan, ablution, reading the holy Qur'an, and supplicating to God. The Holy Qur'an (2: 153) states: *"You who believe! Seek help in patience and prayer. Truly! Allah is with the patient believers."* And: *"Those who believed in the oneness of Allah (Islamic Monotheism), and whose heart find rest in the remembrance of Allah: verily, in the remembrance of Allah do hearts find rest"* (Qur'an,13: 28).

A study examined the impact of Qur'anic therapy and its role in mitigating psychosocial problems. The study was done on a random group of participants (121 patients) of both genders (Saged et al., 2018). In this study, the Qur'anic therapy consisted of several sessions of listening to the participants' verses from the Holy Qur'an for a particular period. Then, the patients were given a remedy programme. The study aimed to determine the effectiveness of the Qur'anic therapy and explore patients' acceptability. The study has employed quantitative methodological approaches to achieve the validity and reliability of the research. The study's findings revealed that 92% of the patients had supported and accepted the argument that the Qur'an can offer an effective healing treatment. Moreover, those who frequently received Qur'anic therapy courses had been cured successfully, and 81.8% of the patients deemed the Qur'an capable of promoting health (Saged et al., 2018). This study has empirically supported the idea of the ability of the Holy Qur'an by only listening to its verses to elicit effective relief for those who complain of psychological problems. Moreover, the study asserted that patients must trust their healers to reach effective outcomes. In addition, the study emphasised the positive and significant correlations between willingness and effectiveness and the positive and significant correlations between effectiveness and responsiveness. Thus, patients who believe in the ability of the Qur'an and its role in their life would be willing to receive the Qur'anic therapy, and they tend to be satisfied with the outcome (Saged et al., 2018).

Similarly, a study conducted to examine the relationship between Islam and mental health found that most Muslims living in the United Kingdom believe in the effectiveness of prayers in managing depression. Furthermore, Muslims consider Islam vital in regulating every aspect of life (Abdel-khalek, 2011). The study argued that prayers are mainly focused on the mind. Thus, it leads to distracting and preventing the mind from perceiving discomfort and pain. Moreover, the physical performance of prayers by taking postures and movements contributes to relaxing the body (Abdel-khalek, 2011). Based on the attachment theory by John Bowlby, having a constant and stable attachment is effectively related to maintaining

good mental health status, with the more excellent capability of coping with stress, enhancing productivity through robust relationships, and promoting self-esteem (Sabry and Vohra, 2008). Therefore, establishing a strong and solid attachment with God is associated with more functioning life and stable psychosocial life:

*“... And whosoever puts his trust in Allah, then He will suffice him...” [Qur’an, 65:3].*

Various types of research conducted on participants following different religions showed that those who are religiously bounded and obliged to their faiths tend to have more stable mental and physical health. Indeed, the studies on Islam found the exact correlation between practising the Islamic faith and better mental health. Thus, it can be said that there is a positive relationship between being religiously devout and having a healthier life (Abdel-khalek, 2011). Indeed, Islam provides Muslims with the appropriate tools, by the Islamic values and practices, to help them handle life stressors and harsh circumstances.

Additionally, in psychiatry, the association between religiosity and compliance to biomedical treatments has been investigated, where studies were conducted to evaluate the associations between mood disorders and drug addiction (Borras et al., 2007). Indeed, the studies revealed that the higher level of religiosity is related to the higher tendency of patients to satisfy and adhere to the treatments. The positive association between the two factors (religiosity and adherence to treatment) can be understood by the contributions of that enhanced life’s quality, more social bonds, and more optimistic acceptance of the illness by believers. More evidence supports the positive relationship between religion and the improved ability of patients to cope with schizophrenia (Borras et al., 2007). Accordingly, religion, with all its related aspects to spirituality, concentrates on reaching decisive answers to life’s questions. Religiosity can be manifested by particular physical, societal, and ritual actions that can be considered beneficial for patients who suffer from the consequences of mental disorders. The former facts regarding the capability of religious beliefs and practices to enhance adherence to medical treatments should be applied and used in the clinical field when managing schizophrenia cases. Thus, psychiatrists who work on improving the compliance of their treatments, specifically with schizophrenia, should combine the religious components with their treatment plans and add them with the presentations of the illness (Borras et al., 2007). According to the psychiatrists who participated in this study, the Islamic culture influences their understanding of psychiatry as Islam gives keys to establishing stable mental health.

They argued that religion could play a role in psychotherapy since the spiritual approach can sometimes be used as a supportive therapy. Some psychiatrists stated that religion plays a significant role in the rehabilitation stage of the treatment scheme for the addiction. Islam's role in managing mental illness is undoubtedly more evident and recognisable among faith healers. According to the faith healers who participated in this study, their motivation to become a faith healer was to help people and let happiness enter their life to gain blessings from God for doing good deeds. They believed that reciting verses from the Qur'an and sayings from Prophet Muhammad to solicit Allah would help cure their patients' mental illnesses. They named their work Ruqyah and mentioned that the prophet and his companions performed the practice of Ruqyah for treatment. In the Qur'an, it was said that the Qur'an was sent down as a healing and a mercy to those who believe. The faith healers considered it crucial to have a solid belief in your heart about the value and usefulness of Ruqyah to make the treatment effective and gain a beneficial outcome.

Contrary to what is primarily known about Muslims' belief in mental disorders that supernatural forces cause these, it is worth mentioning that Islam makes it compulsory to attain proper treatment for illnesses. Islamic teachings encourage accessing health services for medical issues and medication adherence. Muslims believe in the importance of medications as Prophet Muhammed has taught them that Allah didn't send a disease unless a remedy has been sent down for it (Ateeq et al., 2014). Therefore, Islam promotes enhancing the range of knowledge about treatment remedies. An evidence of Muslims' positive attitude toward mental health treatment is that the first psychiatric hospital in the world was established during the golden era of Islamic civilisation in Baghdad, Iraq, in 705CE by Al-Razi, who is one of the most outstanding Islamic physicians (Sabry and Vohra, 2013). Al-Razi interpreted psychiatric disorders as physiological problems and introduced and discussed ideas such as the definition of mental illness and its symptoms as well as psychotherapy methods. Indeed, several psychiatric hospitals were instituted in Arabic countries from ancient times: Baghdad 705 A.D (during the monarchy of the caliph El Waleed ibn Abdel Malek), Cairo 800 A.D, and Damascus 1270 A.D (Tzeferakos and Douzenis, 2017).

Moreover, Ibn Sina, known as Avicenna in the West and one of the most outstanding Islamic physicians, rejected the idea that possessing Jinn would cause mental illness (Sabry and Vohra, 2013). But Islamic scholars at that time didn't contradict the concept of religious

counselling by faith healers. Nowadays, many Western countries are willing to incorporate Islamic psychotherapy within their strategies and evidence-based treatment. This is because of the studies that showed the effectiveness of Islamic cognitive therapies in treating and managing patients with anxiety and depression with results comparable with the Western cognitive methods (Sabry and Vohra, 2013). Similarly, a study conducted in Saudi Arabia revealed a significant impact of spiritual and cognitive therapies on patients with schizophrenia (Wahass and Kent, 1997).

The explanatory model of illness, which illustrates how a person understands and comprehend their illness, asserts the influence of cultural and social beliefs (Chilale et al., 2017). This model explained how people react to their illness according to their understandings and ideas about the causes of illness, its symptoms, and treatment options. According to the explanatory model of illness, help-seeking behaviour and utilisation of health services could be determined by the patients' actual understandings of illness (Abbo, 2011). According to Kleinman (1980), there is a difference between disease and illness as the disease is the biological fact that could be investigated and treated, while illness is the cultural domain of that fact. He also emphasised that social and cultural perspectives must be integrated to obtain effective healing practices. Derek Summerfield (2008) claims that the Western knowledge and interpretations of mental illness can't be functional and practical with individuals living in developing countries as their perspectives of mental health are culturally constructed since it is based on society and the current situation. He added that since the 1970s, ethnographic studies have shown that mental disorders' manifestations, pervasiveness, and attributions differ considerably between different cultures. Similarly, Pat Bracken (2014) argues that the complex structure and formation of human feelings, moods, thoughts, and behaviour can't be explained reductively by applying clinical neuroscience materials. He asserted that mental disorders are not only problems examined in laboratories but also have cultural and contextual contributory factors.

### **6.3 Understandings of Mental Health Problems Understood by Faith Healers and Psychiatrists**

According to the faith healers who participated in this study, one of the leading causes of mental health problems is a weak and inadequate attachment to God, which makes the person

unable to cope with life stressors, eventually leading to distress and sadness. The faith healers elaborated more when they claimed that those with a solid and adequate connection with God would maintain stable mental health. At the same time, others with an improper attachment will be depressed if they face difficulties in their lives, such as losing children or getting a divorce or losing jobs and facing financial struggles.

Similarly, a qualitative study conducted in the United Kingdom to explore the understandings of Muslims about mental health as a concept, and the way they tackle and handle mental disorders, discovered that the participants tend to believe that mental disorders and psychological distress happen due to the consequences of wrong actions done by people. In contrast, good things occur by the will of Allah (Weatherhead and Daiches, 2010). Thus, they deemed the reasons for mental health problems to be a punishment from God after doing immoral actions, so that life, in general, is considered a test from Allah, and people must tolerate the challenges and difficulties of life with acceptance and patience as this is the normal cycle of life. In addition, the participants agreed that Islam is effective in times of psychological suffering as it gives a sensation of peace and relief. Hence, they rely on it when they face problems by supplicating to Allah, which in turn assists them in handling their mental health issues. The participants claimed they could manage their mental health problems through their strong belief and faith in the power of God without needing medical practitioners. Some of them considered visiting mental health services as a betrayal of their religion, or it can also be the influence of the secular regime on how people perceive life (Weatherhead and Daiches, 2010).

The Islamic clarification of mental disorders supports this view that it begins when doubt and dissociation surround the person leading to an interpersonal conflict of thoughts that develop the symptoms of psychiatric illness (Farooqi, 2006). In addition, it is recognised within Islamic teachings that a weak and inadequate attachment to God is associated with poor mental health. This is because the insufficient connection with God will subsequently cause a feeling of loneliness, and low satisfaction in life, eventually leading to anxiety and even depression (Ghobor et al., 2013).

The other main reason for mental health problems mentioned by the faith healers who participated to this study is Jinn possession. The faith healers posited that Jinn could interfere with the life of human beings causing harm to them. All the faith healers who participated in this study believed in the existence of Jinn as a creature of God because it is mentioned in the

Qur'an in various verses. The participants also believed in the evil eye since it is mentioned in the Qur'an. According to them, it can cause mental health problems by causing harmful influences on a person's life due to the envious feelings of others. Lastly, the faith healers also mentioned sorcery as another cause of mental health problems. Although it is rare and uncommon in Kuwait, it still exists. The faith healers pointed out that sorcery is different from the evil eye as the evil eye occurs through a look from a person who carries envious feelings directed to another person, which could inflict injury to them. In contrast, sorcery is the use of magic and witchcraft by a person who gained power from the assistance and aid of evil spirits. There are several ways to control the Jinn and gain its power. Once the control has been completed, the sorcerer could use the acquired abilities either for good things (to cure patients from their mystical sicknesses) or for bad things (such as harming others because of jealousy). Therefore, those with malevolent drives will probably utilise the power obtained after controlling jinn for harmful purposes (Ally and Laher, 2007).

In Islamic countries and generally in traditional communities, faith healers are treated as public figures known for their capability to provide healthcare. Thus, faith healers in Islamic nations are firstly approached by those who attribute mental illness to being caused by the influence of Jinn (Saged et al., 2018). Muslims commonly believe faith healers can manage mental illness and are also deemed well-skilled in extracting evil spirits (Rashid et al., 2012). Most Muslims trust and believe in the existence of supernatural powers or creatures called Jinn (El-Islam, 2008). The Islamic religion and teachings support the existence of Jinn. This manifested when the Islam religion started to spread in Morocco. The Moroccans interpreted schizophrenia as Jinn possession and depression as the revenge of Jinn (Ally and Laher, 2007). Muslims worldwide have attributed alternative causes to be responsible for mental illness. These beliefs about the existence of such miraculous forces are inherited from one generation to another within the Muslim community and are usually accompanied by fear. Jinn is stated in the Qur'an on several occasions (Al-Habeeb, 2003). Indeed, in the Holy Qur'an, various verses mention the Jinn. For example, one verse says, "...*Suleiman (Solomon) did not disbelieve, but the devils disbelieved teaching men magic*"..". In another verse, the Qur'an indicates the existence of supernatural forces, "*I take refuge with the Lord of the daybreak from the evil of what He has created, from the evil of darkness when it gathers, from the evil of the women who blow on knots, from the evil of an envier when he envies*" (Ally and Laher, 2007).



Based on the Islamic teachings and beliefs, Jinn possession could harmfully influence possessed people and cause illness to them. In Islam, Jinn is a creature made by God, created in various shapes and can cause destructive effects through different evil methods. A Jinn can destroy human life and cause mental and physical suffering by possessing or bringing misfortune to them (Saged et al., 2018). In Islam, it is believed that Jinn is an invisible creature that can be male or female, be a believer or unbeliever of God, live with human beings in the same universe, interfere with the life of human beings, and harm them by various satanic methods (Al-Habeeb, 2003). It is crucial to mention that a Jinn is not always evil. Whether a Jinn becomes bad or good is determined by its impact on others. By the actions of the possessed persons, we can judge if the Jinn is evil or good. So basically, if the acts of the possessed persons were religious and had good manners, the Jinn is good, but if the actions were against religious principles, it is evil. Indeed, an evil Jinn is affiliated with the devil (Ally and Laher, 2007).

Like the Christian and Jewish clergy, the faith healers in Islam, called Imams, are responsible for leading the daily five prayers, declaiming Friday Kuttba (sermons), heading the religious rituals, and regulating spiritual and religious supervision. The Imams in Islam are expected to master the Islamic teachings, the Qur'anic interpretations, and the Hadith (sayings from Prophet Muhammed) to be able to deal successfully with the problems of Muslim followers (Rashid et al., 2012). In the Islamic faith, Jinn possession is believed to interfere with people's actions and behaviour in such a comparable way to the symptoms of mental disorders. The term Sihr in Arabic is commonly used to describe magic, witchcraft, and sorcery. Sihr is used to describe the actions which, if performed, people become close to the devil, so it is equivalent to the word witchcraft in English (Rashid et al., 2012). The existence of the Jinn is not only emphasised in Islam; it is also commonly accepted in Arabic culture it is widely accepted. As explained earlier, a Jinn can take different shapes and types and harm human beings after possessing them, manifesting in sadness, resentment, and even physical illness.

Sorcerers can utilise the Jinn to damage marriage proposals, cause insanity, and cause continuous pain or epileptic fits to affected people. Moreover, possessing Jinn can cause inexplicable, strange and repetitive movements that sometimes can't be explained by psychotic disorders. Sihr (witchcraft) is believed to contribute to convulsions, gaining extra weight, sickness, injuries, abortions, infertilities, and even death. Moreover, a possessed

person might acquire uncanny power and strength, sometimes capable of bending their backs to form an arch shape, spinning rapidly in circles, and expressing themselves as a plural subject (we) in an altered voice and a different language. Others might display various behaviours such as shouting, laughing loudly, rolling eyes, and experiencing a continuous sensation of coldness. Also, when the healers force the possessing Jinn to leave the victim's body, the victim displays extensive twisting of the body, an altered voice, and a distinct facial look. Lastly, nightmares, fatigue, and auditory delusions are other symptoms of Jinn possession identified in Islam (Ally and Laher, 2007).

Witchcraft has existed in various societies, such as Medieval Europe. The roots of sorcery can be traced back to ancient times when the religions of this world originated. However, the acceptance of witchcraft has varied geographically. For example, it is commonly recognised in Africa, Asia, South Pacific and the Caribbean (Ally and Laher, 2007). In Nigeria, it is widely believed across all ethnic and religious groups. Witchcraft is considered part of people's intelligence. The belief in the relationship between mental illness and sorcery has been transmitted to Western communities as it was noticed that in the United States, there was an increase in evil spirit possessions and the number of exorcisms (Ally and Laher, 2007). It is crucial to highlight that the terms Jinn, evil spirits, and demons are describing the same unseen and obscured creatures. It can be said that the different terms are selected and applied to define the possession process based on the religion and the culture as each religion utilises its own specific terms. For instance, Muslims usually use the words Jinn possession, while in Christianity evil spirit or spirit possession are commonly applied (Ally and Laher, 2007).

Interpreting mental disorders to result from possession by supernatural spirits is an ancient belief. Ancient human skulls have been discovered with holes distributed around them, which is explained by a trepanning process. This process was conducted in ancient times to drive out evil spirits (Bayer and Shunaiga, 2002). Thus, it seems that the concept of relating mental illness to Jinn or evil spirits' possession has returned. Most religions believe in the existence of evil spirits. In Islam, in particular, the belief in Jinn and their impact on peoples' lives is a fundamental issue since it has been stated in the Holy Qur'an several times. Muslims believe, based on the Islamic teachings, that Jinn can get into the human body and control the affected individuals, causing mental illness. Therefore, a considerable number of Muslims seek help from faith or traditional healers for an extended period of time before approaching psychiatry

(Bayer and Shunaiga, 2002). This is because the psychiatric stances have distinguished between actual possession and pathological ailments based on the American Classification of Mental Disorders (Diagnostic and Statistical Manual of Mental Disorders, DSM IV), which clarified that spirit possessions should be treated as dissociative disorders and not classified as the unconscious belief of being exposed to Jinn power which will be manifested in the ego-dystonic way of thinking and perceptions (Bayer and Shunaiga, 2002).

There is a strong belief among the people who live in Kuwait about the existence of Jinn. They believe that Jinn possession is real and the cause of mental disorders. Therefore, it is quite common to hear some stories about Jinn during Kuwaiti people gatherings, and some might mention that they have seen a Jinn. Based on their Islamic beliefs, Kuwaitis accept that Jinn has the power to affect humans physically or mentally through possession. Also, they believe that a Jinn can make people speak loudly, hear strange voices, or do repetitive and aggressive movements. Moreover, Kuwaiti people strongly believe in the evil eye. They think that someone could get jealous of their belongings or skills, resulting in a harmful effect on their health. This makes people hide their valuable items and unique capabilities to protect them from the evil eye.

In addition to the identified harmful impact of sorcery and witchcraft, in Islam, it is believed that envy towards others might harm them and affect their health negatively. Muslims attribute mental disorders to a supernatural force called the "evil eye." The evil eye was mentioned in the Holy Qur'an and harmfully influenced human health and actions. The evil eye belief is a popular concept among Muslims. It can be defined as encountering bad luck or misfortune due to envious feelings from other persons toward coveted objects or their owners. (Scull et al., 2014; Saged et al., 2018). It is a relatively popular belief in the idea that a single envious glance at desirable items is believed to cause harm to their owners (Saged et al., 2018). Faith healers in Islam consider the evil eye the second common cause of spiritual illness where some individuals, by their eyes, can affect others. It is believed that the impact of the evil eye could occur even if the able person doesn't intend to harm others as they are born with the power of the evil eye and might not know about it. Also, if the person knows that they have the power of the evil eye and are a good person, they won't harm others, but if they feel jealous observing others' belongings, others might be ill or suffer. The evil eye can cause an inability to sleep normally, lack of appetite, chronic fatigue, and a propensity to be in bad situations (Ally and Laher, 2007).

In Islam, the human being is conceptualised as an organised structure of four main linked components: mind (Aql), body (Jism), self (nafs), and soul or spirit (Ruh). These four main components are constantly interlinked and interact in a harmonious scheme to form a stable body. If any interruption in the harmonious balance occurs, an illness will be the outcome. Human beings can function normally if the natural environment surrounding them is maintained; this natural environment consists of creatures who are tangible and logically described (humans) and uncanny creatures who are unseen and intangible beings (Jinn). Within the defined natural environment, the balance between the four components of human beings, if disrupted, will result in mental or physical diseases that might influence one of the four components of human beings. The previous definition of mental illness, described and explained by faith healers, is comparable with the scientific conceptualisation of mental illness (Ally and Laher, 2007).

On the other hand, the psychiatrists who participated in this study believed that genetic factor plays a significant role in developing mental disorders. This is especially true in Kuwait, where consanguinity is high among Kuwaiti families. Some psychological conditions, such as anxiety and depression, are common among particular Kuwaiti families, while in other families, OCD is common among them. Moreover, the psychiatrists clarified that life stressors are the main causative factors for the non-Kuwaiti people who live in Kuwait, as most of them stay alone, leave their families back home and work long hours. Psychiatrists stated that mental illness is multifactorial, so many genetic, biological, social, and environmental factors exist. Also, they elaborated that the social factors can involve weak family and social bonds. For instance, introverts are more prone to depression. Meanwhile, the environmental factors could be childhood abuse, life stressors, and drug addiction which has been popular among youths recently. Lastly, the participants emphasised that the leading causes of mental disorders in Kuwait are the same as the leading causes elsewhere.

#### **6.4 Forms of Collaborations Between Traditional and Modern Medicine**

The WHO (2000) has emphasised the importance of integrating traditional or faith healing practices in the national health system since 1978. Unfortunately, only a few countries have initiated strategies to promote cooperation between the two sectors and include traditional and faith healers within their official health systems. Successful collaborative results have

been achieved mainly in preventing and treating HIV or AIDS, while little progress was noticed in mental healthcare (van der Watt et al., 2017).

A systematic review study conducted in India and China on the traditional, complementary, and alternative medicine methods used to deliver mental healthcare and maintain psychological wellbeing to assess the effectiveness of these complementary methods for managing mental disorders revealed that these traditional practices are considered a crucial component in delivering mental healthcare services. Thus, these alternative methods were integrated into the healthcare systems of India and China by establishing training programmes and providing health services in traditional, complementary, and alternative medicine (Thirthalli et al., 2016).

The Indian government in 2014 has created a specialised ministry that focuses on providing traditional, complementary, and alternative medicine, called AYUSH systems (Ayurveda, Yoga and naturopathy, Unani, Siddha, Sowa-Rigpa, and homoeopathy). Several movements were undertaken to integrate AYUSH within the medical healthcare system, such as incorporating the practitioners of AYUSH in the national health programmes, merging the AYUSH practices within the primary healthcare services, and strengthening the infrastructural basis of AYUSH. The Central Council for Indian Medicine (CCIM) has established an organised, fixed curriculum and examination scheme for training the AYUSH approaches. The trainees should complete 4.5 years of training and one year of internship in institutes certified by CCIM to be adequately qualified to be registered in state-level and central-level registries. Hospitals that fulfil specific requirements and satisfy particular standards are only approved officially by CCIM and the National Accreditation Board for Hospitals and Healthcare Providers (NABH) to be considered AYUSH hospitals. There were 526 institutes in 2013 that qualified to be AYUSH hospitals, where 127 postgraduate programmes were offered. Annually, approximately 28,300 practitioners are graduated from the AYUSH institutes (Thirthalli et al., 2016).

A study conducted in India to investigate the role and the functions of religious and spiritual healing practices in managing mental illness found that religious and spiritual healing practices if integrated into the psychiatric settings, will not only provide complementary mental healthcare but also reduce the stigma attached to psychiatric settings (Ramakrishnan et al., 2014). The study has also recommended teaching the spiritual healing methods in the Indian medical teachings curriculum and establishing healthcare programmes within the

hospitals that offer spiritual healthcare services to enhance the utilisation of mental healthcare services and overcome the stigma issues.

The National Rural Health Mission has genuinely established an integration programme that allows AYUSH system practitioners to cooperate with the delivery of healthcare services to tackle the problem of the deficiency of healthcare workers. Various programmes have been organised and operated to enhance the merging process and the proposed plan of mainstreaming AYUSH within the formal healthcare system. These programmes include building and developing innovative AYUSH institutes and schools, establishing training courses in AYUSH practices for healthcare professionals, formulating the standardised treating protocols in AYUSH approaches, promoting the conversations between the two sectors to share experiences, providing financial support to pharmacological companies to promote AYUSH treatments within the formal healthcare system, formulating guiding booklets about AYUSH treatments in different languages, offering teaching programmes and courses in AYUSH treatments in India for international students from other countries, enhancing the conduction of researches that assess the effectiveness of AYUSH approaches, developing connecting channels with pharmacists and their organisations, and employing adapted strategies that have been effectively applied in other countries (Shrivastava et al., 2015).

Similarly, in Sri Lanka, as they worked to achieve the goals of the Alma-Ata Declaration (1978), the traditional healers grasped the attention of the authorities to be involved in health promotion and disease prevention. They were part of providing collaborative care to the community. Currently, the traditional practices in Sri Lanka are under the supervision of the Ministry of Health, Nutrition, and Indigenous Medicine. Their practices are recognised in healthcare programmes, particularly community-based programmes. The vision of including the traditional practitioners began in 2004 in Sri Lanka, as the project was initially piloted in the Anuradhapura district and later generalised to cover the whole island. This project concentrates on nutrition, psychological health, the prevention of infectious and non-infectious diseases, kidney problems, and diabetes. Implementing this programme is the responsibility of community health promotion medical officers who are adequately educated in traditional medicine. Indeed, traditional medicine is recognised as a primary factor in delivering healthcare services and managing personal health. Thus, it is theoretically

necessary to integrate traditional medicine to provide primary healthcare (Jones and Liyanage, 2018).

Ayurveda is the official term in Sri Lanka for all traditional medical practices. The term Ayurveda represents the collective system of traditional practices from India with Buddhism 2,500 years ago, as well as Siddha, Unani, and Desiya Chikithsa. The last term is the original system of medicine that existed in Sri Lanka before the arrival of Ayurveda. Thus, an overlap often occurs between the terms traditional medicine and Ayurveda in Sri Lanka (Jones and Liyanage, 2018). The Ayurvedic Act was formulated in 1961 in Sri Lanka. Thus, currently, there is an Ayurvedic Medical Council, the Ayurvedic Formulary Committee, an Ayurvedic Drugs Corporation, Ayurvedic Research Institute and Hospitals, an Ayurvedic Development Fund, and a Ministry of Health that also supports traditional medical approaches. Moreover, an independent Ministry for Indigenous Medicine has been established recently (Aresculeratne, 2002). The Sri Lankan Government's Health Master Plan of 2007–2016, Healthy and Shining Island in the 21st Century, has formulated a plan that includes strategies for tackling the health challenges the Sri Lankan community encounters during the current century. The program has structured its protocols to support a comprehensive project that contains three main elements: preventive, curative, and welfare. The proposed project recognised the role of traditional medicine, such as Ayurveda, Unani, and Siddha were considered an essential part of the health sector. The practitioners of traditional medicine were involved in the integral system of providing healthcare services to offer a holistic healthcare system that also includes and contributes to the delivery of preventive medicine. The commitment to establishing a collaborative framework that brings together traditional medicine practitioners and formal biomedical professionals is not a new concept or idea in the Sri Lankan situation. However, it has a long history since the government stated its initial policy (Jones and Liyanage, 2018).

Another example is China, where 256 institutions in the country offer medical training, and 42 are exclusively based on Traditional Chinese Medicine (TCM) or Chinese herbology. Moreover, 99 modern universities provide training programmes in TCM or Chinese herbology. Currently, around 408,871 on-campus students are studying at the 42 institutes specialising in TCM. The bachelor's qualifications are given after five years of enrolment, and associate college learnings are completed in three years. The procedures to obtain the license to practice TCM are like modern medicine. The candidates must succeed in the

national medical licensing examination to get the degree and become eligible to practice. In 2012, 356,779 practitioners acquired the license to practice TCM, representing 14% of all licenced medical practitioners, including physicians, dentists, public health clinicians, and practitioners of traditional Chinese medicine. The licenced practitioners primarily practice TCM in the official hospitals of China. In 2012, 2,889 hospitals specialised precisely in providing TCM, representing 13% of all hospitals in China. In addition, 15% of the total outpatient and emergency services and 12% of inpatient health services all around China were delivered through TCM hospitals (Thirthalli et al., 2016). This is supported by a study that examined the current role of TCM and its contributions to the Chinese healthcare system. The study revealed that TCM is well integrated within formal health settings. Thus, TCM practitioners are considered essential providers of medical healthcare services (Xu and Yang, 2009). Also, the study claimed that Chinese authorities are obliged to provide the required funding to support the investments in improving and enhancing Chinese medicine research and administration.

Indeed, the communication and cooperation between traditional Chinese medicine practitioners and biomedical professionals are well established in China. This is because biomedical doctors enrol in training courses of 6 months to learn Chinese medicine during undergraduate medical schools and are allowed to prescribe traditional Chinese medications when needed in their everyday work. Moreover, traditional Chinese doctors are employed in general hospitals to offer outpatient and inpatient services in their field. At the same time, 40% of the curriculum contains knowledge about the basics of biomedical and clinical practices in the institutions that specialise in TCM. Therefore, it is customary to notice utilising biomedical treatments in TCM hospitals (Thirthalli et al., 2016).

The other example of successful collaboration between traditional and modern medicine can be found in the health system of Cuba. Cuba could be a very crucial example because Cuba has experienced a noteworthy improvement in advancing its health status since it was able to establish an effective healthcare system with an infant mortality rate of 4.9 per 1000 births compared with the United States, which has an infant mortality rate of 6 per 1000 births, and its infant mortality rate isn't comparable with other developing countries, and even some developed countries as it is much better than them. The Cuban healthcare system has recently integrated traditional medical practices into the integrated health system; thus, the medical field incorporates various traditional treatments within its formal settings to manage different



illnesses (Sánchez and Salmon, 2013). Indeed, there are several traditional approaches utilised by Cuban doctors, such as acupuncture, herbal medicine, trigger point injections, massage, heat therapy, transcutaneous electrical nerve stimulation, magnetic therapy, pyramid therapy, moxibustion, fango therapy (mud), cupping, laser or phototherapy, floral or essence therapy, homoeopathy, yoga, meditation exercise training, and music and art therapy. These complementary approaches in Cuba are named natural and traditional medicine. Indeed, Cuban family physicians are expected to learn traditional, complementary medicine while studying in medical schools. In their first two years, medical students should spend 200 hours learning complementary and alternative medicine. Furthermore, the physiology, anatomy, and clinical courses contain teachings in traditional medicine (Dresang et al., 2005).

Like other Latino cultures, accessing the traditional approaches and obtaining herbal remedies is a prevalent behaviour among the people of Cuba. In addition, the healthcare physicians in Cuba added traditional, complementary, and alternative medicine to their medical curriculums to explore the reasons behind the public acceptance of their approaches and incorporate their practices within their medical treatments (Sánchez and Salmon, 2013). Indeed, complementary and alternative medicine is recognised as one of the medical specialisations in Cuba, which contributes to providing holistic healthcare to Cuban patients (Appelbaum et al., 2006; Sánchez and Salmon, 2013).

Talking about the context of Kuwait, the faith healers who participated in this study pointed out that they knew there was another way to receive mental healthcare and support in Kuwait: psychiatric healthcare centres. They stated that there is no hindrance to accessing medical care services in Islam since the Prophet Muhammad encouraged Muslims to seek help and receive proper treatment from medicine if available and effective. Therefore, they do not oppose the desire of some patients to access healthcare services to receive care in parallel with obtaining their treatments, as stated by seven faith healers who participated in this study. Also, the psychiatrists who participated in this study said they were aware of other sources of mental healthcare services available in Kuwait, such as faith healers. They also admitted that many patients have access to faith healers before visiting them.

It is crucial to highlight the treatment methods used by the faith healers and psychiatrists in Kuwait to identify forms of collaboration between them. According to the faith healer participants, they start by reassuring the patient that Allah is merciful because he did not send

any ailment without curing it, as stated by the Prophet Muhammad. Second, the faith healers will attempt to build trust by taking the patient's history and allowing them to explain their problem thoroughly. After that, the faith healer will perform the Ruqyah, which the faith healers describe as the following: The faith healer will be seated very close to the patient and put his hand on the patient's head. If the patient is a female, he won't put his hand. Then he will start reciting particular verses from the Qur'an such as Al-Fateha or Al-Baqarah and sayings from Prophet Muhammad. Furthermore, the faith healer will recite verses from the Qur'an, then breathe on his hands and rub the patient's body with his hands. All participants explained this approach of faith healing.

According to Al-Habeeb (2003), a faith healer is a religious person who practices the Islamic method of healing to treat mainly mental health problems which are considered by the faith healers to be associated with the evil eye, magic, and jinn possession. Ruqyah refers to reciting various verses from the holy Qur'an and is sometimes accompanied by sayings from Prophet Muhammad. It is performed mainly on those presumed to have mental disorders or metaphysical (Jinn) illness (Md. Sa'ad et al., 2017). During Ruqyah practice, some faith healers might use Zamzam water found only in Mecca in Saudi Arabia. Ruqyah in Islam is an ancient practice that has been performed since the beginning of Islam (Md. Sa'ad et al., 2017). Ruqyah is permissible in Islam as it doesn't include any forbidden words or concepts. Indeed, there are various reliable narrations that Prophet Muhammad had performed Ruqyah practices on several occasions during his life and had explained the accurate way of Ruqyah to his companions. For example, according to "Bukhari" and "Muslim", the most reliable narrators among Muslims, the Prophet Muhammad recited verses from the Holy Qur'an on a companion bitten by a scorpion. In addition, it was narrated that Prophet Muhammad, when he faced fatal illnesses, used to recite specific verses from the Qur'an, then breathe on his hands and later rub his body with his own hands (Md. Sa'ad et al., 2017).

Ruqyah is generally utilised to help people in handling any stressful circumstances. Ruqyah can be used as an alternative approach to relieving stress, as its recitation can provide therapeutic effects on humans, specifically on patients complaining of psychological distress (Md. Sa'ad et al., 2017). Indeed, numerous studies found that the religious psychotherapy "Ruqyah" was effective for Muslim patients in alleviating their distress from anxiety and depression (Sabry and Vohra, 2013). Recent studies discovered that the waves of sounds which carry meaningful and unique ideas could awaken positive human feelings,

imagination, and memories, thus affecting people positively. Bringing relief to psychological stress through Ruqyah and the positive influence of reciting the Qur'an on people can be understood by applying the same theory (Saged et al., 2018). Another contributory factor that illustrates the relief achieved after hearing the Qur'an is the firm belief in God and remembering the strength of God's power while listening to the Qur'an as it is God's words. Contemporary studies proved that reciting some verses of the Qur'an could shift the brain perceptions from tension to relaxation in two directions as both the readers and listeners would be influenced (Saged et al., 2018). Thus, it can be used as a complementary treatment method to make patients with mental illness respond appropriately to the medical treatments.

Muslim faith healers practice a range of faith healing approaches to restore the normal status of their patients after Jinn possession, and Ruqyah is the most applied approach, which consists of hearing particular verses from the Holy Qur'an and remembering Allah (is called in Islam Dhikr) to seek refuge from God. In addition, there are other healing practices utilised by the faith healers, including punctuality in daily prayers, exorcism, herbal medications, having specific water attached by a piece of paper with some words from the Qur'an and others (Al-Habeeb 2004). The Islamic healing practices can be applied in various ways, including cupping, massage therapy, and herbs with medicinal properties. Moreover, the faith healers sometimes use taaweez, which are amulets attached with verses from Qur'an or certain water where they have read some Qur'anic verses on it, burning lobaan (frankincense) and also a particular Dhikr or dua'a (specific Islamic prayers by raising hands asking help from Allah) (Bulbulia and Laher, 2013).

The Muslim faith healers utilise all the different healing approaches (the ones explained above) to treat spiritual illness by eliminating the impact of Sihir. Generally, they apply several combinations of these approaches (Bulbulia and Laher, 2013). Different faith healing approaches can be utilised on the same patient to achieve the appropriate outcome. The actions done by faith healers usually include reciting specific phrases from the Holy Qur'an and then blowing onto either a piece of paper or cloth, or glass filled with water, or taweez (amulet) to make these items holy so they can be later used by the patients who suffer from mental health problems. This is because these materials are deemed to be blessed by God after reciting the Qur'an on them. Taweez is used to acquire protection for the believers, so they provide psychological relief to those who carry it. Some patients tie these taweez (amulets) to their bodies to bring relief to their psychological symptoms (Khosro et al., 2018).

These practices acquired their ability to treat the disease from the power of God, which the faith healers control. Aside from that, accessing the faith healers help the patients to escape from spending the costly expenses of consulting psychiatric physicians and prevent experiencing the stigma linked to mental illness as visiting faith healers from mental healthcare is devoid of the stigma. This behaviour is more dominant and regularly witnessed in developing countries as they prefer accessing faith healers to receive mental care. Also, studies have shown other related factors that contribute to approaching traditional or faith healers, such as family preference and role, financial level, the belief in the ineffectiveness of medical treatments, and the belief in the existence of supernatural forces or spirits. This demands the inclusion of faith healers as they represent an essential part of the mental health workers worldwide (Khosro et al., 2018).

The psychiatrists in Kuwait follow the biopsychosocial approach, which includes pharmacology, psychotherapy, and social support. The biopsychosocial model suggests that biological, psychological, and social variables affect people's understanding and perception of illness. Health and illness can be understood only if all influential fundamental factors have been considered. These can be classified into three levels: physical or biological, psychological, and socio-cultural (Abbo, 2011). Engel 1977 described and emphasised the importance of the biopsychosocial model as a model or approach that is consisted of biological, psychological (involving judgments, feelings, and behaviours), and social factors, which all play an essential role in determining people's behaviours towards disease or illness. Based on the biopsychosocial model, the identified factors can potentially interfere with the outcome of any illness at different organisational levels. Thus, a medical investigation is needed to determine which factors are accountable for the interference with health. However, the biopsychosocial model has been criticised as the model is not capable of faithfully depicting the whole presentation of mental illness and its cure. Nevertheless, it is recognised that the biopsychosocial paradigm should be the central foundation of clinical psychiatry on the ground. Psychiatric practice in the last decades has been oriented toward the biomedical model, which suggests that mental illnesses are brain diseases that have biological roots, and thus require a pharmacological treatment to be cured (Abbo, 2011; Deacon, 2013).

A holistic approach is a model of healthcare that encourages the collaboration of all related factors that contribute to optimum health status by considering all aspects of health: psychological, mental, social, and spiritual. It stresses considering the whole human, thus

assessing patients' physical, mental, social, nutritional, and spiritual issues. Health can only be maintained and stable if a balance occurs between the people and the surrounding environment. Also, beliefs, thoughts, principles and morals impact health. The profound aim of adapting holistic medical care is to use all available treatment methods to improve the health status of the patients in all aspects of life without harming others. Holistic healthcare models intend to treat the sick people themselves, not the illness. Currently, most healthcare systems tend to adapt and apply the biomedical model in managing health issues. Thus, they have invested in running the healthcare system based on the biomedical model. This has been reflected in observing the disrespect and mistrust of biomedical health practitioners towards the traditional and faith healers (Abbo, 2011).

## **6.5 The Interactions Between Faith Healers and Psychiatry**

The idea of establishing the collaboration between mental health professionals and faith healers in Kuwait could be essential to tackling the underutilisation of mental health services in Kuwait. Indeed, as explained earlier, people in Kuwait commonly avoid accessing mental health services because of the stigma attached to psychiatric settings. As Islam is the religion of the vast majority in Kuwait, people tend to rely on their Islamic teaching and religious beliefs when faced with psychiatric conditions. Thus, faith healers in Kuwait are a vital source of providing mental healthcare as many psychiatric patients access them. Similarly, a study conducted in the UK among 156 Muslims of Pakistani origin discovered that they regularly avoid accessing mental health services (Weatherhead and Daiches, 2010). Indeed, decision makers should comprehend the seeking behaviours of people towards obtaining mental healthcare services as this plays a crucial role in formulating healthcare plans. The pathway to care is an extensive explanation of the various sources of healthcare services that have been accessed before consulting the psychiatric health professionals and clarifying all the contributory factors. Indeed, it is a detailed process of studying the behaviour of the sufferers of mental disorders and their families when they decide to obtain mental help (Jain et al., 2012). Patients may simultaneously choose to access more than one treatment method for their mental illness. Thus, the interaction between the different sources of mental help is necessary to attain satisfaction with the provided healthcare. The mental health situation can be understandable since the explanatory model of illness, which illustrates how a person

understands and comprehends their illness, asserts the influence of cultural and social beliefs (Chilale et al., 2017). Thus, applying the biomedical model of mental health to treat patients holding a cultural view about their mental illness is likely to seem unreasonable and impractical. Accordingly, it looks more operative to find an integrative approach that considers the indigenous cultural beliefs of patients (Thomas et al., 2015). This dual approach fits with Kleinman as he posited a difference between disease and illness: disease is the biological fact that could be investigated and treated. In contrast, illness is the cultural domain of that fact. Therefore, social and cultural perspectives must be integrated to obtain effective healing practices (Campbell-Hall et al., 2010).

Many patients approach biomedical healthcare services with concurrent access to traditional and faith healers. Thus, it is essential to establish a collaborative platform to share knowledge and experiences. The WHO has promoted the inclusion of traditional healers in delivering healthcare services since 1978. Still, only a few countries have established collaboration programmes to include traditional approaches within the formal healthcare systems. Most collaborative initiatives targeted the treatment and prevention of HIV/AIDS, neglecting mental healthcare. Both specialist and non-specialist care providers have encouraged the acknowledgement and inclusion of traditional and faith healers to enhance and improve mental healthcare provision (van der Watt et al., 2017).

A systematic review study conducted to examine the effectiveness of traditional healing practices in handling psychiatric disorders and relieving psychological distress pointed out that traditional healers succeeded in improving the conditions of patients with major mental illnesses, such as schizophrenia and bipolar disorder. However, it could be the expected prognosis of these mental illnesses (Nortje et al., 2016). Indeed, the evidence from the studies is insufficient to support the ability of traditional approaches to treating the chronic course of mental illnesses such as schizophrenia and obsessive-compulsive disorder in the long term. Other conditions such as depression, anxiety, somatisation, and social problems, are those mental disorders that might be improved in response to traditional interventions which is equivalent to the reaction acquired from the primary healthcare services (Nortje et al., 2016). Indeed, the previous findings correlated with the current psychiatric guidelines that advocate for the inclusion of psychosocial support as the first choice of treatment for common psychiatric disorders, but as an additional and supplementary treatment method in case of major mental health conditions such as psychoses and mania. Some studies included in the

systematic review illustrated the mechanisms of obtaining positive results from applying the traditional approaches. Indeed, two studies revealed that the positive outcome is related to the patient's belief and anticipation of the proper treatment methods. Patients' beliefs and the unique personal characteristics of the healers are considered the chief principle in traditional healing, resembling Western psychotherapy concepts, therefore proposing that the two disciplines work closely and share some treatments (Nortje et al., 2016).

As described before, there are motivating and encouraging examples of collaboration processes between traditional or religious treating methods and biomedical approaches in different countries. The findings showed a positive impact in improving the utilisation of mental health services and alleviating the stigma surrounding it. For instance, policymakers in India and China realised the importance of integrating traditional or faith healers' practices in the national health system, so they initiated strategies to promote cooperation between the two sectors. Hence, both countries have a well-established system that incorporates traditional, complementary, and alternative medicine within a formal setting (Thirthalli et al., 2016).

Talking about the context of Kuwait, all the faith healers who participated in this study believed that psychiatry complements faith healing, and they have no objection to referring their patients to psychiatrists. Indeed, the faith healers in Kuwait declared that they had advised some of their patients to access psychiatrists as they think psychiatrists should manage some particular cases to receive better treatment. Moreover, the faith healers stated that if they experienced difficulties handling any case, they would advise the patient and their relatives to contact a psychiatrist because they believe the patient would receive better treatment in hospitals. This finding indicates that collaboration between the two groups is plausible.

This finding was found in other studies, such as a study conducted in Malaysia to assess the perspectives and the views of Muslim faith healers in Malaysia regarding their practices in managing patients. The study revealed that all the faith healers who participated in the study were open and accepted the idea of referring their patients to medical hospitals to receive further help (Md. Sa'ad et al., 2017). The faith healers mentioned that they would treat their patients first with their methods. If the patient's condition doesn't improve, they will send the patient to biomedical practitioners. Moreover, the faith healers pointed out that before starting their treatment approaches, they first ask their patients if they have received any prior

medical treatments related to their problem (Md. Sa'ad et al., 2017). Similarly, a study was conducted in Zimbabwe to understand and clarify faith healers' knowledge about the causes and treatments of illnesses. When examining the perspectives of the faith healers towards cooperating with biomedical healthcare professionals, this study found that the majority of the participating faith healers were willing to collaborate with formal healthcare professionals (January and Sodi, 2006). This study clarified the causes that motivate the faith healers to favour collaborating with biomedical health practitioners. First, the faith healers consider such collaboration an appropriate way to have more referred patients from the biomedical side. Second, the faith healers believed that establishing such collaboration means being in similar positions with biomedical health practitioners. Thus, they would receive material resources to improve their work. Lastly, by working closely with the biomedical sector, the faith healers expected to obtain training courses in medical technology and first aid to improve the effectiveness of their practices (January and Sodi, 2006). Another study conducted in the UAE investigated traditional healers' conceptualisation of mental disorders by examining their views and knowledge about phenomenology, causes, treatment, and outcome of mental health problems. The study showed that traditional healers accepted the idea of working closely with biomedical healthcare workers in a collaborative framework (Thomas et al., 2015). Indeed, the faith healers expressed their readiness. They had a strong desire to collaborate with biomedical practitioners, which was recognised by their awareness and familiarity with biomedical diagnostic and therapeutic approaches, for example, utilising some medical terms to describe the conditions during their work and also applying the concept of the emergency room, which is reserved for critical cases that require prompt response. Similarly, a study conducted in South Africa explored Muslim faith healers' understandings of mental and spiritual illness by examining their interpretations of the differences between the two illnesses, the causes, and the proper treatment methods. The study revealed that the faith healers comprehended that the illness could be medical, not only spiritual. Hence, they were open and accepted the idea of forming collaborative settings with psychiatrists (Ally and Laher, 2007). Therefore, the study concluded that the expected outcome of establishing collaboration between faith healers and psychiatrists is to deliver an integrated treatment protocol where religious-based treatment is provided with adjunct medical assistance if required. Therefore, patients receive treatment with more confidence. Moreover, the study recommended decreasing the tension from the different paradigms so



that a balanced mixture of Western biomedical approaches with cultural interpretations should be applied.

Another study that aimed to formulate a dialogue and establish collaboration between informal practitioners (including traditional and faith healers) and formal biomedical professionals to improve the community-based mental healthcare in Kenya discovered that the faith and traditional practitioners were motivated and keen to collaborate with medical practitioners. However, they admitted that they believe medical professionals generally disrespect their practices and are unwilling to refer patients to them (Musyimi et., 2016). The study also asserted that the willingness among the faith and traditional healers to collaborate with the medical sector is deemed a potential preliminary step to establishing coherent partnerships to reduce the mental treatment gap by forming a mutual referral channel.

However, some studies showed that faith healers were unwilling to collaborate with Western medicine practitioners. For instance, a study done to explore and understand the probability of traditional healers in South Africa referring patients who have a mental illness to biomedical practitioners revealed that the healers tend not to refer their patients to medical health services as they believe in the effectiveness of their treatment methods and mistrust the efficacy of Western medicine (Sorsdahl et al., 2010). They would think to refer their patients to the medical sector only if there were signs of life-threatening violent behaviour. Some healers reported that they had directed some of their patients to formal healthcare facilities when the case didn't improve with their healing approaches. However, this occurred after several attempts at traditional treatments such as herbal remedies, resulting in an unwanted delay in receiving the needed medical treatments (Sorsdahl et al., 2010). Likewise, a study conducted in Uganda to investigate traditional healers' attitude toward collaborating with biomedical healthcare providers revealed that traditional healers tend to refer their patients to another traditional healer and avoid referring to medical health practitioners, thereby forming an internal referral system between the healers only because the traditional healers were sceptical about the ability of psychiatric medical professionals to grasp and understand the spiritual illness (Akol et al., 2018). On the other hand, psychiatrists who participated in this study were reluctant and hesitated to collaborate with faith healers. However, they admitted that many psychiatric patients are visiting faith healers. The interviewed psychiatrists emphasised that it is impossible to collaborate with faith healers to treat patients who had already been diagnosed with a major mental condition such as schizophrenia.

A study was conducted among Muslim psychiatrists in Johannesburg to explore their understanding of psychiatric illness and the role of Islam in shaping their perceptions of psychiatric illness. The study revealed that South African Muslim psychiatrists tend to displace and separate their Islamic beliefs while practising their work. They attempt not to impose their Islamic beliefs and religious values on their patients (Bulbulia and Laher, 2013). Nevertheless, it was recognised in the study that the psychiatrists acknowledged the impact of religious values and beliefs and admitted that they influenced their honesty, respect, and compassion during work, and they mentioned that it helped them to remain non-judgmental. Indeed, these values, including being objective, are beneficial and valuable in psychiatry, particularly in a counselling relationship. Furthermore, the psychiatrists mentioned that having shared religious and cultural beliefs with their psychiatric patients has facilitated a profound understanding of their patients (Bulbulia and Laher, 2013).

A study done to examine the perspectives and beliefs of psychiatrists regarding the link between psychiatry and religion found that psychiatrists tend to be less religious and practice religion minimally in their life compared with their patients (Cox, 1994). This indicates a recognisable distance between the medical health professionals and their patients, which is called the religiosity gap. There is evidence that unsympathetic health workers can't acknowledge patients' religious perspectives and beliefs about their mental illness, thus not satisfying the patients' needs. Therefore, it is necessary for mental healthcare services in a community with diverse cultures to adopt a healthcare system that considers the religious principles of the society. It is required to add the principles of transcultural psychiatry and comparative religion in the medical teaching syllabus to teach and train mental health professionals with these principles. It is obligatory to consider religious values and beliefs to provide inclusive and comprehensive mental healthcare services. Indeed, to provide more reactive and responsive healthcare to the users, the religious history and ideas should be thoroughly investigated and understood. This process should be routinely applied in the clinical assessment to form more culturally competent healthcare services (Cox, 1994).

## **6.6 Broader Understanding of Mental Illness**

In every culture, the prevailing values and beliefs shape the basic understanding of the diagnosis and treatment of mental illness. Cultural perceptions and views direct the lay theory of psychiatric disease and impact how people deal with psychiatric conditions and affect their mental help-seeking behaviour (Rashid et al., 2012). For example, in developing countries,

mental disorders are commonly believed to be caused by supernatural forces, like witchcraft and possession by evil spirits, and these concepts are seldom found in Western culture. Indeed, health and illness are chiefly constructed based on cultural concepts. Cultural relativism suggests that understanding mental illness is unique and distinctive in every cultural context (Thomas et al., 2015). The sociocultural context determines people's experience of mental illness, their reactions towards it, and how others interact with them (Teuton et al., 2007). Vontress (2005) claims that in the psychiatric field, the best mental health treatment choice for patients is the one that corresponds and harmonises with the patient's culture. Therefore, applying and imposing Western ideas of mental illness will be perceived as foreign and impractical treatments for patients with non-biomedical perspectives about their mental health problems. Subsequently, mental health practitioners should be aware and sensible of all the common health conceptions based on various sociocultural backgrounds, mainly when their culture is inconsistent with the dominant cultural beliefs of the community.

One of the dominant research areas in contemporary anthropology is the cultural construction of meaning. How patients with various disorders comprehend and make meaning of their experience of their illness and how they describe such experience have been investigated profoundly (Lemelson, 2004). Kleinman (1980) has meaningfully differentiated between disease and illness, and his differentiation applies to physical and mental health problems. The condition is attributed to the health issue's biological aspects that are amenable to diagnostic and therapeutic medical measures. At the same time, the illness is the cultural domain of the health issues, providing meanings to the disease from sociocultural perspectives. In other words, illness is the cultural interpretation of the patient's sufferings. Accordingly, mainstream medicine must appreciate the traditional counterparts contributing to constructing the illness's meanings. Rashid et al. (2012) argue that in each culture, there is a particular interpretation of illness that is unique and valuable based on the pervasive understandings in that culture.

Indeed, the interaction between the various healthcare providers is recognised by the classical explanatory models of illness theory suggested by Kleinman and his colleagues. Based on Kleinman's (1980) explanatory model of illness, healthcare providers, patients, and their families have their private way of interpreting the causative factors of their condition, its physiological progress, pathological description, and expected treatment methods. That is to

say, the explanatory model of illness is defined as how people understand their health problems in terms of causative factors, triggering agents, symptoms, the detailed progress of the problem, and treatment choices. These understandings are shaped based on cultural values and historical, social, and political factors (Kleinman 1980). All these explanations will influence where and when patients seek healthcare and how they respond to the available healthcare. Kleinman emphasised that health treatment methods should be relevant and coherent with the dominant sociocultural context (Abbo, 2011). Every community has its characteristic values about the illness, its expected course, available options of treatments, different types of healthcare providers and centres arranged and organised to form the cultural structure of the community. Therefore, the healthcare system of every culture is created by the various available healthcare sectors with unique conceptualisations based on different explanatory models.

The model shows that medical health professionals are approached by patients who explain their illness through biological explanations. In contrast, those patients who understand their illness by cultural interpretations tend to visit faith or traditional healers. Each of these two healing schools has its particular treatment method related to each health provider's knowledge and proficiency and the purported cause of illness (Akol et al., 2018). Patients might simultaneously use two or more treatment methods for the same medical event. Thus the interaction between the healthcare providers is necessary to ensure contentment with the provided healthcare. Kleinman has blamed the biomedical sector for disregarding patients' beliefs and leaving their health needs unsatisfied by avoiding giving meaning to their illness and rationale for the planned treatments. The biomedical industry has always dominated the healthcare system by imposing its explanatory model of disease, so symptoms are understood based on physiological and psychological interpretations, and treatments are selected based on scientific standards (Kleinman, 1977, 1980). In developing societies, non-compliance with medical therapies could be the natural outcome of neglecting the patient's explanatory model of illness (Campbell-Hall et al., 2010). This illustrates the reasons behind the popularity of faith and traditional practices as a crucial component of the health system worldwide.

In correlation with the classical explanatory models theory proposed by Kleinman, the faith healing practices with their underlying explanatory model of illness have persisted in being an effective health agent in several regions around the world for yielding meanings and interpretations of illness (Lemelson, 2004). Indeed, the religious aspects represent a vital

aspect of patients' exploratory models of their illness. Religion has a significant role and impact on how patients perceive and handle the sufferings of their illness (Canel Çınarbaşı et al., 2019). By appreciating the patient's explanatory model of illness, the mental health professionals will be able to deal with their patients in a way that matches their interpretations of the illness and correspond suitably with their expectations of treatment options, thus minimising the pain and fostering recovery. Therefore, an integrative approach that includes positive elements of different healing systems could be an effective way to be adapted to mental health. This integrative approach will integrate and incorporate the medical and non-medical practices in a balanced manner with no supremacy over any counterparts.

Allopathic medicine is the widespread model for global health, supported by scientific evidence and legitimacy. The role played by allopathic medicine in controlling and curing communicable diseases is undoubtedly recognised. Indeed, the current medical field has experienced unprecedented development in the last decades, as there were some particular diseases incurable, and by now, their management has become simple and achievable (Ahmed et al., 2007). However, in the psychiatric context, allopathic medicine has struggled to satisfy the local communities as patients often visit religious healers to receive mental help. According to Ally and Laher (2007), psychology, which is Western science, has been transformed into non-Western cultures to apply its fundamental scientific basics to verify its applicability internationally. However, it is irrational to fulfil the mental health needs of people in non-Western countries and to interpret their experience of mental illness by applying Western-based knowledge and philosophies. Therefore, the potential solution for such a dilemma is to structure a methodological framework by incorporating specific functional and cultural elements (Ally and Laher, 2007).

It is noteworthy to clarify that broadening the understanding of mental illness should focus on its aetiological factors and expand the knowledge of mental illness's diagnostic and therapeutic aspects to achieve better mental help for the patients. Indeed, more physicians are starting to appreciate faith's role and its impact on health. Thus, they sometimes attempt to utilise it as a synergistic factor to obtain more holistic healthcare (Ahmed et al., 2007). Holistic medicine provides healthcare service by incorporating all the related influential elements to reach the optimum level of health in all its aspects, including the physical, mental, social, and religious elements (Abbo, 2011). Thus, it asserted taking care of the whole person by involving their life's physical, mental, social, religious, nutritional, and

environmental aspects. Views, opinions, concepts, and behaviours that affect health must be integrated into the treatment plans. Health can be adequately comprehended when it is perceived as a combination of biological, social, and mental factors rather than solely as a biological concept (Abbo, 2001). The chief goal of holistic medicine is to utilise all existing treatment approaches to improve health at all levels of well-being without any harmful side effects. Holistic medicine targets the patient, not the illness (Abbo, 2011).

Many people return to their religion to seek consolation and relief when facing difficult times such as illness. It helps them handle these situations since their physical and mental cognitive functions deteriorate and become less effective in such circumstances (Ahmad and Khan, 2015). It is broadly known and appreciated that religious and spiritual practice can optimise people's general health. Thus, it is accepted and expected that modern psychiatry embraces the concept of holistic healthcare, which is comprehensive healthcare that considers proper physical, mental, social, and religious aspects in providing healthcare services. Historically throughout the world and across ages, psychiatric disorders were understood to result from possession by demons or evil spirits. This explanatory model of psychiatric disorders has existed in most faiths and religions, such as Hinduism, Buddhism, Judaism, Islam, and Christianity (Uvais, 2018). Therefore, it is essential that mental health professionals not underestimate the strength of faith healing practices and avoid labelling some of their patients as religiously deceived. Rashid et al. (2012) have criticised mental healthcare workers for neglecting spiritual beliefs in their medical assessments. Indeed, there have been several demands and requests to incorporate culture and religion in delivering mental health care. Booysen (2016) claimed that psychiatrists treating Muslim patients should be adequately informed and aware of the Islamic literature regarding mental illness. It is recommended that psychiatrists digest the Islamic literature about Jinn possession and its correlation with mental disorders to understand the reasons behind the success of some faith healers in managing particular cases when biomedical approaches fail to do so (Booyesen et al., 2016; Stafford, 2005).

## **6.7 Conclusion**

To sum up, this chapter explained and interpreted the findings of this study to acquire their significance. This chapter attempted to comprehend and examine the possibility of forming a collaboration between faith healers and mental health professionals in Kuwait from a theoretical perspective. Theoretically, it is possible to arrange the strategies for establishing

the collaboration as the two sectors are responsible for shaping the mental health status in Kuwait. Furthermore, there were several successful examples of establishing potential cooperation between the two sectors globally, indicating that there is unlimited opportunity to structure the collaboration plan theoretically. Although the two groups in Kuwait have different understandings of mental illness, they have interacted with each other, proving that collaboration is possible. Having looked at the chance of establishing the collaboration from a theoretical perspective, the next chapter will examine if, despite the tensions, the partnership could be feasible in a practical perspective.

# Chapter 7

## Practical Discussion

### 7.1 Introduction

The previous chapter explained and interpreted the findings from this study to investigate the chance of establishing collaboration from a theoretical perspective. It was found that it is possible to theoretically form the collaboration between faith healers and psychiatrists in Kuwait. This chapter shares the same purpose as the former chapter, which is to obtain the meaning and importance of the findings. This chapter should help reach a new understanding of the research problems being investigated. However, in this chapter, the opportunity of establishing collaboration between the two mental healthcare providers in Kuwait will be examined from a practical perspective. The research questions of this study are:

#### **Main Question**

What are the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait?

#### **Sub-questions**

What constitutes faith healing?

What is the role of faith healers in providing mental healthcare?

What is the role of professional mental health service providers?

What are the commonalities and differences in faith healing and professional mental health service providers?

What mechanisms establish collaborations between official mental health services and faith healers?

In this chapter, the collaboration between traditional and modern medicine will be investigated to determine the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait. Moreover, the possibilities for establishing collaboration between faith healers and biomedical healthcare providers in Kuwait will be examined to help answer this research's main question. Also, in this chapter, the challenges that might face the collaboration project will be discussed thoroughly to help answer



the same main question. Several proposed methodologies of establishing collaboration between faith healers and mental health workers in Kuwait will be presented and examined in this chapter to help answer the research question about the mechanisms to establish partnerships between official health services and faith healers in Kuwait. Lastly, in this chapter, the advantages and disadvantages of the proposed collaboration programme will be identified, which will add a further enlightening contribution to the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in Kuwait.

## **7.2 Collaboration Between Traditional and Modern Medicine**

Demanding the inclusion of non-biomedical healthcare practitioners in the formal health system was repeatedly announced by the WHO. For instance, the WHO Executive Board in 1975 proposed establishing training in traditional medicine and encouraged healthcare workers' use of traditional healing practices. Traditional healers treat a broad range of health problems, representing a considerable proportion of health workers, but their methods are often unofficially recognised. Therefore, several proposals have been made for gathering further knowledge about the traditional practices and conducting training programmes and studies to enhance the effectiveness of traditional healthcare practices and motivate their inclusion within the healthcare system (January and Sodi, 2006).

This standpoint has been promoted and consolidated by the 2008 Alma Ata conference, which produced the World Health Report that asserted the need for incorporating culturally based treatments that match patients' beliefs. This can be achieved by providing healthcare services in harmony with patients' indigenous values and beliefs, and traditional medicine is suitable for this endeavour. Currently, two WHO plans formally ratify the recognition of traditional healers in care: the WHO's Traditional and Complementary Medicine Strategy 2014–2023, which support and reinforce traditional healers as a potential element in providing comprehensive healthcare, and the WHO Mental Health Action Plan 2013–2020, which highlights and emphasises on establishing collaboration with traditional healers to promote mental health (Akol et al., 2018).

There are various advantages of accessing the traditional healers if compared with biomedical health practitioners from many different points. First, the traditional and faith healers have the same social and cultural background as their patients. The second point is that traditional

healers understand the concept of having an appropriate personality that facilitates gaining the patients' confidence in contrast to biomedical treatments that concentrate on therapeutic procedures, with little attention to the personality of the healthcare provider. The third advantage is the potential of traditional and faith healers to provide a comprehensive treatment by incorporating the physical, mental, religious, and social aspects in their treatment methods, unlike modern medicine, which relies increasingly on technology and over-specialising techniques. Fourth, the traditional healers are the first line of contact in several developing countries because of the availability and accessibility of their health centres. The fifth advantage is that traditional health treatments mostly include the patient's family members and other related members such as friends, thus providing a collective treatment as the companions are involved in giving the medical history and deciding the best remedial action. Thus, traditional approaches are more relational as they facilitate solid kinship between the patient and the adjacent people and foster the patient's reintegration. Lastly, the utilisation of traditional healing services is more cost-effective than formal healthcare services since it mainly relies on the donations of the patients and their accompanying families as there is no mandatory cost to access them (Sorketti et al., 2012).

Mental illnesses are abnormalities in cognitive functions, feelings, and behaviours. Mental health problems are becoming significant issues affecting healthcare systems worldwide. They are responsible more than any other illnesses (including cardiovascular disorders and cancer) for most disabilities in the developed world (Bahceci et al., 2013). The WHO stated that mental or behaviour abnormalities affect one person out of four people at any moment of their life in developing as well as developed countries. Various methods of treating mental illnesses include medications, electroconvulsive therapy, and psychotherapy. Many mental illnesses are curable, but most become chronic with a high tendency to reoccur. The relapse of mental illness is linked to non-compliance with psychiatric medications. Moreover, the non-compliance rates on scheduled appointments for patients visiting the outpatient services in psychiatric hospitals have reached between 10% and 55% (Bahceci et al., 2013). The side effects of psychiatric medications are the main cause of the high rate of non-compliance among psychiatric patients. Psychotropic drugs have many side effects, such as gastrointestinal upset, increased weight, sexual malfunction, and sedation. Patients who are diagnosed with schizophrenia or bipolar disease and patients who complain of prolonged and severe anxiety or depression must take the medications constantly during their entire life.

Conversely, complementary and alternative medicine (CAM) methods are routinely recognised as more natural and secure from a public perspective. This contributed to numerous people seeking help from complementary and alternative medicine to receive mental care as a choice of mental healthcare. Complementary and alternative medicine is described as all diagnostic, curative, and preventive approaches that play an adjunctive role in the mainstream medical field by fulfilling the unmet demands of mainstream medicine and expanding the theoretical frameworks of medicine (Bahceci et al., 2013). Over the last decade, complementary and alternative medicine has been accessed frequently in many countries. For example, in the United States, the rate of utilising complementary and alternative medicine rose from 33.8% in 1993 to 42.1% in 1997, and 76.6% of American citizens had used at least one complementary and alternative medicine therapy (Bahceci et al., 2013). This could be related to the impact of high immigration waves towards the United States where the immigrants usually retain their cultural beliefs and carry it with them even after living in different culture. Indeed, a study conducted to determine the use of traditional Chinese Medicine (TCM) among the Chinese immigrants in the United States revealed that nearly 100% of the Chinese patients who participated in the study had utilised and relied on their traditional medicine to obtain treatments mainly for abdominal pains, musculoskeletal pain or fatigue (Wu et al., 2007). In fact, the Chinese immigrants represent a considerably large percentage of the total immigrants in the United States (Wu et al., 2007). This could illustrate the rise in using the traditional medicine in the US even among the American citizens. Indeed, there was an obvious impact on the American society after introducing the different cultural methods to them as it resulted in rise of utilising the traditional Chinese medicine, particularly acupuncture and Chinese herbal medicine (Lu and Lu, 2014). The reason behind the popularity of TCM among the American people is the widespread belief of the high safety of the herbal medicine in comparison to the adverse side effects and the toxic effects of western medicine (Lu and Lu, 2014). Indeed, a study done to determine the prevalence of herbal medicine use among US adults and to evaluate the contributory factors of utilising herbal medicine among US adults found that the use of herbal products has raised during the last years where more than one third of the participants (38%) revealed a prior use of herbal medicine (Rashrash et al., 2017). Moreover, the confidence of the effectiveness and the safety of herbal medicine was one of the contributory factors of the high tendency towards using the traditional medicine (Rashrash et al., 2017). The other explanation of the rise in the use of traditional medicine in the US is the globalization process. Indeed, the

globalisation has allowed the South Asian medicine, including the Ayurveda and Chinese medicine to be seen as alternative to biomedical medicine and became part of the widely used term Complimentary and Alternation Medicine (CAM) (Sujatha, 2020). For instance, yoga has globalized to become widely used throughout the world since it has attracted numerous people in various countries and cultures as source of mental health treatments (Sujatha, 2020). The other factors that might be related to the rise use of traditional medicine in the US is the accessibility and the availability of health care services to the poor communities within the American society as health care services are inaccessible in some areas.

Also, in Turkey, the rate of utilising complementary and alternative medicine is between 58% and 70%. For mental illness, the rate of complementary alternative medicine used for treating mental disorders was 35.2% in Taiwan, 34% in the United States, 51.9% in Australia, 68% in Canada, and 22.2% in Turkey. Religious-based therapies were the most used CAM therapy. Faith healing practices were the most popular approach applied among other CAM therapies to manage mental illness (Bahceci et al., 2013).

Indeed, the literature emphasises on the crucial role of faith healing approaches as it is believed that their centres represent an influential agency and environment for healing. Healers mentioned stories of how they managed to cure severe physical and mental disorders by performing their religious methods of prayers and remembering and believing in the power of Allah. The literature in this area has revealed that religious people who practice ritual habits are less likely to have depression or anxiety, are more satisfied with life and have better health. They also tend to be more accepting of life's calamities and illnesses, thus coping better with them (Rashid et al., 2012). Therefore, health professionals need to consider such power of religion and faith and not to treat such people as religiously deluded. Psychiatrists have been criticised for neglecting the crucial role of religion. Psychiatrists who motivate their patients to maintain stable religious status since spirituality can help improve treatment, coping, recovery, and prevention. Kleinman has distinguished between disease and illness, and this differentiation can be applied to physical and mental disorders. He argued that the disease is humans' biological state, which can be investigated and treated using medical science concepts. In contrast, illness is the cultural domain of disease or the social construct of reality since it gives meaning to the disease from a patient's values and beliefs. Western medical science can't declare to be above its traditional counterparts, as every

culture has its unique interpretation of illness that is reasonable and logical to the meanings that frame that culture (Rashid et al., 2012).

The traditional and faith healers offer their clients a culturally appropriate treatment approach. The non-medical (including traditional and faith healers) practitioners provide healthcare services appropriate to their patients because they correlate correctly with the indigenous explanatory models of illness. The explanatory model of illness is understood as how the patient understands the cause of their illness, triggering factors, the common symptoms, the predicted process of illness, and the proper treatment methods. The biomedical model matches the main explanatory model of Western culture, which illustrates the illness by physiological and psychological interpretations, using scientifically oriented treatment approaches. In developing countries, the patient's non-compliance with the medical treatment protocols could be the outcome of ignoring the hegemonic explanatory model of illness within non-Western cultures (Campbell-Hall et al., 2010).

Modern psychiatry is a Western production that has transformed developing countries to convey knowledge and expertise and to demonstrate psychiatry as an objective discipline, not influenced by personal opinions, and as global science. In correlation with a global orientation, psychiatrists have applied the theoretical frameworks and philosophies which are created in the West to interpret the behaviour of people living in developing countries. The enthusiasm to prove the internationality and inclusivity of the psychological sciences has led psychiatrists to consider culture as an obstacle. Thus, terrible consequences result from selecting the wrong treatment choices (Ally and Laher, 2007). The individual's previous exposure to mental disorders and the created experience, their reaction toward the incidence and how adjacent people react and perceive the problem are all affected intensely by the sociocultural context. The healer is a crucial element of this sociocultural context. The healers of any particular healing method have an essential impact on how people perceive and interpret the health problem and on shaping the experience of the health issue. In psychotherapeutic settings, the excellent practitioner is the one who merges with the patient's culture. Indeed, applying the Western biomedical perspective of mental illness will probably be perceived as exotic and ineffective by those who hold non-medical interpretations of their illness (Thomas et al., 2015). Psychologists and psychiatrists who are ill-informed will probably use medical terms such as paranoid delusions and auditory hallucinations to clients who thought the devil or spirits possessed them or that dynasties had talked with them.

Therefore, it is irrational in developing countries, where about 80–90% of patients depend on traditional healing approaches, to solely explain the condition of the patients and the psychological symptoms by referring to sophisticated philosophical psychiatry, which has been imported from the West.

A potential key to resolving this dilemma is to combine and integrate the theoretical and conceptual frameworks of psychiatry with the cultural common beliefs and interpretations. Western models should recognise cultural or religious explanations within developing societies as an assisting tool in coping with mental illness, which merits additional value and consideration. Therefore, it is necessary to broaden the comprehension of the cultural role and integrate the gained understanding of the cultural impact into the diagnostic and therapeutic procedures to aid patients with non-western backgrounds (Ally and Laher, 2007). The integrative healing system might reveal a more practical approach as it provides healing treatment methods derived from the patient's culture. Studies have suggested that such an integrative healing system can offer meaning for the patients and their families, which eventually positively influences the progression and result of the mental disorders. The holistic (integrative) approach is a balanced combination of biomedical and traditional methods, acknowledging the advantages of each sector without granting supremacy to any side (Thomas et al., 2015).

The legitimacy and the acceptability of faith and traditional healers and their collaboration with them is a debatable topic. The various opinions in the literature about this topic can be classified into three categories. The most prominent view supports the complete separation between scientific biomedical approaches and the magical way of thinking adopted by faith and traditional healers. Doctors for Life (DFL) advocate this point of view, a universal association with representatives from many physicians, dentists, veterinarians, and other medical practitioners. The second category supports the view that biomedicine represents only one aspect of the world, which does not essentially mean the truth. Those who hold this point of opinion claim that both biomedical drugs and traditional treatment can provide effective healing. In contrast, others are unconvinced with the efficacy of any therapeutic procedures. The last category is the integrative view. In this view, scientific medical practices and traditional approaches are believed to be social actions with meaningful cultural values. Both approaches (medical and traditional) work based on the underlying biopsychosocial paradigm, illustrating the efficacy of both healing interventions. This point of view

(integrative view) is the one that encourages establishing a collaboration between traditional and faith healers. For the integrated approach to be adapted, the medical sector must respect the different explanatory models of mental illness that people hold and work on improving mental health literacy (Sorsdahl et al., 2010).

There is abundant literature that has discussed and examined the relationship between the traditional or faith healers and biomedical practitioners and how the two healthcare providers can interact to provide mental healthcare. There were three main choices to outline the interactions between the two sides: incorporation, cooperation or collaboration, and total integration. The views of mental healthcare professionals and traditional healers towards the suggested choices showed that both preferred the cooperation or collaboration choice since this type of interaction maintains a private space for each side as they work autonomously; an example of this type of interaction is the mutual referral. Moreover, they found that mental health workers who trained and worked based on Western psychiatry pointed out that patients with mental disorders would obtain proper and beneficial care with the integrated approach of both psychiatric and traditional treatments. Also, they revealed that the interactions between the two treatment approaches are unproblematic. This dual treatment approach accords with Kleinman's perspective and conceptualisation of illness and disease, as the psychiatry field deals with disease problems, and traditional methods address the patients' illness apprehensions (Campbell-Hall et al., 2010).

### **7.3 Examining the Challenges for Collaboration Between Faith Healers and Psychiatrists in Kuwait**

One of the essential steps of forming the collaboration between faith healers and psychiatrists in Kuwait is examining the challenges that might face the collaboration project. Indeed, the capability to establish the collaboration between faith healers and psychiatrists in Kuwait can be ensured when initially the obstacles have been identified to find ways to overcome such barriers.

According to the faith healer participants of this study, the psychiatrists in Kuwait show disrespect and distrust towards their ways of treatment by looking down on faith healing. On the other hand, some faith healers manifest disrespect and distrust towards psychiatrists when they refer complex cases to more experienced faith healers instead of psychiatrists, whose

methods they deem harmful. Therefore, the faith healer participants in this study admitted that one of the barriers to establishing the collaboration between the faith healers and psychiatrists in Kuwait is the lack of trust among faith healers and mental health professionals. Another obstacle that the interviewed faith healers have identified is the endorsement by the government, as faith healing practices are still considered illegal here in Kuwait. The faith healers elaborated that the Kuwaiti government tends to adopt a secular regime. That perspective does not fit with the idea of collaborating with religious methods, which minimises the opportunity to establish the collaboration. Moreover, faith healers stated that the obstacles to forming collaboration could be due to not having a clear job description for each side.

On the other hand, the interviewed psychiatrists in this study believed that each side is attached to its method of treatment and believes in its approach's effectiveness and superiority, so each side will try to dominate the collaboration, leading to an unsuccessful partnership. All the interviewed psychiatrists stated that they have never communicated with faith healers, so they have no relationship with any faith healer in Kuwait. The psychiatrists believed faith healing is not comparable to psychiatry in any perspective as their work is not based on evidence as no research has been conducted to prove their effectiveness. In contrast, psychiatry is based on evidence from scientific research. Some psychiatrists elaborated that they cannot deal with an unknown field, so they cannot trust them and are afraid of the abuses that could happen to the patients. Moreover, psychiatrists identified a crucial impediment to collaboration in Kuwait, which is not having previous experience in formulating the strategy of the collaboration process.

The faith healers are not recognised as legal healthcare providers in Kuwait, and their healing centres are not officially organised and regulated. Thus, it would be challenging to establish a collaboration with an unauthorized practice. A further dilemma that might hamper initiating the first contact with faith healers and make it difficult is that there is no association in Kuwait that represents the faith healers. In addition, a mutual mistrust and disdain is inherited by some psychiatrists and faith healers in Kuwait that could make each side hesitant to cooperate with the counterpart.



According to this study's literature interview, several obstacles were hindering the formation of the collaboration. For example, the inherited disrespect and mistrust between the two healing systems was found to be one of the main barriers as there is rivalry and feelings of superiority, where each side considers its practice and knowledge superior compared to the other side, thus creating distrust and disrespect to each other's (van der Watt et al., 2017). The review found that medical practitioners viewed the treatment approaches used by traditional and faith healers as an illicit way of treatment, and they also considered such practices as regressive and backward. The review pointed out that Muslim faith healers considered their treatment methods more effective than biomedical ones because their work is based on the will of Allah and his prophet. They were unwilling to work with biomedical practitioners since they believed that the two approaches function completely differently (Kpobi and Swartz, 2018). Both practices have robust, well-established healing systems derived from historically rooted beliefs based on the perspectives of their society, and each system has its own well-developed explanatory and rational basis. Thus, the difficulty is preventing one side's imposition over the other. Integrating traditional and faith healing practices within the healthcare system is expected to face resistance and difficulties (Thomas et al., 2015). Indeed, several researchers have pointed out that many collaborative plans and strategies were unsuccessful because they were created on a unidirectional basis as biomedical practitioners have disrespected and underestimated the merits of traditional healing practices. Numerous medical professionals could benefit from the psychosocial interventions applied by traditional or faith healers (Campbell-Hall et al., 2010).

The idea and the concept of forming a collaboration with religious endeavours have been hindered and rejected by the long-lasting historical conflict between religion and science. Historically, religion harboured science, which made many clergy members and priests responsible for providing healthcare to patients. The pervasive view of the causative correlation between spirituality and the illness and the role of religion in delivering treatments persisted until 1000–1300 CE, when the first medical institute was established in the West and started teaching doctors, thus separating them from other practitioners and healers. During the Renaissance (1200–1700 CE), scientific knowledge and intellectual learning developed and advanced, establishing higher education institutes. In the beginning, churches accepted the development in science and didn't reject it, but later a conflict occurred between the church and science after denouncing Aristotelian empiricism. During this period, the church prevented the priests and clergy members from being involved in operating

surgeries and instructed them to concentrate on religious duties. This segregation between religion and science expanded after the Greek scientific traditions. As science advanced rapidly, the gap widened between religion and medical practice. For instance, Johann Blumhardt in Germany was aggressively maltreated by doctors who prevented him from practising spiritual healing on patients and forced him to refer patients. In 1846, he decided to give up the spiritual treatments. Thus, science and religion were further separated (Osafo, 2016). Also, researchers asserted the negative role of colonisation and the transfer of Western medicine to Africa, as it contributed to generating unequal power. This unbalanced power led to degrading and stigmatising traditional African healers and approaches (van der Watt et al., 2017).

The other obstacle to collaboration identified in this study's literature review was the concern of malpractices occurring in the faith healing centres. According to the review, one of the main barriers hampering effective cooperation between the two fields was worries about the safety issue and human rights abuses that can happen in the faith healing practices (Ae-Ngibise et al., 2010). Scepticism and distrust were identified as a shared belief among most mental healthcare workers toward the traditional interventions, which is a serious obstacle to forming potential collaboration. Many mental healthcare professionals and policymakers distrusted and doubted the effectiveness and safety of traditional healing practices, and they expressed their fears about the malpractices of traditional interventions (Ae-Ngibise et al., 2010). A discussion of forming a potential partnership between traditional and medical sectors would be unfruitful without highlighting and discussing the reality of having some human rights abuse incidences occur to the patients who have accessed the informal healers. One of the goals of forming the collaboration project between the two healthcare systems must be to eliminate malpractice behaviours by identifying the underlying reasons and employing proper solutions (Burns and Tomita, 2014). There is significant evidence that unsupervised and unregulated provision of traditional healing approaches has many serious patient complications. For instance, incidences of acute poisoning have occurred regularly in the traditional healing settings, with some ultimately causing fatalities. The mortality rate is projected to be 10,000–20,000 per year. An investigation conducted over five years (1991–1995) which was part of the Johannesburg forensic database, revealed that traditional herbal medications contributed to 43% of poisoning cases (Sorsdahl et al., 2010).

Moreover, some case reports from Saudi Arabia revealed some critical consequences after utilising traditional healing methods, such as severe dehydration, disturbance in vision, and occasionally causing blindness, coma, kidney problems, and even death (Al-Rowais et al., 2010). Similarly, a study conducted in Ghana to discover the obstacles and permitting factors of establishing a mutual collaboration between mental health professionals and faith healers mentioned that the human rights violations occurring within the traditional and faith healing approaches is a critical issue in hampering the possibility of forming bidirectional cooperation between the two sides as it was reported that there are maltreatment abuses, exploitations and misuses in the centres of some traditional and faith healers, such as compulsory fasting, physical violence that might end in death, restraining with chains, and forced confinement (Ae-Ngibise et al., 2010). The malpractices could be due to several related factors, such as the low mental health literacy and information among the traditional and faith healers. Also, their culturally oriented beliefs and understandings of the aetiology of mental disorders could be related to their abusive behaviours. At the organisational level, other participatory factors could be the lack of official regulation of the healers' centres, no mental health laws protecting the human rights of the patients, and the predominant stigma in the community making malpractices more tolerable. Therefore, collaboration efforts must interpret the local reasons behind the abuses and implement practical solutions to amend these drastic behaviours (Burns and Tomita, 2014).

Many faith healers currently don't follow the proper Islamic faith healing practices based on reliable Islamic scholars, to the degree that they have started to utilise approaches that contradict Islamic principles. Unfortunately, some persons who are supposed to be healers based on Islamic teachings irrefutably follow procedures against the Islamic faith and even sometimes cooperate with Jinn to support them (Md. Sa'ad et al., 2017). This is disquieting and dangerous in the community, particularly for the people living with mental illness, since they commonly cannot differentiate between the actual healers and the pretended ones. In addition, low religious information among the patients makes them an easy target and vulnerable to manipulation. This could contribute to faith healers getting a bad reputation and could cause harmful effects on patients, such as making them susceptible to sexual abuse, endangering their lives, and increasing the cost of treatments. However, many faith healers practice their job based on accurate instructions and the correct principles of Islam (Md. Sa'ad et al., 2017). However, it might be crucial to mention that the medical healthcare professionals must also contemplate and observe their practices, as human rights violations

do not only happen within the traditional settings but also in biomedical settings, such as superfluous restraining of some patients and the unhygienic and unacceptable conditions in some psychiatric hospitals (Campbell-Hall et al., 2010).

In addition to the malpractice that frequently accompanies faith healing settings, there is another problem: inadequate proof of the efficacy of their practices. Indeed, scepticism and distrust were identified as a shared belief among most mental healthcare workers towards the faith and traditional interventions, which is a serious hamper to forming potential collaboration. Many mental healthcare professionals and policymakers distrusted and doubted the effectiveness and the safety of faith and traditional healing practices. Very little clinical evidence discussed the quality of non-biomedical practices, although this subject has been a fundamental topic in the literature. Therefore, the validity and usefulness of traditional faith healing practices must be investigated and proved. Yet it is challenging and difficult to evaluate the effectiveness of such methods (Campbell-Hall et al., 2010). To integrate the faith healing approaches within the medical sector, particularly the psychiatric treatment, the faith healers should have adequate mental health knowledge about the different mental disorders and accept the idea of referring the patients to the medical field when required. A study in Pakistan showed that 34% of breast cancer patients hadn't received prompt medical care because they rely on CAM for treatments. It is well-known that non-medical healers haven't received medical training as they haven't enrolled in medical schools, so their inadequate medical information and knowledge may threaten the patient's life (Al-Rowais et al., 2010). The biomedical ethics rules are another dilemma that hinders the partnership between the two sectors. This is because medical professionals are obliged and informed to whom they can work based on the biomedical ethics rules. Therefore, their reluctance to collaborate and work closely with faith healers could be due to biomedical ethics constraints. Furthermore, several faith healers lack sufficient knowledge about mental illness, thus minimising the opportunity for mental health workers to engage with them (Osafa, 2016).

#### **7.4 Proposed Methodology for Collaboration Between Faith Healers and Psychiatrists in Kuwait**

The participants of this study from both sides provided several suggestions from their perspectives about proposed ways to establish collaboration. As long as they represent vital elements of the collaboration programme, their recommendations are precious to be

considered. The interviewed faith healers of this study suggested that the collaboration must be established under the supervision of multi-sectorial official authorities' partnerships such as the Ministry of Health and the Ministry of Islamic Affairs. Furthermore, they emphasised that the collaboration should be a step-by-step process that involves forming a plan for the collaboration, selecting the proper place and time, accepting each other and not being dominant in work. They also stressed being cautious when selecting the appropriate faith healer. Also, the participated faith healers stated that there must be regular joint meetings to discuss each other's treatment methods and share experiences. Lastly, the faith healers recommended organising workshops, forums, and conferences to be attended by both faith healers and psychiatrists to learn from each other, share knowledge, and show the other side their way of treatment to persuade each other.

Similarly, the interviewed psychiatrists of this study recommended multisectoral cooperation between the Ministry of Islamic Affairs and the Ministry of Health to select qualified faith healers and psychiatrists to launch the foundations of the collaboration project. Also, they suggested that joint meetings and conferences be organised and conducted to learn from each other and share knowledge. However, the psychiatrists emphasised having faith healers inside the psychiatric hospital with particular tasks, so the collaboration should be under thorough supervision from their side to ensure no harmful impact on patients.

Also, the literature review of this study has highlighted several mechanisms of establishing collaboration between faith healers and mental health workers in Kuwait. For instance, the review recommended having a strategy of building mutual respect between the two sides as this is considered a prerequisite for establishing the collaboration process. Indeed, openness, understanding, and acceptance of each other's practices and beliefs are necessary and essential, and without mutual respect, collaboration can't be achieved (Ae-Ngibise et al., 2010; van der Watt et al., 2017). Reports have shown that the cooperation between the formal and informal healthcare providers has been stimulated and encouraged after eliminating distrust and gaining interest from both sides (Musyimi et al., 2016). Thus, building respectful relationships between the two healing systems is necessary to form an equitable, collaborative environment that motivates each side's interests in promoting patient care. Several steps are required to build the trust between the two sectors, which include: arranging initial contact with informal healers to invite them for events, regulating meetings to discuss the objectives of the collaboration project, organising plans and ensuring to reach the final

decisions by conjoining the perspectives of both the formal and informal practitioners (Musyimi et., 2016).

The second proposed approach was educating faith healers and health professionals about each other's treatment methods and diagnoses as that can promote and accelerate the collaboration process because education will help bring the two philosophies closer to each other's (van der Watt et al., 2017). The interaction between the two sectors is closely related to the education level of both sides since a high level of education could build mutual trust and enhance the interaction consequently (Osafo, 2016). According to Musyimi et al. (2016), faith and traditional healers and medical professionals need to involve in egalitarian meetings constantly and bi-directional discussions to bridge the gap between them and to obtain further understanding of the practices of each side to improve the delivery of mental health services collectively. Indeed, mutual understanding and respect can enhance the patients' mental health outcomes after dialogue formation. The healing skills and basic knowledge of mental disorders that are gained by faith and traditional healers from managing their patients who have mental illnesses can form the basis of formulating the training programmes for faith and traditional healers to attain adequate mental knowledge, thus increasing the opportunity of licensing their practices (Musyimi et., 2016). Faith healers must be adequately educated to recognise common mental illnesses and to understand the proper timing of referring the critical cases (Khoso et al., 2018).

Furthermore, educational training could help make the healers more familiar with mental treatment methods. Thus, they would be more cautious when prescribing their treatments to avoid any interactions with the medical drugs (Bulbulia and Laher, 2013). A study done in South Africa to understand the referral behaviours of the traditional healers when they faced patients with mental disorders revealed that the educational programmes for traditional healers to learn about psychiatric disorders are critical. In addition, the study highlighted that organising programmes based on scientific theories could enhance the traditional healer's knowledge and skills, making them reliable referral resources for patients. More research should be conducted to explore the suitable ways of formulating and implementing healthcare programmes that improve the knowledge and increase the referral practices among traditional healers (Sorsdahl et al., 2010). At the same time, biomedical practitioners must receive training on the traditional and faith healing approaches to respect, value, and facilitate cooperation with them. For example, medical professionals study a six-month course in

traditional Chinese medicine in medical schools and are allowed to prescribe traditional Chinese medications in their regular medical work. Moreover, traditional Chinese practitioners are employed officially in general hospitals to deliver outpatient and inpatient health services in their field (Thirthalli et al., 2016). Also, in the United States, many medical schools have started to include teaching materials that illustrate the relationship between religion and health, thus motivating medical students to embrace and realise the concepts of traditional healing (Osafu, 2016). One way to improve the medical teaching curriculum in medical institutes is to add spiritual assessment as a vital element in the practice of medicine. The underlying causes behind instructing the healthcare professionals to devote part of their time to assess the patient's religious needs are various: many patients are dedicated religiously and keen that their spiritual needs are met when consulting mental healthcare professionals, religion plays a crucial role in assisting the patient's ability to handle the illness, religious actions and values impact the outcome of illness, hospital admission makes the patient isolated from religious sources, and their religious values and beliefs highly influence patient's decision-making regarding their treatment course. Thus, the appropriate way to deal with this aspect by health professionals is to take a detailed religious history from the patients, refer them to faith healers when required, perform prayers with them, and form a rapport with faith communities (Osafu, 2016). There were recurrent demands on healthcare professionals to adopt the inclusion of religion and culture when dealing with mental disorders. If healthcare providers treat Muslim clients, they must know the fundamentals of the Islamic faith. It is recommended that psychiatrists digest the Islamic literature about Jinn possession and its correlation with mental disorders to understand the reasons behind the success of some faith healers in managing particular cases when biomedical approaches fail to do so (Booyesen, et al., 2016). From the medical practitioners' side, there are concerns regarding the possible risks of applying the traditional and faith healing interventions, such as toxicity and adverse interactions between herbs and medical drugs. This encourages obtaining further knowledge about traditional and faith healing by looking optimistically at the other alternative methods.

The biomedical practitioners and traditional healers must accept the diverse knowledge bases in their practices and be sure of the coexistence of different approaches to practices. It would be a substantial achievement if both sides were involved in an open and respectful dialogue about their different approaches. Applying this openness in structuring the medical school curriculum would facilitate the exchange between the two health providers by making the

newly graduated medical doctors more open-minded towards accepting the other alternative treatment methods. Ultimately, this will enhance awareness of the diversity of healing approaches, promoting cultural competence. The determination of the mental health workers to cooperate with faith and traditional healers and motivate their patients to consult non-biomedical providers rely decisively on the current evidence. Therefore, research exploring the validity and effectiveness of traditional and faith healing approaches in treating psychiatric conditions must add to the literature a new evidence-based treatment method that can contribute to medical care. Also, research can illustrate the exact mechanisms of action of such practices. The new findings may also enhance the assimilation of mental illnesses. Lastly, researching faith and traditional approaches may discover a new novel treatment method for treating common psychiatric conditions; for instance, combining medical treatments with traditional techniques could be the ultimate solution (Abbo, 2011).

Third, the review asserted that the official governmental recognition of faith healing practices is the cornerstone of the collaboration project. The government recognises faith healing practices as a vehicle for better collaboration. Regular official governmental visits to faith healing centres are recommended, as that could legitimise the faith healing practices and develop a secure environment to cooperate without fear of exploitation (van der Watt et al., 2017). The WHO mental health Global Action Programme Intervention Guide (mhGAP-IG) asserted that non-medical practitioners, including faith and traditional healers, are a potential solution to minimise the mental treatment gap in low-income countries. In contrast, the WHO Mental Health Action Plan 2013–2020 reinforced the involvement of faith and traditional healers as vital healthcare providers to accomplish the goals of the proposed plan. The question remains on how to reconcile the two approaches collectively and rationally (Musyimi et., 2016). The collaboration could be a significant opportunity for informal practitioners to obtain recognition and high esteem considerations and ensure safe practices. Also, the informal practitioners view collaboration as a means to receive governmental financial support. Indeed, it is recommended to have regular visitations by the official authorities to inspect and supervise the traditional and faith healing practices. These supervisions will facilitate the legitimisation of non-biomedical practices so that the healers can cooperate without fears and hesitations (van der Watt et al., 2017).

The fourth mechanism is the establishment of a multisectoral mental health advisory group. According to Campbell-Hall et al., 2010, establishing a multisectoral mental advisory group



in which representatives of faith healers and mental health workers are included in this group could be an optimum method to form a collaboration between the two sectors. This advisory group could work on each field's strengths and weaknesses to plan a collaboration process scheme.

The fifth suggested mechanism that the literature review has highlighted was forming regular dialogue sessions between the different mental health providers. It is fundamental and crucial to creating a cooperative dialogue regularly between faith healers and psychiatrists since these dialogue sessions could help in developing an environment of dynamic exchange and an opportunity for knowledge sharing, which would help in understanding and appreciating the practice of each other's and each sector will value the input of the other sector (Teuton et al., 2007; Wamba and Groleau, 2012). Focus groups can develop a unique environment that enables active interactions between the debaters, thus allowing each sector to learn from the other side and recognise and accept the weaknesses of their work. By recognising the limits and the weakness of their practices, the healthcare providers will be more resilient and flexible in sharing knowledge and working with other therapists. Indeed, focus groups have been proved to be a remarkable tool for reducing the tension between the two healthcare approaches as they had a beneficial impact on medical health professionals (Wamba and Groleau, 2012).

Lastly, the review suggested developing a therapeutic referral between the two healing systems. Indeed, another way of cooperation between the two healing systems is via the referral of patients; therapeutic referrals simply refer some patients from one sector to another (Wamba and Groleau, 2012). The readiness and the desire to cooperate with the other side is considered a motivator to formulate the potential channels of communication to form mutual partnerships, which will help reduce the treatment gap for mental illnesses by creating a stable referral process (Musyimi et al., 2016).

## **7.5 Examining the possibilities for collaboration between faith healers and psychiatrists in Kuwait**

All nine faith healers in this study showed a willingness to collaborate with mental health professionals as they think that would be an ideal opportunity for them to learn a new aspect or a new way of treating the patients, and the additional learned knowledge will be

complementary to their actual practice. In addition, the interviewed faith healers claimed that such collaboration could provide official recognition of their work so they might receive financial support from the government. Also, the faith healers were motivated to receive medical training to be eligible to work with psychiatrists.

On the other hand, the interviewed psychiatrists were reluctant to collaborate with faith healers. However, they admitted that many psychiatric patients are visiting the faith healers. Thus, the psychiatrists emphasised that collaboration might be possible with particular conditions such as dissociative disorder that can be treated with talk therapy. The interviewed psychiatrists put a condition to work with faith healers, which is to research their work to prove its effectiveness. Some psychiatrists welcomed the faith healer's contribution to their treatment with rigorous supervision. Similarly, a study was done in three sub-Saharan African countries (Ghana, Kenya, and Nigeria) to explore the attitudes and opinions of non-biomedical practitioners, including traditional healers, faith healers, and medical practitioners, towards establishing cooperative healthcare for patients with mental disorders. The study revealed that medical healthcare professionals mainly accepted the idea of collaboration and recognised the ability of non-biomedical practices to manage mental disorders, thus admitting that they represent undeniably important sources of mental healthcare. However, the biomedical practitioners have demanded a condition to proceed with the collaboration, which was to have regulatory control and supervision of traditional and faith healers by the medical sector, and also required to conduct training programmes for traditional and faith healers to comprehend the biomedical paradigm (van der Watt et al., 2017).

The previous findings confirm that the potential of establishing cooperation between faith healers and mental health professionals for holistic mental healthcare exists in Kuwait. Both sides showed relative willingness to work collectively and form concurrent access to the two sides by patients. Even though faith healers are considered an undeniable source of mental health care in Islamic and Arabic societies, the mental health service decision makers and stakeholders in Kuwait have always focused their attention on Western medicine and have excluded faith healers from implementation in the national policies. Muslim faith healers have a vital role in eliminating the stigma attached to mental illness due to the acceptance and trust among the patients who seek mental healthcare from them. Their position can be strengthened and improved by providing adequate training and education to be eligible to join

in the psychiatrists' work. The findings of the current research have revealed various suggestions and implications for enhancing utilisation of mental healthcare services through faith healers' partnership with the official mental health systems. Therefore, the partnerships between the two mental healthcare providers should advocate equally the various explanatory models of both approaches to reach a shared accepted perspective that stimulates cooperation by acknowledging each sector's complementary role in maintaining the mental health status. This must include enhancing the mental health professionals' appreciation of religious healers' explanatory model for mental illness and vice versa. Second, the confidence in the effectiveness of each approach by the counterpart should be improved to stimulate additional interactions and contact between the two sides, as they currently tend to work separately. More precisely, the mistrust of traditional and faith healing approaches and lack of enthusiasm among psychiatrists must be addressed. Third, the healthcare services the faith healers provide must be controlled and supervised to prevent unethical actions and enhance the quality and hygiene aspects. These suggested implications can help formulate policies that guide the collaboration between the two main mental healthcare providers.

A study done in Sudan to investigate the outcome after applying traditional healing approaches to patients with mental disorders offers valid, practical, and evidence-based findings for decisions makers to utilise them to improve the current mental health policies and can be applied in other counties with similar cultural context. The study revealed that traditional healing centres represent a valuable community-based organisation that offers mental help to patients with cultural beliefs about their mental illness. Also, the study reinforced the importance of modifying the widespread beliefs, behaviours, and practices toward mental illness and what is perceived as proper health treatments by raising awareness to reduce the extent of stigma and enhance the utilisation of mental health services.

Furthermore, community inclusion and contribution to mental healthcare providers must be ensured. The study also highlighted expanding the delivery of mental healthcare services by incorporating the primary healthcare centres and traditional practitioners to enhance the early detection of cases with psychiatric disorders, thus reducing the time of leaving the patients with mental illness untreated. Also, we should increase the financial resources and develop more mental health workforce to cover all community needs. In addition, it is crucial to conduct more research concerning the relationship between mental illness and traditional treatments and their role in meeting the requirement of the community concerning mental

health. Lastly, providing further funding and more health personnel is essential to ensure the accessibility and availability of mental health services (Sorketti et al., 2012).

In Kuwait, the potential to establish a collaboration programme is closely linked with political acceptance and acknowledgement. Thus, it is essential to officially authorise the practice of faith healing and motivate the authorities to provide proper funding to facilitate the first stages of the collaboration programme. Thus, advocacy campaigns and calls must be constantly operated to foster acceptance among decision makers and stakeholders in Kuwait to endorse the required regulations and laws to help progress the collaboration programme. Indeed, advocative campaigns are important to convert the attitudes from refusal to approval.

## **7.6 Advantages and Disadvantages of the Proposed Collaboration Programme**

Based on the proposed mechanisms of establishing the collaboration between the two sides, one of the crucial advantages of having such a partnership is improving the utilisation of mental health services, as people commonly avoid approaching psychiatric services because of the attached stigma. Therefore, the collaboration would help bring mental health services to more culturally accepted settings by working closely with the faith healers who perform culturally constructed treatment methods. Indeed, biomedical treatments could be more acceptable, particularly among those firmly connected to faith healing practices as they consider allopathic medicine culturally foreign. That is to say, the positive outcome of establishing the collaboration has a holistic approach by integrating the faith healing practices within the official healthcare system in Kuwait. The faith healers in this study confirmed that the outcome of such collaboration would be positive for patients as they will receive two different treatment methods to get more integrated and cohesive solutions. In addition, the interviewed psychiatrists clarified that if the collaboration is established, the outcome probably will be positive as some patients will receive more convincing and preferable ways of treatment based on their culture. Likewise, in a study conducted to identify the obstacles or motivating factors of establishing bi-directional partnerships between informal practitioners (faith and traditional healers) with the formal mental health practitioners in Ghana, the findings from this study revealed that when medical nurses worked jointly with faith and traditional healers in equivalent manners, and they appreciated the psychosocial care provided by them, the faith and traditional healers in return have motivated their clients to

access medical health facilities and encouraged their patients to take their biomedical drugs (Ae-Ngibise et al., 2010).

Indeed, integrating traditional and faith healing practices into the formal health system would increase the chance of patients receiving mental help as they will have more than one treatment option. In addition, by obtaining a further understanding of traditional and faith practices, mental health professionals will acquire other acknowledgement and awareness of their patient's behaviours and attitudes, consequently encouraging health professionals to employ more culturally sensitive treatment methods. The integration could also be a motivating factor to further research on the validity and effectiveness of traditional and faith healing. This is because the faith and traditional healing methods might provide new concepts and add new theoretical knowledge to contemporary scientific western psychiatry. This happened when mindfulness-based cognitive therapy for depression was initially derived from meditative religious traditions. Indeed, the role played by the culture in various aspects of psychological treatments has been appreciated in the last decades. This impacts amending the fourth edition of the Diagnostic and Statistical Manual, and these amendments have remained without elimination in the fifth edition of the Diagnostic and Statistical Manual. The fourth edition of the Diagnostic and Statistical Manual has changed to encapsulate cultural elements and integrate them into health treatment protocols. The cultural elements that have been incorporated include cultural assessments by exploring the patients' cultural identity, religion, and spiritual beliefs (Thomas et al., 2015). The provision of culturally appropriate treatment protocol encourages the patients to respond positively and utilise the prescribed medications. In addition, when medical doctors apply these protocols daily during their work, they eventually would accept and respect their patient's cultural beliefs. With such respect and acceptance, it will be uncomplicated and more straightforward to proceed with the integration process (Thomas et al., 2015).

A systematic review study to explore the efficacy of traditional healing approaches in managing psychiatric disorders and their roles in mitigating psychological distress has found that mainstream psychiatry assesses the effectiveness of the psychiatric treatments by utilising a validated scale that measures the improvements based on the relief of symptoms (Nortje et al., 2016). This simple way of assessment attempts to consider the core aspects of evaluations, such as specificity, objectivity, and quantifiability, eliminating vagueness and confusion. It concentrates on the disease's biological aspects, neglecting the social and

personal elements that shape the illness. Although this way of judging is undeniably compelling, this way is built on particular cultural assumptions, and by doing so, there is a high possibility of neglecting some valuable aspects in assessing the effectiveness that are applicable to other cultures. Less precise and more personal elements for measuring the effectiveness, such as satisfaction or helpfulness, were used by some of the included studies in the review could be able to assess the effectiveness from different perspectives, which might be crucial to some patients. The former aspects or outcomes are beneficial indicators of the patient's capability to work productively and the patient's perception of their health status, so these outcomes are economically and socially significant. Many of the reviewed studies mentioned the difference between disease and illness, indicating that symptomatic improvements do not always mean achieving the optimum effectiveness (Nortje et al., 2016).

The other advantage of the collaboration is enhancing the basic understanding of mental illness since both sides would receive a new perspective from the other side. The faith healers, by receiving medical training and collaborating with mental health professionals, will enhance the effectiveness of their approaches. The faith healers who participated in this study believed that the benefits of collaboration with patients would be by reducing the doses of the psychiatric medications as he is now receiving complementary treatment through faith healing approaches. Similarly, the biomedical healthcare providers would learn how to adapt culturally preferred treatment choices from understanding and knowing the faith healing practices. According to the interviewed psychiatrist in this study, the faith healers in Kuwait would be educated after the collaboration so they will not diagnose their patients with Jinn possession, evil eye effect, and other common misconceptions. Thus, patients will receive prompt medical treatment without excessive delay. Literature has shown that collaboration with the medical sector has improved the confidence, knowledge, and skills among the faith and traditional healers and enhanced the transparency of their practices with the timely referral of their patients (Musyimi et al., 2016).

The third advantage of the collaboration is regulating faith healers' work as they practice their job in Kuwait without any authorised supervision and regulations. Another study conducted in the UAE to investigate traditional healers' conceptualisation of mental disorders by examining their views and knowledge about phenomenology, causes, treatment, and outcome of mental health problems, showed that the healers were unhappy and unsatisfied with the unofficial recognition of their practices as that might motivate sorcerers to exploit the

situation. The study highlighted that an obvious advantage of integrating traditional healing within the formal healthcare system would be facilitating and achieving proper regulation of the traditional practices (Thomas et al., 2015). Indeed, by licencing and recognising the practice of faith healers officially, any possible harmful methods used by faith healers could be prevented, thus reducing potentially adverse consequences on patients. Some faith healers who participated in this study pointed out that some faith healers in Kuwait are not well-qualified and do not probably follow the correct Islamic treatment methods.

The fourth advantage is offering a cost-effective treatment choice. As explained in the results chapter, people in Kuwait prefer utilising the private sector because it is less stigmatised, but the cost is high, which might prevent them from seeking mental healthcare. Therefore, the collaboration can offer another treatment method that is less stigmatised and more affordable. The economic aspects of healthcare delivery are vital to be recognised as the foreigners in Kuwait represent two-thirds of the total population, so it is crucial to provide considerably affordable healthcare services.

## **7.7 Conclusion**

In conclusion, this chapter has attempted to comprehend and examine the possibility of forming a collaboration between faith healers and mental health professionals in Kuwait from a practical perspective. The chapter presented various efficacious collaboration examples from different countries, indicating that collaboration is practically manageable to be formed. Also, the challenges that might face conducting the collaboration programme have been identified, such as the illegal recognition of their work, inherited disrespect, and mistrust among mental health professionals. Several proposed collaboration mechanisms were suggested and examined from a practical perspective. For instance, it was recommended that the collaboration be established under the supervision of multi-sectorial official authorities' partnerships such as that between the Ministry of Health and the Ministry of Islamic Affairs. After that, the expected advantages of establishing the collaboration process have been investigated and recognised, such as improving the utilisation of mental health services in Kuwait, enhancing the understanding of mental illness among both mental healthcare providers in Kuwait, and also obtaining better regulation on the faith healers' work after authorising their job. It can be stated that it is practically feasible and economically favourable to establish a well-organised collaboration programme between faith healers and mental health professionals in Kuwait.

# **Chapter 8**

## **Emerging Framework (Recommendations)**

### **8.1 Introduction**

The previous two discussion chapters interpreted the findings of this study to help answer the main research question: What are the opportunities for faith healers and health professionals to collaborate in providing mental healthcare in the context of Kuwait? The two discussion chapters examined and investigated the chance of establishing the collaboration between the faith healers and psychiatrists from theoretical and practical perspectives. It was found that forming a partnership between the two mental healthcare providers in Kuwait is possible. Several proposed partnership mechanisms were suggested and examined, and the expected advantages of establishing the collaboration process have been investigated and recognised.

In this chapter, recommendations derived from the arguments discussed and illuminated in the previous chapters will be listed to develop an emerging framework of recommendations. This chapter will consolidate the results and conclusions from this thesis and highlight how these results contribute to forming a practical framework for establishing the collaboration between psychiatrists and faith healers in Kuwait. This chapter will start by combining theory with practice to form a solid basis for the proposed framework of the collaboration process. After that, the possible collaboration between mental health professionals and faith healers will be clarified. Then, the proposed framework for the cooperation between mental health professionals and faith healers in Kuwait to provide holistic mental healthcare will be identified and explained. Later, the policy and practical implications of the proposed collaboration framework will be revealed and presented to aid in improving the mental health status in Kuwait. Finally, a conclusion will be drawn, highlighting the main points in this chapter.

### **8.2. Combining Theory and Practice**

This study showed that religion and culture influence mental illness perceptions and treatment. This indicates that the current prevailing explanatory model of mental illness must include faith and religion. Faith healers are significant human resources for delivering psychiatric therapies. They provide cultural-based treatment approaches that correlate



accurately with the native explanatory model of mental illness within the Kuwaiti society. A great majority of the Kuwait population is Muslim. Therefore, the Islamic faith profoundly impacts Kuwaiti culture and health-related behaviours. Based on Islamic teachings, Muslim followers respond actively to physical or mental illnesses by seeking medical help and following medical advice to protect their health. If their condition doesn't improve, they can rely on prayers, meditation, and patience with their illness's course (Canel Çınarbaşı et al., 2019). Remembering the power of God and reciting the Holy Qur'an have significant healing effects on the body and soul of Muslims. Faith healers utilise the recitation of particular verses of the Holy Qur'an and prayers to cure their patients. Religion is deemed a crucial element in structuring the health beliefs of its followers, thereby shaping the behaviours, understandings, and values of people towards healthcare (Ypinazar and Margolis, 2006). Thus, it is vital to gain better insights into the religious beliefs towards health and illness to form a culturally suitable healthcare system. It is becoming more comprehensible that Muslim patients' attitudes and reactions to disease are closely related to the particular nature of the Islamic religion, as has been indicated and highlighted by many medical doctors and nurses who were treating their Muslim patients (Ahmed et al., 2007). Religion and religiosity are crucial cultural factors that must be considered in the provision of practical psychology (Crosby and Bossley, 2012).

The Kuwaiti health system is repeatedly criticized because it is dominantly based on biomedical services. This criticism has been accompanied by another disadvantage of the healthcare system: the ignorance of faith healers as being fitted outside the legal healthcare system, although considerable people are approaching them. Indeed, the faith healing practices in Kuwait are not officially recognised, and they don't have any connections with the formal psychiatric settings. Another resentment was also identified from pathologising the religion and its related practices in the Kuwaiti context, as the applied therapeutic guidelines seldom state them. In Kuwait, where a significant part of the population accesses faith healers as the first line of contact to receive mental healthcare, analysing this behaviour is essential to form the appropriate public health plans. Promoting the prompt response and rapid detection of mental disorders is crucial to reducing and tackling the comorbidities accompanying severe psychiatric conditions such as schizophrenia. Generally, the decisions of selecting which practices to be approached are related to various factors, such as accessibility, the cost of treatments, attitudes and predilections, and the patient's values and views. The situation in Kuwait is different as clinical mental health services are easily accessible. It is commonly

believed that the prevailing cultural belief is a significant obstacle to choosing the mental health services. The mental health services are underutilised since it is believed that psychiatrists are unable to help them. A standard view among Kuwaitis is that biomedical treatments can cure physical illness but are ineffective against Jinn possession and witchcraft, considered common causes of mental illness. Also, it is critical to value the role of stigma in effecting and determining the available choices in pathways to care. An extensive amount of evidence supports the reality of having a stigma attached to mental disorders and mental health services. Thus, it represents a real obstacle for many people seeking mental healthcare. This study emphasizes the significant impact of stigma on hindering people from seeking mental healthcare since both psychiatrists and faith healers coincided and agreed on the stigma towards psychiatric disorders in Kuwaiti society. In Kuwait, Muslim faith healers have an essential role in minimising the stigmatisation towards psychiatric illness because of the notable acceptance and confidence towards their centres, particularly among those patients who prefer to seek mental treatment from them. Their role can be utilised astutely by incorporating their practices with the psychiatric professionals to benefit from their expertise. Despite comprehending some of the chief principles of mainstream psychiatry, the faith healers were performing “ruqyah” as a primary tool to diagnose and manage patients with mental health problems. The participated faith healers hope their Islamic spiritual healing practice can be integrated into mainstream psychiatry.

Demanding the inclusion of non-biomedical healthcare practitioners in the formal health system was repeatedly announced by the WHO. For instance, the WHO Executive Board in 1975 proposed establishing training in traditional medicine and utilising the traditional healing practices by the healthcare workers. Traditional healers treat a broad range of health problems, representing a considerable proportion of healthcare’s workforce, but their methods are often unofficially recognised. Therefore, several proposals have been made for gathering further knowledge about the traditional practices and conducting training programmes and studies to enhance the effectiveness of traditional healthcare services and to motivate their inclusion within the healthcare system (January and Sodi, 2006). This standpoint has been promoted and consolidated by the 2008 Alma Ata conference, which produced the World Health Report that asserted the need to incorporate culturally based treatments that match the patients’ beliefs. This can be achieved by providing healthcare services in harmony with the indigenous values and beliefs, and traditional medicine is suitable for this purpose. Currently, two WHO plans formally ratify the recognition of

traditional healers in care: the WHO's Traditional and Complementary Medicine Strategy 2014–2023, which supports and reinforces traditional healers as a potential element in providing comprehensive healthcare, and the WHO Mental Health Action Plan 2013–2020, which highlights and emphasises on establishing collaboration with traditional healers to promote mental health (Akol et al., 2018).

Indeed, recently there have been several attempts and numerous health projects to form a collaboration between faith and traditional healing practices and the medical sector. In Kuwait, however, there are no prior attempts to form such an integrative approach. This could be related to the minimal knowledge about Islamic teachings that explain mental health. There is little documentation about Islamic healing practices and their role in curing mental disorders. Thus, there is a need to gain further understanding of how these approaches operate and work in the context of Kuwait to know all the different interacting domains of mental health in Kuwait. The collaborative efforts can be accelerated and sustained by obtaining all the required knowledge. The utilisation of faith healing approaches to bring curative mental health treatments is unexpected to be diminished soon. The compatibility between the healers and patients' beliefs about the aetiologies of mental disorders is the key reason for its popularity and the pervasive utilisation of faith healings. As a result, the attempt to collaborate between faith healing and medical practitioners is a proper step forward in the correct direction.

Nevertheless, the inadequate data about the faith healing practice and its practitioners is a critical disadvantage and hinderance to form successful cooperation. The inadequacy of knowledge could reflect the tension and uncertainty between the practitioners of both healthcare systems. Yet, understanding their treatment approaches and endorsing their utilisations for patients are two separate issues. This study has demonstrated detailed descriptions of the treatment approaches of Islamic faith healers in the Kuwaiti context about diagnosis and treatment for mental disorders. Despite the limitations of this study, the findings offer a vital primary step in comprehending mental healthcare and practices in a Kuwaiti context. The findings from this study asserted that comprehensive treatment approaches should be applied when dealing with patients with mental disorders. Thus, results from this study can inform healthcare planners and decision makers on the significance of integrating culture and religion in delivering holistic mental health services among Kuwait's population.

### **8.3 Possible Collaboration Between the Mental Health Professionals and Faith Healers**

Faith healers are considered one of the leading mental healthcare providers in Islamic nations, where most of their populations are Muslims (Ali and Gul, 2018). The strong relationship between faith healers and their patients has resulted in beneficial consultations, particularly with patients suffering from minor or mild episodes of anxiety, stress, and even depression. Meaningful outcomes are expected to be obtained after visiting faith healers for those who voluntarily decided to approach them. The patients often perceive these beneficial outcomes from consulting the healers without actual relief of symptoms. The illustration behind the usefulness of these healings is not adequately understood. However, repetitive social interventions can produce more effective results than a single concise intervention (Nortje et al., 2016). Indeed, faith healers' respect and trust and healing approaches have produced positive outcomes. The inherited cultural beliefs are the primary motivator that encourages people to visit the faith healing centres. The faith healers are part of the cultural structure of the community, so they are utilised as a health resource. Thus, the collaborative project could produce substantial enhancement in the utilisation of mental health services. For patients with religious perceptions about their mental illness that don't match mainstream psychiatry, the potential synergy can yield more holistic healthcare.

As this study demonstrated, all the faith healers who participated were willing to collaborate with psychiatrists and regarded the work of psychiatrists as vital to the treatment and management of mental disorders. Indeed, faith healers showed respect for the medical sector and predicted beneficial results from mutual recognition of the religious and biomedical domains of health. The present study's findings tend to reinforce the findings of prior studies that have indicated most faith healers were open and motivated by the idea of forming bi-sectoral collaboration (Arias et al., 2016; January and Sodi, 2006; Md. Sa'ad et al., 2017). The faith healers pointed out that they tend to ask their patients if they are currently under medical treatment before proceeding with their religious therapies. Faith healers in Kuwait were motivated to establish the collaboration as they saw it as an opportunity to legitimise their practices officially. Thus, they will be provided with material resources to improve their work and receive medical training courses that promote the efficacy of their treatment methods. This desire will be reflected in enhancing the chance of intersectoral partnerships

and pointing to the main areas that will facilitate such intersectoral partnerships, eventually improving the provision of mental health services to the Kuwaiti people.

Similarly, some of the psychiatrists who participated in this study were willing to cooperate with faith healers if this was their patients' preferred treatment choice. Although, most of the psychiatrists pointed out that they had never collaborated with faith healers in the past. This indicates that communication channels between the biomedical sector and faith healers are absent and non-existent. Thus, developing the missing channels might benefit by improving the medical practitioners' knowledge of the non-biomedical approaches. Moreover, creating the communication channels would increase the awareness of the faith healers about the biomedical treatments, thereby reducing the chance of having adverse interactions between the two healing methods and preventing any harm from occurring to the patients from administering their procedures.

Although all participating faith healers did not oppose the concept of referring their patients to mental healthcare services, in most scenarios, they initially attempted to cure their patients by applying their own methods. They will decide to refer the patients to receive medical treatment only when they fail to treat the case. The faith healers strongly believe in their ability to cure mental illnesses by performing religious-based acts, such as prayers, reciting verses from the Qur'an and remembering Allah. The former points are critically important as they might lead to delays in obtaining the required medical treatments. What is known in psychiatry is that prompt response is crucial to reaching a better prognosis. In this regard, the faith healers should receive medical training in psychiatric management to accept the medical treatments and apply them when needed, potentially increasing the chance of recovery.

A systematic review study conducted to examine the effectiveness of traditional and faith healing practices in handling psychiatric disorders and relieving psychological distress indicated that it is evident that traditional or faith healers can deliver an effective psychosocial therapy (Nortje et al., 2016). It pointed out that traditional or faith healing practices can alleviate distress and cure the mild symptoms of common mental illnesses, like anxiety and depression. The study also highlighted that even though there are obvious dissimilarities within traditional practices, the traditional or faith healers are generally capable of managing the neurotic disorders that psychosocial therapies can treat. Conditions such as depression, anxiety, somatisation, and social problems, are mental disorders that might be improved in response to traditional interventions, equivalent to the response

acquired from the primary healthcare services. The previous findings correlated with the modern psychiatric guidelines that advocate for the inclusion of psychosocial support as the first choice of treatment for common psychiatric disorders, but as an additional and supplementary method of treatment in case of major mental conditions such as psychoses and mania (Nortje et al., 2016). It appears acceptable to conclude that many patients, particularly those with mild symptoms and favourable anticipations, obtain subjective benefit from consulting their faith or traditional healers. Various studies have revealed that traditional or faith healing approaches are more efficient with patients complaining of neurosis than patients who complain of psychotic conditions (Kurihara et al., 2006; Razali and Najib, 2000). Indeed, it is claimed that traditional or faith healings could be effectively equivalent to modern biomedical approaches in particular conditions, such as personality disorders, alcohol addictions, psychosomatic and somatoform syndromes, and acute or reactive psychotic states (Lemelson, 2004). The mental health professionals in developing countries should not oppose utilising patients with neurotic disorders who use religious treatments as long as they don't interact with the medical treatments (Razali and Najib, 2000). If faith healing approaches have been evidenced to provide adequate mental treatments, faith healing should not be labelled as an obstacle to psychiatric care. Thus, studies should investigate proper strategies to integrate faith healing approaches into the healthcare system.

A systematic study was conducted in Nigeria and Ghana to determine the effectiveness and cost-effectiveness of establishing a collaboration programme between traditional or faith healers and formal healthcare professionals for managing and treating patients with mental illnesses where traditional and faith healers have received training for two days about the common symptoms and signs of psychotic disorders and the various manifestations of these disorders. Both sides (traditional or faith healers and physicians) received training in employing integrative healthcare where roles of each side have been identified, possible obstacles and facilitatory agents have been determined, and the projected outcomes were decided (Gureje et al., 2020). After six months of the trial, the primary outcome has been assessed. In this collaborative healthcare plan, the patients will receive medical psychotropic drugs only after checking if they are under any traditional medicines, like herbal remedies, and will be supervised for any possible side effects or interactions between the different healings. The study found that those patients who received the collaborative healthcare programme had significant improvements in symptoms, had a healthier recovery, and had more productive working habits compared to those who received ordinary healthcare. The

collaborative approach managed to alleviate the symptoms and reduce the remission of the illness. It enhanced the complete personal roles and esteem as it was evident that self-stigma was tackled effectively. Indeed, this study has shown that establishing a collaboration between traditional and faith healers and medical health professionals for managing patients with mental illnesses is feasible and that such partnerships can optimise the overall health outcomes and profound decreases in healthcare costs (Gureje et al., 2020).

In addition, it has been recognised that ignoring the patient's belief system could impact the therapeutic alliance negatively. This represents a challenging situation as therapeutic compliance is regularly identified in various healthcare models as a crucial element in maintaining psychological treatments (Pouchly, 2012). Indeed, treatment non-compliance is considered a challenging factor in several mental disorders, such as schizophrenia. Therefore, mental health workers should produce compatible descriptions of the illness with their patients to enhance compliance with psychotropic medications, and religiosity is one of the essential elements in illness descriptions, particularly schizophrenia (Borras et al., 2007). The commonly held beliefs have influential power in the treatment course known in psychiatry as the placebo effect, which can illustrate the positive outcome of some non-biomedical approaches. Thus, it can be understood that ignoring and rejecting the faith healings might lead to reducing compliance and minimising the adjunct positive impact (Pouchly, 2012). Employing the expertise of faith healers could be valuable and helpful for both the patient and physician. Therefore, the best-recommended solution seems to be establishing collaboration with faith healers.

Given the powerful affinity of Kuwaiti people to believe in faith healers, it becomes a requirement to establish a collaborative shared healthcare system between such crucial healthcare providers and the medical sector. Faith healers can be alerted to the importance of referring their patients to the medical field if they fail to help any of their patients. In the same context, biomedical practitioners will be able to learn at least the basics of the religious healing interventions so that they would accept referring their patients when needed. A brief introduction of faith perspectives to the biomedical health workers can be sufficient to attain more respect and esteem for the patient's beliefs and attitudes. This will potentially aid the healthcare workers in applying more culturally proper and accepted healthcare. Moreover, establishing collaborative healthcare between faith healers and psychiatrists would increase the available treatment options for patients with mental illnesses, thus enhancing patients'

satisfaction because they will find at least one preferable treatment method based on their perspectives. The collaboration will also stimulate ambitious researchers to conduct studies that explore the efficacy of non-medical healing practices. It is possible to find beneficial and valuable aspects in faith healing approaches that can improve the current scientific treatment guidelines (Thomas et al., 2015). Another benefit of forming a bi-sectoral partnership between faith healers and medical practitioners is regular supervision of faith healing centres. This is crucial because harmful consequences might occur by applying the faith approaches, which is not the focus of the present study. Similar to medical interventions, any treatment interventions have side effects and sometimes harmful outcomes that might cause death.

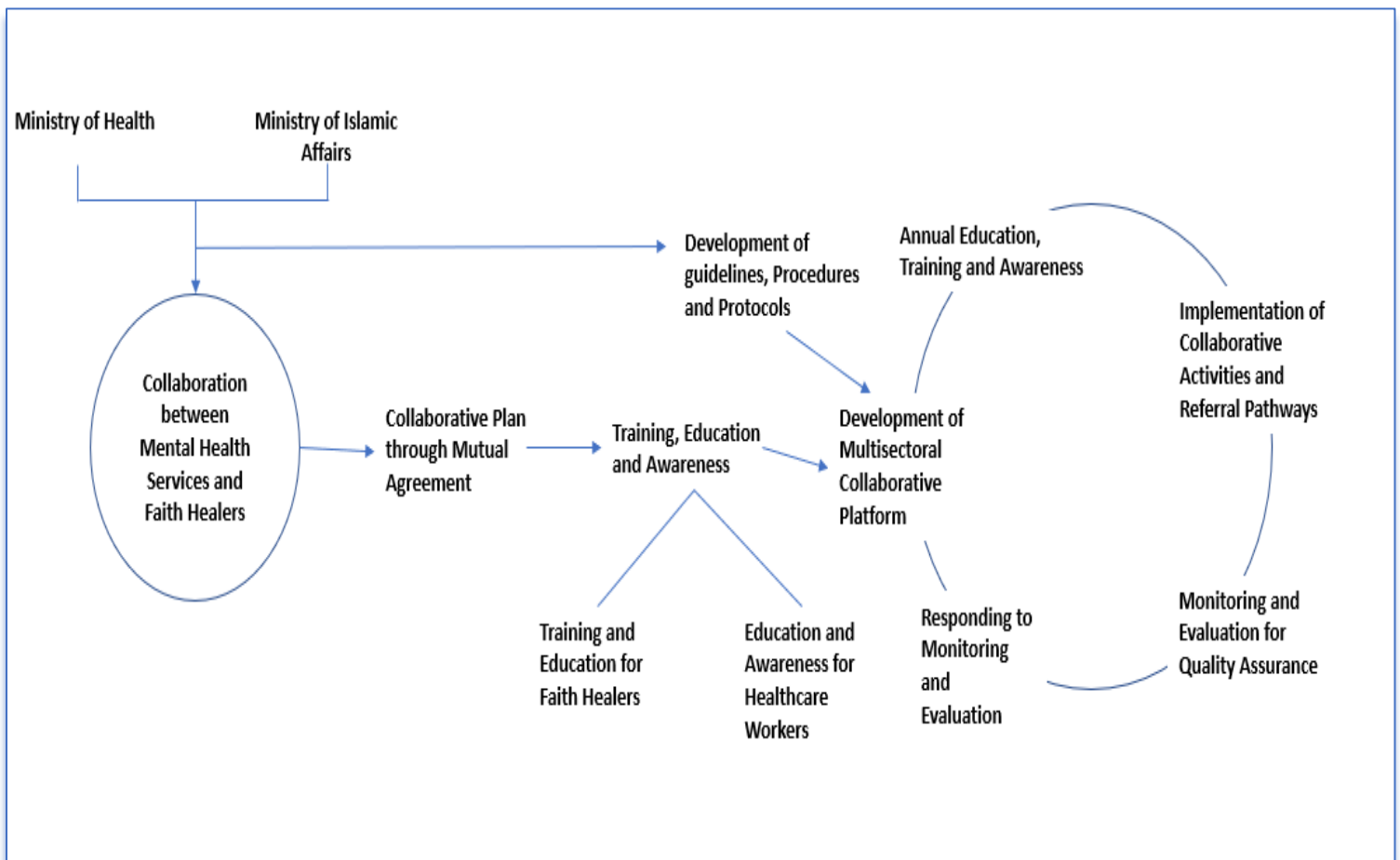
Collaborative healthcare between faith healers and psychiatrists should be urgently endorsed since faith healers deliver critical mental healthcare to a significant proportion of the Kuwaiti community. However, there are preceding requirements before starting the collaboration, such as legal recognition of faith healing by the government of Kuwait. In addition, further comprehension and knowledge regarding the proper form of creating collaboration is required. Indeed, the task now is how to integrate faith healing with the mental health structure as one of the complementary approaches. The biomedical and faith healing practices showed readiness and desire toward the collectively shared approaches. Still, the gap remained concerning the framework of structuring collaborative healthcare. As a result, it is necessary and recommended to develop a collaborative healthcare model that fills the identified gap, which will promote the active interactions between the two mental health providers as many patients in Kuwait have a cultural explanatory model of their mental illness, thereby utilising both systems concurrently and moving to cross them, eventually affecting the treatment adherence negatively. Both healing modalities have a meaningful and well-structured treatment system derived from deep-rooted beliefs and understandings that have created an explanatory framework for each system. Thus, the difficulty is to prevent the hegemony of one approach over the counterpart. It is noteworthy that any adjustment in service delivery will face objections and obstacles. However, mental health practitioners must also realise the weakness of their practice and view the other approaches respectfully so that it will not destabilise their clinical psychiatry. Pragmatic solutions to collaboration have been suggested in this study. It is hoped that these will encourage decision makers to create an action plan to enable collaboration by enabling equal opportunities for all the available treatment choices.



## 8.4 Proposed Framework for Collaboration

This section corresponds to the completion of the aim and objectives of this study by developing a framework for establishing the collaboration between psychiatrists and faith healers in Kuwait. The proposed framework (as shown in Figure 8.1) contains several elements representing the critical steps to forming the partnership between the two leading mental health providers in Kuwait. The elements of the proposed framework are as follows: the multi-sectoral partnership between the Ministry of Health and the Ministry of Islamic Affairs; the collaborative plan through mutual agreement; training, education and awareness: training and education for faith healers, education and awareness for healthcare workers; developing guidelines, procedures, and protocols; development of a multisectoral and collaborative platform; implementation of collaborative activities and referral pathways; monitoring and evaluation for quality assurance; and annual education training and awareness.

**Figure 8.1: The proposed framework for the collaboration between faith healers and psychiatrists in Kuwait (Source: Author)**



## **Collaboration Between Mental Health Services and Faith Healers**

### **8.4.1 The Multi-sectoral Partnership Between the Ministry of Health and the Ministry of Islamic Affairs**

The collaboration process should be accomplished by reciprocal cooperation, which would need the participation of both sides in honest discussions of goals and motivations. These discussions may be facilitated by efforts from the Ministry of Health and the Ministry of Islamic Affairs. The interviewed faith healers of this study suggested that the collaboration must be established under the supervision of multi-sectorial official authorities' partnerships such as the Ministry of Health and the Ministry of Islamic Affairs. Similarly, the interviewed psychiatrists of this study recommended multisectoral cooperation between the Ministry of Islamic Affairs and the Ministry of Health to select qualified faith healers and psychiatrists to launch the foundations of the collaboration project.

Nevertheless, several barriers to forming the intersectoral partnerships were projected since both sides have different beliefs and perceptions regarding the aetiological factors and appropriate treatment practices. Therefore, it is debatable whether it is practical and achievable to structure a collaborative framework since faith healers and psychiatrists showed some concerns and worries about undermining their underlying health system of mental healthcare. Thus, an integrative approach that doesn't dominate and impose one particular side over the other but looks for the common areas between them to reinforce and strengthen is the ideal approach that should be implemented. It is vital to develop well-structured models that adopt a collaboration at the national level, and both healing systems should accept it. Unfortunately, there is a lack of sufficient data and knowledge about how to initiate collaboration between the two healing systems. However, this study emphasised that the collaboration should be step-by-step by first forming a plan for the collaboration. The first step in establishing such collaboration is to comprehend the relationship between the various healthcare providers. The results of the present study have facilitated a better understanding of the current relationship between faith healers and psychiatrists in Kuwait. Furthermore, through a mutual agreement in each phase of the collaboration process, all the biomedical and faith healers involved in this process will be ready to work collaboratively to improve the

lives of their patients and improve the quality of care for patients with severe mental illnesses.

#### **8.4.2 Collaborative Plan Through Mutual Agreement**

This study indicated that openness, understanding, and acceptance of each other's practices and beliefs are essential, and without mutual respect, collaboration can't be achieved.

Furthermore, the study recommended building mutual respect between the two sides as this is considered a prerequisite for establishing the collaboration process. Therefore, any attempt to form reciprocal collaboration must include promoting bi-directional respect and trust from both fields. Indeed, to obtain a successful collaboration, the faith healers must view this collaboration as an egalitarian partnership, and their practices must be perceived as beneficial. Thus, the collaboration must not be perceived as a termination of their practices. It should be viewed as a progression and professionalism of their practice. According to Cox (1996), the collaboration can be functional only when the explanatory model of mental illnesses among faith healers fosters the involvement of all the sophisticated mental illnesses by including the biological factors and being aware of the psychotropic medications and psychotherapy. On the other side, psychiatrists must also appreciate faith healers' religious beliefs and respect their treatment approaches. Both practitioners must view the collaboration as a continuous development of both practices, not an end. It should be perceived as a protection, appreciation, and assistance source.

In this study, the participating psychiatrists pointed out that the complexity of confirming the scientific validity of faith healings has made it difficult to refer their patients to faith healers. In addition, even though the faith healers were open to accepting the biomedical interventions, the solid and firmly embedded values and the traditional practices of both practitioners are challenging to harmonise and join together in a single approach. This has reflected on having a distrust between the psychiatrists and faith healers. Trust stimulates and encourages the collaboration between two main sectors of the mental health system in Kuwait, and in the absence of trust, cooperation will be impractical and unachievable. Indeed, the lack of mutual trust contributed to low referral rates between the faith healers and psychiatrists, as revealed in this study. Trust is crucially required to have successful collaboration between biomedical care practitioners and faith healers.

This study showed that shared trust and respect are possible and can be accomplished only when each side attempts to comprehend and recognise the values and insights of the other practice and actively engages with their fields. They must realise that all treatment methodologies, whether biomedical or religious, can positively impact health. Thus, it is crucial to advocate for a stable relationship between the two healing systems by ensuring balanced and egalitarian partnerships with shared interests in improving the health status of their patients. Accordingly, frank discussion is required to explore a common ground which can be the foundation of establishing an effective collaborative healthcare system. It was indicated that successful cooperation could be found by reaching profound mutual understandings of the other practice's basic structures and prevailing ideologies. Both practitioners should understand that by this partnership, they are sharing the responsibility of improving the mental health status of the whole community. Psychiatrists and faith healers must be open and flexible in accepting the diverse knowledge provided in this collaboration process. It would be fruitful if both sides engaged in productive and respectful dialogues learning the reverse treatment approaches. In Kenya, a successful collaborative model was created between the medical sector and traditional practitioners where referral channels were established between the two sides in one HIV/AIDS treatment and counselling centre. It was found that the stable and adjacent relationship has contributed to building solid and respectful associations between the two sides and enhanced the working environment in the two sectors (Campbell-Hall et al., 2010).

#### **8.4.3 Training, Education, and Awareness**

Educating healthcare practitioners and faith healers about each other's discipline and acquiring knowledge about the practical side of each treatment approach may enable forming collaboration through predetermined, careful, and vigilant efforts to bring the two philosophies closer to each other. Indeed, one of the proposed approaches in this study to establish the collaboration was educating faith healers and health professionals about each other's methods of treatment and diagnosis as that can promote and accelerate the collaboration process because education will help to bring the two philosophies closer to each other. The interaction between the two sectors is closely related to the education level of both sides since a high level of education could build mutual trust and enhance the interaction

consequently (Osafo, 2016). It was recognised that conducting training programmes was essential to bridge the gap and thus accelerate the partnership.

#### **8.4.3.1 Training and Education for Faith Healers**

Most faith healers in this study had partial comprehension and limited information about mental disorders, their courses, causes, and different types. They believe that mental illnesses mostly happen due to Jinn possession. Therefore, some participating faith healers are hesitant to refer their patients to psychiatrists since they consider them unable to treat the impact of Jinn possession or witchcraft. They also indicated their hesitancy to refer their patients because they believe that the medical field is irreconcilable with their faith healings.

However, the faith healers in this study seem to know only the basics of medical practice regarding how mental illnesses can be cured medically. It is also important to highlight that the absence of formal teaching in the accurate Islamic principles among some faith healers in Kuwait is disquieting. These misconceptions could lead to practising treatment approaches against the Islamic principles of healing which could result in inappropriate faith healing practices.

The education background is vital to enhance the faith healers since it plays a significant role in advancing and improving their knowledge even in their practices, like acquiring further knowledge in the proper Islamic healing approaches. Moreover, acquiring basic knowledge and awareness of the biomedical treatment approaches and general medical and mental health information is vital for the faith healers since it will aid them in making accurate decisions, for instance, when adjunct medical assistance is required by realising the scientific foundations of mental illnesses. Accordingly, after obtaining a better understanding of the different mental disorders by the faith healers, there would be a potential increase in the utilisation of mental health services by elevated referral rates from faith healers. The arranged training and educational programmes to support and educate the faith healers are expected to have beneficial effects by encouraging shared decisions to be made by both the faith healers and biomedical practitioners since faith healers, after joining proper training and receiving an adequate education, would be more open to receiving guidance and instructions from the medical sector as they are now accepting and recognising the mental knowledge. The faith healers will become ready and well-prepared to engage in a collaborative healthcare system after enrolling in educational programmes organised and delivered by medical professionals.

#### **8.4.3.2 Education and Awareness for Healthcare Workers**

Psychiatrists should be aware that by establishing the reciprocal partnership between them and the faith healers, a more comprehensive and efficient healthcare system might be produced since the collaboration would enhance the utilisation of mental health services, thereby reducing the burden of mental illness on patients as well as the whole community. They should understand and become more aware that extensive evidence supports the collaboration between mental health professionals and faith healers as they agree on its role in improving the overall mental well-being of their communities (Pham et al., 2020). Based on the findings of the present study, it is recognised that to form an equitable, collaborative system of healthcare, the orientation of mental health practitioners should be shifted from a completely biomedical paradigm that emphasises medical diagnostic and therapeutic measurements to meanings-oriented approaches, as illustrated by Kleinman (1980), which is adapting various cultural interpretations of the illness. All mental healthcare workers, including psychiatrists, psychologists, and psychiatric nurses, are encouraged to accept all the cultural explanatory models of mental illnesses. They should be aware that some patients may rely on faith healing approaches in addition to asking for their consultations. The psychiatrists in Kuwait must admit that many Kuwaiti citizens utilise faith healing treatments to obtain mental healthcare. Thus, it is necessary to formulate health plans that enable active interactions between them.

A logical concern by the psychiatrists is that conflict and tension might occur when attempting to form the collaboration because of the ultimate differences in the explanatory models of health and illness. However, psychiatrists must be reassured by reminding them of the several discrepancies and disputes between other professionals, such as the psychological and psychiatric understandings of psychosis. This happened when psychiatry described the aetiologies as an imbalance in the biological and chemical substances of the brain and must be addressed with medications. At the same time, psychologists supported the fact that trauma is the cause of psychosis. Even though there were significant differences between the two disciplines, they worked closely. The two disciplines successfully established collaboration after years of disputes and arguments (Pouchly, 2012). This suggests that different systems can integrate into one collective system. In addition, the conflicts might have added further understanding of many mental disorders. Thus, conflicts should not be viewed as obstacles to forming collaboration. Although possible disputes could happen, these

conflicts can promote honest debates and encourage information sharing, eventually enhancing holistic healthcare acceptance (Pouchly, 2012).

#### **8.4.4 Developing Guidelines, Procedures, and Protocols**

A procedure and protocols to facilitate establishing the collaboration project must be developed. The protocols will contain several guidelines that will ensure efficient collaboration between the mental health professionals and faith healers in Kuwait. These guidelines include the following:

- It is necessary to endorse new legislation regulating and supervising faith healing centres.
- There is a necessity to endorse new guidelines for managing cases of mental illnesses that ratify incorporating faith healing treatments with biomedical treatment guidelines and psychotherapy to handle the patients who believe in religious and cultural aetiologies of their mental illness.
- Biomedical ethical rules must no longer prohibit psychiatrists and all health workers from cooperating with non-biomedical practitioners.
- There is a need to assess the therapies used by faith healers to fulfil the prerequisites of the Medicines Control Council. All treatment methods utilised by faith healers must be scientifically evaluated before including them in clinical practice, such as detecting any side effects that could happen after applying them.
- Faith healers can refer their patients to receive medical help if their approaches are ineffective. This acts as a complementary help to their interventions. On the other hand, psychiatrists can acquire knowledge about the fundamentals of faith healing so they can refer patients to faith healers when applicable.
- Collateral provision of healthcare by both practitioners can be applied initially at the preliminary stages where autonomy is preserved, yet faith healers and psychiatrists work together. This will help to deliver culturally sensitive healthcare services to those patients with cultural beliefs. Indeed, utilising faith treatments unaccompanied by receiving medical consultations could lead to delayed diagnosis and adverse consequences. Thus, the current pharmacological and psychotherapeutic therapies must be integrated with faith healing approaches.

- Faith healers must prepare and undergo medical training to empower their crucial adjunct role in the collaboration. The training must be under the supervision and guidance of the psychiatrists and cover various aspects, such as the common symptoms and signs of mental illnesses, the unique courses of the different types of mental disorders, the therapeutic medical procedures for common mental illnesses, the side effects, and the possible interactions with faith treatment practices, and other topics.
- Design safe physical areas within faith healers' centres and distribute medical psychotropic drugs to their centres to be utilised when required for their patients after ensuring that the faith healers received adequate medical training.
- More dialogue and open discussion should be supported and organised between faith healers and medical practitioners. These honest discussions must cover essential topics and concerns, such as proposing ways to overcome the distrust and disregarding behaviour among psychiatrists towards faith healers.
- The medical school curriculum must contain teaching elements about faith healings. This will produce newly graduated doctors who are flexible and open in learning and utilising faith healing therapies. Osafo (2016) suggested developing a medical teaching curriculum to promote the interaction of faith healers and mental healthcare workers.

#### **8.4.5 Development of a Multisectoral Collaborative Platform**

First, it is vital to maintain a balance in power between the two sides. This study showed that the psychiatrists were hesitant to work in an equally collaborative system because they perceived themselves to have higher authority than faith healers. On the other hand, faith healers pointed out that they have less power when they deal with mental health practitioners because of the illegal recognition of their work. The faith healers are unsatisfied with their status since the government neglects their role. The participating faith healers view the collaboration project as an opportunity to obtain recognition, appreciation, and a secure working environment. Therefore, licensing and legitimising the faith healing practices is essential to create an equilibrium in terms of the given power to each sector. Acquiring sufficient mental health knowledge and an adequate understanding of mental illness and demonstrating the capability of curing the mental illness on several occasions is essential to



promote the authority of faith healers and enhance the chance of formalising the faith healing practices. The government representatives can organise regular visitations to the centres of faith healings to facilitate and accelerate the formalisation process and procedures and eventually offer a safe working environment to actively engage with the partnership without fearing any lawful ramifications.

Second, it is crucial to establish a multisectoral mental health advisory group to formulate and design the best plan for forming integrative healthcare between the leading mental health providers. Representatives of faith healers and mental health workers are included in this group to negotiate and agree on the optimum method to form a collaboration between the two sectors. This kind of advisory group could work on each field's strengths and weaknesses to plan a collaboration process scheme.

#### **8.4.6 Implementation of Collaborative Activities and Referral Pathways**

Referral is one of the mechanisms that can be employed to establish an effective collaborative healthcare system between faith healers and mental health professionals. Therapeutic referral means referring some patients from one sector to another (Wamba and Groleau, 2012). The faith healers in this study reported that they had directed their patients on several occasions when they did not respond to their treatment to either a health facility or another faith healer. This behaviour of referring agitated patients or those who showed signs of dehydration to the medical field could be the opening step to a potential integral collaboration programme between faith healers and the medical field in providing healthcare to patients with mental disorders. Indeed, their desire and readiness to cooperate with mental health professionals is a potential opportunity for forming reciprocal partnerships by creating a stable referral process.

Nevertheless, the referral usually happens after applying recurrent and prolonged faith healing interventions, thus causing a delay in receiving the proper medical treatments. The communication channels and the referral cooperation between faith healers and biomedical practitioners are minimal, so it is necessary to reinforce these referral pathways as currently, it is running in one direction from faith healers' side to clinicians only, and this situation makes the faith healers perceiving their practice as unacknowledged. Psychiatrists should consider referring their patients to faith healers when the faith healing approaches match the patient's values and expectations; they should also consider applying faith healing

interventions within their medical practice. Therefore, creating operative collaboration between the two sectors that support the referral systems is compulsory. The referral can be strengthened after endorsing the recommended guidelines, which include conducting education and training programmes for the faith healers and health workers and certifying the biomedical ethical rules that permit medical doctors to collaborate with nonbiomedical practitioners. The developments in therapeutic referral will allow the patients to obtain holistic care and treatment.

Another mechanism can be implemented by arranging visitations to the psychiatric hospital to observe the outpatient medical care services and emergency care services, where faith healers and mental health professionals mutually examine some patients to provide beneficial cooperative healthcare and treatment.

Moreover, the collaboration could be established by regular knowledge-sharing meetings between biomedical practitioners and faith healers. This can promote respect and value for the input of the opposite approach and encourage sharing opinions and philosophies. A focus group is considered a suitable way to create an interactive discussion between the two fields since focus groups have been evidenced to have a powerful impact on medical health professionals. It was an effective mediator to lessen the tension and conflicts between different concepts of meaning. Modifications have efficiently been made since the focus group facilitated and made biomedical practitioners open to collaboration (Wamba and Groleau, 2012). By its interactive nature, focus groups produce a dynamic atmosphere of exchanging ideas and thoughts, thus allowing each health provider to learn from the other provider. It also makes each health agent recognise the weaknesses and limitations of its practice. Such recognition will generate resilience and openness within the collaborative healthcare system (Wamba and Groleau, 2012). A study conducted in Kenya to identify the obstacles and results of forming a dialogue between faith healers and traditional healers, and mental health workers revealed that the formation of the conversations managed to make the mental health workers more willing to cooperate with non-biomedical practitioners as long as this collaborative work will improve the lives of their patients. They also pointed out that such dialogues have added new thoughts and meanings that make them enthusiastic and encourage them to behave differently (Musyimi et al., 2016).

Another approach is task shifting, as supported by this study. Only a few published studies advocated task-shifting with faith healers, which training faith healers can achieve in the

frequent medical, mental health therapies, identification of mental disorders, therapeutic referrals, and other mental health roles (Pham et al., 2020). The WHO recommends task shifting to support the inadequate medical workforce in low-income countries. It is considered one of the effective public health interventions to overcome a shortage of trained health workers where newly recruited staff who are less qualified and received less training replace the experienced and well-qualified ones in a planned manner so by this replacement they obtain proper training and solve the shortage problem (Osafu, 2016).

#### **8.4.7 Monitoring and Evaluation for Quality Assurance**

Evaluation can be defined as a systematic assessment of the accomplishments of a particular mission or programme (Neumann et al., 2018). Patton (2008) describes the evaluation as an organised gathering of data and information about the actions, features, and outcomes of programmes to produce opinions and decisions about the programme and its effectiveness and give advice and instruction for upcoming programmes (Patton, 2008, p. 39). The evaluation process has been described as generating valuable information about a particular activity to inform decision makers. This information includes an assessment of the objectives' accomplishments and judgments about the targeted activity's outcomes and significant effects (Skinner, 2004). The evaluation is a continuing process with repeated periodic intervals of assessments. These arranged periodic reviews represent the monitoring task. It is argued that to achieve valuable and long-lasting adjustments to a programme. There must be a systematic, profound, and comprehensive evaluation process.

As Neumann et al. (2018) explain, evaluation has various advantages and contributions. These are as follows:

- Decrease ambiguity so more accurate decisions can be made, and correct actions will be taken in a programme.
- Strengthen the trustworthiness and reliability of those responsible for the programme and its execution.
- Recognise what fits appropriately with the programme and what can't work effectively (operations, effectiveness, efficiency), and determine the potential sites to improve the programme.
- Perform necessary changes for constant enhancement of the programme.

- Learn from the programme's progress, acquire more relevant information and discover the positive and the negative points to inform where the modifications and improvements must occur.
- Enhance commitment to conducting the programme, raise awareness, and acquire further understanding, acceptance, and support for the programme and its execution by exchanging information and explanations with others.

Furthermore, it is crucial to highlight that there will be tools for monitoring and evaluating the collaboration process. These tools will be applied to collect data. In each stage of the collaboration process, data will be collected from various sources (questionnaires, interviews, focus groups, and observations) between 6 to 12 months. Details of the collaboration programme will be attained by regular questionnaires to be conducted to obtain the responses from both faith healers and psychiatrists about the collaboration. Additionally, interviews and focus groups will be organised to evaluate the partnership effectively. Observation is another tool that will be followed to get regular reports assessing the entire programme and the performance of faith healers and psychiatrists.

The previously identified tools will include several elements to facilitate evaluating and monitoring the collaboration programme. These elements are chosen because they will help judge the programme. These elements are designed as questions such as:

- What are faith healers' and psychiatrists' feedback about the programme processes?
- What was effective, worked well, and didn't work correctly from their perspectives?
- Are they aware of what they are supposed to achieve?
- How well and appropriate are staff working together?
- Do they know and agree on what goals they are aiming for?
- What do they like and dislike?
- How well is the programme being implemented?
- What are the challenges and barriers facing the collaboration process?
- How do patients respond to the new collaboration steps?
- What are their perceptions of their new roles?
- What are their perceptions of the effectiveness of the collaboration?
- What has changed from the original work, and why?
- What needs to be approved or any changes that must be considered?

Moreover, in the evaluation and monitoring, there will be indicators which are used to measure the changes throughout the collaboration programme, such as:

- Number of patients referred by faith healers to mental health services to receive medical treatments
- The number of patients referred by psychiatrists to faith healing practices to receive adjunct religious treatment
- The number of training sessions conducted to inform faith healers with the medical knowledge
- The number of training sessions led to raising awareness of psychiatrists about faith healing practices
- The number of dialogue discussions and focus groups organised
- The number of visits by advisory groups to faith healing practices
- The number of medications used by faith healers to deal with their patients
- The number of progress reports produced

#### **8.4.8 Annual Education Training and Awareness**

Faith healers and clinicians need to attend educational training courses regularly to understand the positive role of the other side to promote mutual appreciation and build sufficient confidence to proceed with improving mental health services. Consequently, training and awareness must be carried out annually to maintain skills and knowledge. Crucially, the training curriculum should contain contents from updated biomedical knowledge and approved religious healing methods. Moreover, regular and recurrent supervision of the two mental healthcare providers' performance should be carried out to ensure that the obtained knowledge and skills from the training sessions are adapted and accurately utilised and practised.

#### **8.5. Policy Implications of the Proposed Framework**

The present study provides practical and evidence-based knowledge for decision makers to employ in formulating new health policies and plans that focus on improving Kuwait's mental health system of Kuwait, and it applies to other contexts and countries with similar faith healing practices and similar cultural backgrounds. Indeed, the reflections on the results of this study produced some crucial policy implications. The several suggested implications

from this study's results hopefully would help improve access to mental health services through the collaboration of faith healers with clinical mental health systems. The policy implications of this study are discussed below.

- Inter-sectoral collaboration should be endorsed between the Ministry of Health, Ministry of Islamic Affairs, Ministry of Media, and Ministry of Education to focus on enhancing community awareness, changing erroneous cultural views and beliefs about mental health in general, and motivating the use of mental healthcare services. It is suggested to follow solid, time-framed, measurable steps to enhance public awareness of mental health. The community's thoughts, beliefs, and behaviours towards the psychiatric hospital and psychiatric health services must be modified to encourage approaching the mental health services and to mitigate the stigma attached to psychiatric settings.
  - It is predicted that the conclusions of this study will aid mental health professionals in cooperating with Imams through outreach campaigns to assist them in their crucial role of enhancing the uses of the appropriate mental health services since, at the moment, patients with mental illness appear to be missing their psychosocial needs. We suggested the inclusion of Imams as their high positions within the community and their high reputations will add trust and social cohesion to the outreach services. Moreover, Imams will help identify concepts consistent with Islamic principles.
  - Indeed, numerous mosques are scattered throughout Kuwait, so Imams at Mosques, when delivering sermons on Friday (Juma'a) prayers, could speak about how manageable mental illness is and educate the community about mental illness from an Islamic perspective as well as a medical view so their misconceptions and fear towards mental disorders may be modified and the reliance on the supernatural clarifications connected with mental illness could be minimised.
  - Another method that could be adapted in mosques is allowing clinicians to give lectures explaining the non-religious, medical causes of mental illness, thus helping reduce the stigma towards psychiatric settings and improving mental healthcare services.
  - In addition, mental health education programmes should be performed inside the schools to increase the knowledge level of the pupils about mental

disorders, thereby modifying their behaviours towards mental illness, such as early seeking mental healthcare and reducing stigma behaviours.

- Additionally, the Ministry of Health and other stakeholders should organise collaborative work with the broadcasting agencies of Kuwait to design and structure media programmes that could send clear messages to the public that stimulate acceptance and behavioural changes concerning mental health issues. Enhancing public awareness of mental health through utilising educational programmes by transmitting the messages through the various available media platforms is considered a productive way to mitigate stigma and improve the use of mental health services.
- The official authorities should ratify and license the faith healing practices to organise the healthcare services delivered by faith healers and empower them to occupy an official position within the formal mental healthcare system. This authorisation will promote establishing an official organisation for the faith healers where all faith healers must be registered to be permitted to practice faith healing treatments. The organisation of faith healers will help identify the number of faith healers and the locations of their centres, thus aiding in monitoring their work and enhancing the accountability of faith healers. Moreover, this official recognition will facilitate training programmes to enable the faith healers to understand the concepts of mental illness, which will produce positive health outcomes for the patients. Another potential advantage is to prevent any false faith healer from pretending to offer faith healings. The lack of authorisation allows some faith healers to join this practice for lucrative purposes; therefore, their incorrect interventions can cause harmful effects on the patients. Consequently, the legal authorities urged to adjust and improve the current Mental Health Act to include and encompass the work of faith healers and later disseminate the revised Mental Health Act.
- The medical schools need to modify and update their teaching curriculums to contain and consider the faith and cultural perspectives in the medical field. Indeed, teaching the faith healing approaches to medical students will motivate them to be more open to getting involved in dialogues with the faith healers. Also, they will accept the diversity in treatment approaches. In addition, the medical treatment guidelines need to broaden their mental health treatment approaches and integrate spiritual assessment

as a vital component of the regular medical health assessments. This is because faith healing centres in Kuwait represent a crucial community resource for mental healthcare as the Kuwait culture appreciates and respects faith healers' values and roles.

- Enhance and increase the capacity of the available mental health services to facilitate their access since the decision to consult mental professionals depends highly on the accessibility of the health services.
  - Provide further financial support and increase the workforce to fulfil the mental health services requirements. Indeed, providing adequate human resources with sufficient funding is essential to improve the accessibility and availability of mental health services.
  - Our study participants recommended developing more mental healthcare facilities, as only a single psychiatric hospital is available in Kuwait, with active mobilisation of mental healthcare to extend to the peripheral general hospital and expand the mental health coverage for the whole population.
  - Recruit additional medical staff specialised in psychiatric healthcare to support and strengthen the existing mental healthcare system. The capacity of the mental healthcare workforce throughout the country must reach an adequate level after recruiting. The general working environment within the psychiatric health facilities must be improved to encourage the mental health workers to work productively and offer optimum mental healthcare.
  - Escalate the progression of the integration of psychiatric healthcare services into the primary healthcare centres by formulating a strategy to incorporate mental healthcare in all the scattered primary care centres in Kuwait.
    - Evaluate the current health policies and regulations regarding mental health. The evaluation should produce legislation permitting general practitioners at the primary healthcare centres to prescribe psychotropic medications.
    - Provide mandatory training sessions for all primary healthcare workers to identify and treat common mental illnesses.
    - Provide the primary healthcare centres with fundamental psychiatric drugs.



- Provide officially updated guidebooks that contain mental illness management guidelines in primary healthcare centres.
  - Organise regular visits by psychiatrists who work at the psychiatric hospital to the primary health centres to monitor and supervise the management of mental illness.
- Conduct and establish the collaboration between mental health professionals and faith healers. Policymakers must understand and accept that different factors interact in mental healthcare delivery. In Kuwait, the healthcare plans and policies are chiefly oriented and focused on the biomedical healthcare model. Thus, it is necessary to endorse new health policies and legislations that allow combining faith healing services with formal mental health services to optimise the provision of beneficial mental healthcare as it is suggested by this study to establish communication channels between faith healers and mental health professionals by creating a channel of referrals. The present study emphasised conducting prior educational programmes before the beginning of the mutual referral system to teach the faith healers the various types of mental illnesses and their common symptoms so they will be well-equipped and empowered to give constructive and positive engagement. As a result, the government must allocate significant financial resources to the mental healthcare field to support and surge the collaborative efforts and promote the partnership between faith healers and health practitioners. Ultimately, the joint programme will yield more holistic healthcare by integrating faith healing and medical services.

## **8.6. Practical Implications of the Proposed Framework**

- It is vital to educate the Kuwaiti people about all the available healthcare services so they will be aware and thoroughly informed of the various approaches and make confident decisions about which practice they can utilise. The poor mental knowledge and stigma attached to psychiatric settings influence mental cognitive help-seeking behaviour. High education level has a beneficial impact on the general mental health status.
  - It is recommended to include all powerful stimulating agents in public education, such as the media, non-governmental organisations, and education

institutions, to work together in organising a supportive system that would tackle the stigma issue and improve the utilisation of mental health services.

- Healthcare practitioners, famous public figures, political leaders, and community leaders should all participate in mental health advocacy programmes to enhance these programmes' widespread coverage and influence. It is essential to include the community in advancing the provision of mental healthcare services.
- Public mental health knowledge must be enhanced by distributing educational posters and signboards which contain instructive pictures and religious idioms to send encouraging messages to the public to improve the use of mental health services.
- Initiate mental health education programmes for the faith healers, which should be composed of several meetings and practical workshops to improve their mental health knowledge and enhance their recognition of mental health problems. It is crucial to teach the faith healers about the symptomology of common mental disorders and when it is obligatory to refer their patients. These awareness and educational programmes are highly suggested to strengthen the mental health knowledge of faith healers. Hence, they become more capable of determining the proper time to refer the critical cases.
- Forums should be organised with the mandatory attendance of faith healers, psychiatrists, and community leaders to exchange thoughts, knowledge, and ideas for the appropriate collaboration. It is suggested to arrange such gatherings regularly between faith healers and mental health professionals as they both represent important undeniable sources of mental health services in Kuwait.
- Certifying any medical healthcare system and providing financial support is highly affected by supportive evidence of its efficiency and validity, which is regularly considered a condition to acquire acceptance and approval by decision makers. Similarly, mental health professionals require scientific evidence to accept and support receiving treatment from faith healers for their patients. Therefore, research is needed to examine the effectiveness of faith healing practices in managing mental disorders to yield an evidence-based treatment intervention that could improve the medical practice. Indeed, research is essential to explain faith healing approaches' exact and detailed process. Also, for the healthcare professionals to accept combining

the medications utilised by faith healers with their medications, they must understand the expected harms that might occur, the overdose effect, and the possible interactions after combining both approaches. Thus, there are demands to investigate the faith healing approaches extensively. Also, the quality of care provided by faith healers require further modifications to minimise malpractices and enhance hygiene. These elements should be addressed to move forward with the proposed collaborative healthcare system.

- Political will is a vital contributor to enhancing the delivery of mental healthcare services in Kuwait and promoting the cooperative healthcare system between the leading two mental health providers. Thus, healthcare providers must continuously lobby to change the current situation by forcing the powerful authorities to accept the collaboration project. Civil society and human rights organisations can help exert high pressure on the governmental sector. The policymakers must put the improvement of mental healthcare in its priorities.
- More research about mental health should be encouraged, particularly research concerning the correlation between mental health and faith healing. Hopefully, studies on faith healing interventions might discover a new efficient treatment therapy that can handle the burden of mental illnesses. Indeed, future research initiatives must be conducted with a focus on the regional area of the Middle East and Kuwait in particular, where very few studies have been undertaken. Conducting further studies about mental health in Kuwait is crucial. As shown in this study, the data is insufficient and needs expanding to understand Kuwait's mental health situation better. Finally, future research initiatives should look for a culturally sensitive mental healthcare model that applies to Muslim patients by incorporating Islamic principles.

## **8.7 Conclusion**

In this chapter, a recommended framework to establish the collaboration between mental health professionals and faith healers has been presented and analysed. It was found that such a framework is considered a pragmatic solution that will help adapt an integrated approach of collaboration between the two leading mental healthcare providers in Kuwait. Optimistically, the suggested framework would help improve Kuwait's mental health situation. Demanding collaboration between faith healers and the medical sector is an accurate decision to be endorsed in the current healthcare system. Thus, advocates for the collaboration programme

should look for the appropriate approaches mutually suitable by the two sides to support collaboration by appreciating the significant role of each treatment way in enhancing the utilisation of mental health services. It is hoped that the proposed framework will encourage decision makers to develop a roadmap strategy to foster collaboration by offering equivalent opportunities for all the existing sources of mental healthcare.

## Chapter 9

### Reflection

#### 9.1 Introduction

The researcher's assumptions, beliefs and thoughts can influence the outcome of the conducted research; thus, I have tried to be reflexive in all stages of this research. Reflexivity means continuously reflecting on the research and the researcher's position and function in the research process (Bryman, 2001). This is vital as the researcher is the chief element involved and engaged in the conduct of the research (Bryman, 2001). During the entire research progression, the researcher must continuously reflect on the produced interpretations and understandings they generate from the participants' inputs and theirs (Charmaz, 2006; Mruck and Mey, 2007). Reflexivity is a continuous process in qualitative studies, where self-reflection is crucially needed in the research practice, the attained understanding, the generated explanations, beliefs, and behaviours towards the collection of data, analysis, and writing phases (Creswell 2013). As said by Nightingale and Cromby (1999), reflexivity's ultimate goal is to explore the possibility by any chance that the active contribution of the researcher in the study impacts the overall research process. In this regard, I was cognizant of the possible influence of my background and clinical experience as a Kuwaiti medical doctor on this study. This is because I have a robust medical knowledge of mental disorders and their treatment and management. However, I have attempted to import the reflective skills I learned from being a medical doctor and use them while conducting this study so that they enhance my realisation and consideration of the potential influence of my thoughts, values, and position in the research. According to Devers and Frankel (2000), the researcher must be completely aware of their influence while conducting the study. This is more important and relevant when the researcher is considered the chief tool in conducting the study, as in this research. I was the only person involved in running the study and the main self-regulator concerning the participation in the semi-structured interviews and autoethnography of my perspective on the research topic. It is recognised that the researcher's perspective is involved in building and shaping the meaning of the research (Munhall, 2007).

Reflexivity is an approach to exploring reality from the exact perspectives of the participants more than from analysing their views (Green and Thorogood, 2011). It emphasises the importance of being self-reflective in the research to eliminate any possible impact of the

political and social surroundings and the researcher's interferences, as this will aid in producing more confident findings (Green and Thorogood, 2011; Mays and Pope, 2000). It also involves being transparent in explaining and demonstrating the position and function of the researcher in data collection and analysis. Reflexivity promotes transparency and honesty in research to enhance its trustworthiness and rigour (Pyett, 2003).

Therefore, the researchers' belief and views can influence their work, making their research never value-free. Researchers are similar to a community; they have different levels of power and esteem (Seale, 1999). As a result, they must be honest about the potential impact of their power and abilities. The research should be honest by explaining all the underlying assumptions and determining them to minimise their effect (Ritchie, et al., 2013).

The purpose of reflexivity is to make the researcher's position and function clear and evident in the research (Angen, 2000; DeVault, 1996). The researcher must clarify their epistemological stance, explaining how the data analysis was conducted and how the conclusion was derived. Thus, to be transparent while conducting this study, I tried to be visible in the research by reflecting on the potential impact of my background and my values on the outcome of this research. Every step carried out during this study was extensively described. I have tried to describe the data collection methods and sampling process, the applied analytic tools and the research analysis.

## **9.2 Why this PhD?**

My motivations to research mental healthcare in Kuwait's cultural context and its role in determining mental help-seeking behaviours stemmed from personal and professional reasons. My background and position influenced the research topic I selected to explore. I am a Kuwaiti citizen who has worked as a medical doctor, mainly in the primary healthcare sector, for more than four years. Thus, I have been in close contact with numerous patients with mental disorders and realised that many patients have never accessed mental healthcare services. My motivation to enhance the use of mental health services was stimulated by the noticeable reluctance of my patients to accept a referral to psychiatric care centres and my struggle to convince them. I understood how crucial the role of religion and cultural values in influencing the response to mental health problems and recognised the profound extent of stigma toward mental illnesses. Accordingly, I am motivated to help improve mental healthcare in Kuwait.

The patient's values, beliefs and treatment expectations have broadened my perspectives in mental healthcare and encouraged me to think of adjusting some of my own mental health beliefs. This provoked some uneasy feelings towards my psychiatric practice skills and knowledge, particularly at the beginning of my career. With time, these tense feelings diminished as I started comprehending the different angles of mental healthcare. By applying some reflective concepts and activities, I discovered that I am unaware of some of my patients' needs. Being reflective about my thoughts and emotions permitted me to accurately value the importance of the cultural aspects in constructing meanings and shaping understanding by individuals. This recognition has also encouraged me to appreciate the impact of cultural factors when analysing and satisfying the mental health needs of my patients. I hope to be able to meet the mental health needs of my patients in Kuwait by considering their values and beliefs.

During my working experience in primary healthcare facilities, I worked closely with doctors from various specialisations to provide the appropriate healthcare services, which enhanced my capabilities and increased my confidence in building relationships with the participants of my study (psychiatrists and faith healers). My work experience in providing healthcare services motivated me to improve the healthcare system and inspired me to become strongly committed to sharing the challenging experiences of my patients with mental illnesses to improve mental healthcare services and ultimately obtain more positive health outcomes. I engaged in this study as a person who had accurately seen Kuwait's mental healthcare situation, including its weaknesses. I firmly believe that to achieve the best delivery of mental healthcare services, patients' cultural and religious values must be appreciated and involved in the treatment approaches. These beliefs and this working experience are the central stimulants that induced me to choose this topic that advanced into this thesis.

## **9.3 Experience of the PhD: From Conceptual to Reality**

### **9.3.1 Engagement with Literature**

In the beginning, when I started to engage with literature search, there was limited available published literature about faith healing practices in the Middle East and Kuwait in particular, despite only a few studies conducted in some Arabic countries showing the widespread utilisation of faith healing treatments by sufferers of mental illnesses. There is a dearth of

studies on mental healthcare in the Middle East and the Arab world. This can be understood and expected as neglect and disregard for mental health are common in Arabic countries. The current healthcare policies and strategies in Kuwait and most Arabic countries are designed and formulated to treat physical health with little attention to mental health. Mental health is a challenging area of research in the Arab world because of the stigma surrounding it, which enforces a repellent environment and impacts even on people intending to research it. I was surrounded by negative thoughts and comments about my area of research from relatives and friends who were also medical doctors and doing PhD studies in the United Kingdom. This led me to be frightened of disclosing my topic to any further friends and relatives. Initially, because of the scarcity of literature about my research topic, I had a stressful time as it was challenging to conduct a study with a dearth of reliable sources. I was doubtful whether I could complete my study, which imposed extra pressure on me, so I started thinking about changing my research focus.

However, I viewed that as an advantage that could add strength to my study because no prior research or study has explored the faith healing practices in Kuwait. Currently, no study has focused and examined the impact of faith healing practices on the mental healthcare in Kuwait. Thus, my study is significant since it will reveal and explore the ambiguous world of faith healers and their approaches. Consequently, my feelings turned upside down as I began to view my topic as an exciting and thought-provoking area of research. I could convert the negativity surrounding me to positivity by commencing an encouraging experience that I am highly motivated to discover. My supervisors played a crucial role in this aspect as they believed in my topic, so they elevated my confidence. They encouraged me to continue and explained that I could rely on other lessons and sources from other countries, such as India, China, and Africa since traditional and faith healing practices are standard in these places. An extensive literature review and research yielded and identified valuable peer-reviewed resources that incited my critical thinking and perspective on establishing an integration process between faith healers and mental health professionals. I was aware of the possible influence of my previous knowledge and my underlying expectations on the study outcomes. Thus, I intentionally prevented my thoughts, position, and prior information from influencing my research process of the relevant literature. Attending regular supervision meetings was beneficial as my supervisors informed me to be more vigilant when analysing the literature and remain neutral and unbiased when selecting the proper relevant literature. I was mindful that I am susceptible to unintentionally immersing my underlying beliefs and assumptions



within the research process. Thus, I deliberately remained impartial and will support the idea of integrating faith healing with mental healthcare services only when the existing literature and theories prove its efficacy and practicality.

### **9.3.2. Developing the Methodological Framework**

Initially, I was thinking of developing my methodological framework based on the three chief dimensions of my research focus: the two leading mental healthcare providers (psychiatrists and faith healers) and the service users (patients). I believe that patients who suffer from mental health problems, are one of the chief determinants in shaping the mental health care pathway and in making the decision of whom health care service will be utilised. But I was perhaps ambitious about obtaining ethical approval to include patients with mental health disorders. They were excluded from the sample due to ethical concerns as they were regarded ineligible to provide reliable and valid consent. Moreover, in hindsight, the inclusion of decision makers in the sample is expected to add further benefits to this study as I could assume their managerial positions would have strengthened the arguments of this study. Therefore, it is regrettable that no decision makers were included in this study. However, Ziebland and McPherson (2006) argue that for research findings to be considered reliable, they must represent reality by having representative data that can be achieved by being impartial. This involves not just recruiting participants who are easy to approach but also those who are privileged. Therefore, I was convinced I could satisfy my ambitious yearning with the experience, knowledge, ideas, and issues the two groups would have added to this thesis.

Reflecting on the inclusion of two completely different sectors (psychiatrists and faith healers) to obtain extensive data from each side, analysing them separately, and later combining the two outcomes is vital as this might have a profound impact on the whole research process. Limiting the number of groups of participants into two main categories could have contributed to attaining a deeper examination of the research by focusing on the primary mental health providers. For example, the involvement of patients' thoughts and perspectives has already been mentioned and clarified as desirable. However, interviewing more frontline health practitioners might have allowed more identification of differences between the two mental healthcare providers, extensive investigation of their treatment methods that might have strengthened the obtained results on understanding the connections between faith healers and mental health professionals, and more profound recognition of the

needs to establish collaboration between the two sides, and evaluating the suitable mechanisms or channels to achieve that collaboration. In this study, more concentration and attention were applied to mental health professionals and faith healers and their relationships, their social interactions and professional communications with each other, their understanding of mental health and illness, and their professional roles and tasks.

In this study, the phenomenological approach was followed. The reason behind choosing the phenomenology design is used when the researcher attempts to explore and investigate a phenomenon by interpreting how people understand and respond to that phenomenon (Creswell et al., 2007). Other methodological approaches were fully considered to be used in this study. Still, the phenomenological approach was chosen as this study explores a phenomenon occurring in Kuwait about the concurrent access to two mental health providers: faith healers and mental health professionals. Semi-structured interviewing was selected to be the suitable method to conduct this study. This is because interviewing is recommended to reach individual construction and experience of any given phenomena. Initially, non-participant observation was the second chosen method. However, because of the situation of COVID-19 in Kuwait and the impact of the related restrictions and precautions, I discussed with my supervisors at York and my supervisor at Kuwait University the possibility of carrying out my fieldwork. We agreed that the interview part of the research could be done through video conferencing. However, the observation part of the research has been dropped. Instead of the observations, I have decided to examine my personal and professional experiences with psychiatrists and faith healers in the past as an autoethnographic exercise (supported by Ellis, 2002 1, Maréchal, 2010 2). I will only be examining my own experiences and will not engage anyone beyond the psychiatrists and faith healers as per my approved ethics application. It is worthy of reflecting on the autoethnographic approach and of exerting additional attention as O'Connell Davidson and Layder (1994) claimed that when the ethnographic work and its qualitative analytical approach are employed in a study, there is a high tendency that the researcher will interpret the findings based on their values. Their cultural beliefs and social status, thus bias could occur from the influence of predisposing assumptions and position.

In this study, I realised that obtaining ethical approval requires me as the researcher to employ extensive care in the data collection and the analysis stages of the research process. It was not a straightforward task to attain the ethical approval as there were several

requirements, primarily filling out the ethics form and completing all the sections to submit it in advance to be reviewed and processed to ensure it fulfils all the requirements before being granted the ethical approval of my study. Significantly, this process has enhanced the safety and added further protections for the participants of this study, and also made meaningful adjustments to the methodology of the study. Indeed, the main crucial benefit of this experience was helping me be more aware and understand that the participants' safety is the critical element in formulating research design. Moreover, I was cognizant of the potential negative impact of insider-contingent bias, which occurs when dominating the participants' responses, so the construction of meanings deviates. This bias could have unfavourable negative consequences on the research analysis if not handled.

### **9.3.3 Scoping Review**

A scoping review was performed following the methodology Arskey and O'Malley (2005) described to examine and map the existing literature discussing the collaboration between faith healers and mental health professionals. The initially conducted scoping review significantly affects the aim and objectives of this study and the chosen methodological approaches. This research has followed the phenomenological qualitative approach, which generally supports and encourages the process of completing the literature review before the beginning of data collection. The literature review was deemed an essential requirement for accomplishing this study. The scoping review was supportive and contributed to shaping the research structure. However, it was necessary to employ the scoping review as a critical element of outlining the study beyond my beliefs, personal values, prior assumptions, and attitudes. Moreover, my literature review provided a robust foundation for my research and enhanced my knowledge about my research topic. In addition, the literature review promoted and justified the reasons for choosing the research topic and selecting the aim and objectives.

My scoping review revealed that faith or traditional healing practices are popular alternative sources of treatment that continue to be utilised throughout the entire world from ancient times to the present. Despite abundant effective modern health services, people approach faith or traditional healers to receive help for physical or psychiatric disorders. My values and expectations might have impacted the scoping review's highly sensitive knowledge and data. I harmonise with several of the ideas and concepts produced from the scoping review. As the primary researcher in this study, I must subside my private assumptions and preconceptions and remain neutral in analysing the obtained data.

Therefore, when searching for literature on my research topic, I tried to reach all relevant and potentially applicable literature that would help reduce and eliminate any personal and biased way of thinking. I applied what Arksey and O'Malley (2005) highly recommended: to formulate broad keywords and search terms for the literature research to obtain all potential and relevant literature on the topic. Search terms were chosen and developed according to the three essential elements of the research question: 'faith healer', 'collaboration', and 'mental health'. During the research process, many keywords for this review were selected, such as: faith heal\*- collaboration\*-mental health- service\*- healthcare- mental illness\*- treat\*- barrier\*- religion\*- Kuwait- Middle East- psychiatr\*. Indeed, numerous keywords were employed to cover all the different angles of the study. Moreover, the truncations (\*) and synonyms were employed to obtain all potential and relevant literature. Afterwards, Boolean operators 'and/or' were used to combine the initial broad literature search results and filter them to attain the final selected studies. I believe that by applying this search process, the chosen keywords have managed to comprehend and reach the research topic from different directions and prevent any potential bias from the researcher.

Moreover, I have accessed several databases to obtain peer-reviewed studies, such as PsychINFO, PubMed, MEDLINE, Scopus, and Web of Science. These databases were selected because they are recognised in international health, medicine, and psychology and produced potential and relevant literature. Moreover, the websites of the WHO, Kuwait Ministry of Health (MOH), United States Agency for International Development (USAID), World Bank, African Development Bank (AFDB), and Asian Development Bank (ADB) were visited since mental health is an essential aspect of their work. Other grey literature was obtained by consulting search engines such as Google Scholar and Google. Generating the literature from various sources has ensured and helped to prevent the contribution of my values and assumptions and neutralise the obtained literature from any unintentional bias.

Abundant literature was reached. However, much of the obtained literature didn't appropriately correlate with the purpose of this study. However, the review progression remained focused on evaluating the opportunity to form a collaboration between mental health professionals and faith healers in Kuwait. Accordingly, the scoping review and the discovery of new perceptions and beliefs concerning the phenomenon of concurrent access to the two mental healthcare providers have produced a greater and more sophisticated understanding of mental healthcare in Kuwait. My scoping review has provided meaning to

the research focus and offered a detailed and profound description of the phenomenon. The review contributed to accomplishing findings concerning the opportunities for faith healers and health professionals to collaborate to provide mental healthcare, which fulfils one of the primary objectives of this study: to explore and examine the opportunities for faith healers and mental health professionals to collaborate to provide mental healthcare in the context of Kuwait.

The literature review analysed the factors affecting the opportunity to form a collaboration between mental health professionals and faith healers in Kuwait. It provided a rationale for the study's aim of establishing such a partnership. Hopefully, it would help to cause a shift in decision makers perspectives so they would be motivated to adopt a plan of providing a more holistic healthcare system.

#### **9.3.4. Fieldwork**

Since the phenomenological approach has been selected for this study, interviewing was chosen as the suitable method to conduct this study. This is because interviewing is recommended to reach individual construction and experience of any given phenomena. Interviewing is appropriate to understand how people think and feel towards a particular topic and how they act accordingly based on their interpretations.

As a Kuwaiti citizen who had previously contacted the two groups of my participants (psychiatrist and faith healers), I felt on many occasions that I have an inner knowledge and unique understanding of the participants from both groups. Still, to achieve impartiality and objectivity in this study, I repeatedly reminded myself that I am a neutral researcher looking at the research as a foreigner. Indeed, I was mindful that my background, position, and emotional status could inadvertently affect the obtained findings if they were unaddressed. For instance, when psychiatrists expressed their frustrations towards mental health services as they were dissatisfied because of the shortage of mental health staff and the low prioritisation of the authorities towards mental healthcare, I shared with them such feelings as I was also unhappy and frustrated from the mental health situation in Kuwait. This evoked emotional reactions as I developed empathy with their concerns and understood the changes they felt driven to accomplish. Also, I was unhappy and disappointed when I listened to the complaints of some faith healers about feeling disrespected by mental health practitioners. When I started interpreting the obtained data, all the former feelings had to be carefully

checked and controlled. By recognising the potential impact of these emotions, I have always attempted to restrain and hold my feelings. I frequently recall that I should act as an unbiased investigator; I often felt I was trying to forget and detach from my personal and professional identity as a Kuwaiti citizen and medical doctor. Eventually, the participants' input and contributions genuinely matter in this research. In addition, I considered the probability that my prior knowledge and values could influence my way of analysing the findings. Therefore, I tried not only to include and describe the conclusions that harmonised with my predisposing assumptions. On the contrary, I was vigilantly reflexive by observing my beliefs, thoughts, and whether desirable or undesirable towards the research focus area and the research outcomes.

The other dilemma I faced during the interviews was that it was highly expected that some of my participants might raise private and intrusive questions about me. This is because of the nature of the Kuwaiti community and Arabic societies in general that are socially united where people constantly interact during work and social events, so social rapport and support are more dominant than social privacy. Thus, Arabic people traditionally tend to ask private questions in their social gatherings, such as marriage proposals, number of children, occupation, wages and income, and other personal questions. As a result, there is a high tendency to be asked one of these questions, and if I attempt to ignore their individual questions, I will create unwanted barriers between them and me. When such situations occurred during the interviews, I struggled to maintain an equilibrium between protecting the confidentiality of my personal information and creating trust. I was cognizant of the power dynamic within the semi-structured interviews, so although I attempted to be friendly and responsive to my participants, I tried to concentrate on the research area focus and not saturate the discussion with my accounts. Maintaining a balance while conducting the interviews was a challenging task. Therefore, I decided to give the participants the chance to speak after the interviews if they wanted to discuss with me my knowledge and unique experiences, which would help in doing the interviews mainly oriented towards the participants' experience, and by doing so, the issue of the power dynamic between my participants and me will be resolved. In addition, I attempted to tackle this problem by redirecting the concern and attention to the primary research topic, and many participants reacted positively to this.

Several challenges will appear after a researcher conducts interviews with participants sharing a similar ethnic background. This is called 'assumed similarity.' The researcher's challenge here is to preserve their private identity while conducting the interviews (Raja, 2015). Since I am Kuwaiti and belong to the community I am investigating, I had to contend with mixed emotions. However, the primary feeling I held was my determination and motivation to help my community by accomplishing this study. Conducting interviews with participants who shared my cultural beliefs produced unanticipated contradictions. This is because sharing cultural views with my participants assisted me in developing good relationships efficiently from the first set of interviews, which was essential to proceed efficiently with the interview process. I completely understood their narratives since I share the same cultural identity. On the other hand, sharing my cultural background and belief with my participants had undesirable and unfavourable consequences. Their answers to my research questions might be concise and brief as they expect me to be familiar with their treatment practices, mental health values, and attitudes. The assumed similarity could adversely affect the research results as the participants' input might be inadequate because they consider me part of the Kuwaiti society, so there is no need to extend their answers. Therefore, when the assumed similarity was felt during some of the interviews, I exerted extra effort to encourage them to elaborate on their answers.

Furthermore, it was crucial to focus more on my cultural values and beliefs when conducting the interviews and to perform the data analysis since every participant has a unique view and understanding within the same cultural context. People living in the same country have different cultural perceptions and viewpoints and share the same culture. Since I was firmly attached to my research topic and focus, I was apprehensive about becoming excessively engaged in the research process. Critical thinking and self-assessment are vital tools to tackle this issue. From the beginning, it was crucial to recognise and reflect on my views, values, behaviours, and comprehension of my research subject. My thoughts, attitudes, emotions, beliefs, behaviours, and expectations were continuously observed and scrutinised by different approaches, such as having regular meetings with my supervisors, sharing thoughts with my colleagues, and having a written diary after interviews.

To fulfil the requirements of the reflexive process, I recognised and controlled my thoughts and ideas before conducting the interviews. When a reply or answer received in the study doesn't match the researcher's expectations, the researcher should admit and identify these

predetermined ideas and expectations (Koch and Harrington, 1998). Consequently, to reduce the potential impact of my beliefs and views on the outcome of the interviews, I wrote diary notes that contained my emotions during the interviews. I also added my feelings before and after all the conducted interviews. I was thinking reflexively by attempting to include all my thoughts and feelings when I was conducting each interview. This has been achieved by considering all my prior assumptions and ideas about my research when I conducted the interview and wrote the transcribed report, thus attempting to determine any influence or linkage of this knowledge with my research results. This reflexive approach was applied for the upcoming interview to create an extended and linked process of reflexivity.

The reflective notes I have gathered in my diary were inspirational and stimulating as they helped me comprehend a broader understanding of my participants' contributions. The reflective notes are listed below.

- The majority of faith healers gave very long answers in their interviews, and they were very keen to illustrate their faith healing practices by giving long explanations, which might be related to their desire to change the widespread view about their practice and to correct common misconceptions about their work, particularly with the unlawful recognition of their job. Therefore, I attempted to be empathetic and emotionally engaged with my participants, and my learning and training as a medical doctor enabled me to do that. This is simply because I cared not only about what kind of data my participants gave me but also about the participants' journeys. The interviews were not a practical means to grasp the data from the participants and work on it but were a means to understand their experiences.
- The majority of faith healers mentioned very detailed history about their patients and knew very private information about their patients and their families and friends, which could illustrate the preference to approach them by many patients as faith healers build strong and trustworthy rapport with their patients.
- Some faith healers invited me to their centre to observe their work. I replied that I could not accept their invitation because of COVID-19 restrictions and precaution measures. This indicates the willingness of faith healers to show the good side of their practices and their hunger to obtain official recognition for their work. Many participants were highly motivated to resolve the issue of legal recognition. They thought changing the political will was necessary to move forward with official



acceptance. While the participants expressed their concerns, I experienced solidarity with them in pursuing the resolution.

- Some faith healers were reluctant to participate in the interviews because they assumed that a study done by a medical doctor from a foreign university in the United Kingdom would aim to show their practices negatively and criticise their work. However, I managed to convince some of the hesitant faith healers by explaining the actual aim and objectives of the study and ensuring them that this study was not designed against their work, and I was completely neutral. Fortunately, some of them changed their mind and decided to participate.
- The illegal recognition of the faith healing practices probably influenced some faith healers' answers in the interviews since several faith healers tried to reply to some questions broadly, avoiding talking about themselves. For example, when I asked them about their motivation to become faith healers, many tried to avoid mentioning the financial benefits. Still, they said other faith healers might practice faith healing for a lucrative purpose. I understood their response due to the sensitive issues I was discussing with them and was also prepared to receive some rejections to answer specific questions.
- On the other hand, many psychiatrists gave very short and brief answers to the interview questions because they assumed that I, as a medical doctor, should know the answers and that there was no need to go into details. It is important to note that I felt that mental health professionals use professionalism and they consider themselves part of the global community of psychiatrists. They can't counteract their treatment protocols and guidelines. In addition, they can't work against the political will of the local authorities.
- Some psychiatrists were unhappy with some interview questions because they felt these were against their scientific beliefs and principles. I encountered this reaction when I asked about what their actions would be if they found difficulties in treating some patients and when I asked if they had any previous contact or experience with faith healers.
- The interview with the first psychiatrist was the most difficult one as he asked me frankly in the middle of the interview about my opinion towards the collaboration. He said he felt I was not neutral and more towards the collaboration between the two sides. I tried to reassure him that I was completely unbiased, and he felt that because I

asked several questions about the collaboration. I was trying to get all the required information and the best outcome from the interview. Fortunately, with the later interviews, I put in mind to act very neutrally when presenting my topic and when asking the questions to the interviewees. Thankfully, I managed to do so as I haven't faced the same problem again.

### **9.3.5 Analysis**

A significant advantage of having a long and sufficient period to complete this study is having more space and time for the reflective approach to observe my feelings during the analysis. While writing the outcomes of the interviews with my participants, I included my feelings and thoughts to capture all my beliefs and perceptions and minimise their possible influence on the findings. I tried to examine my results several times by thinking reflexively and applying the reflexive measures that acknowledged my presumptions and feelings that could have influenced the results. Thus, in the analysis stage of this research, all the generated meanings and understanding were created primarily based on their appropriateness with the data. This has been carried out carefully to ensure that the analysis represents the data, not the researcher's assumptions and thoughts. According to O'Connell Davidson and Layder (1994), the analysis and explanations of the study results must be understandable and rational to the study participants. Correspondingly, the generated themes and subthemes from the analytic process of this study were purely connected with the participants' contributions, appreciation, and feedback.

Reflection is associated with observation and perception during the research process and is linked with the perceived power in the analysis (Hunter et al. 2002). Glaser (1978) claims that the researcher must be a critical thinker so that they can distinguish and detect the significantly relevant data that can add more profound perceptions to the meanings. Also, Glaser (1999) argues that the researcher must be capable of being undisturbed and patient with the uncertainty and misunderstandings with their data, as grasping the data isn't straightforward. I attempted to be patient and determined to wait for my data's theoretical meanings to be achieved, allowing me to create applicable codes that provide relevant interpretations of the findings. In addition, my regular meetings with my supervisors have assisted and enhanced the reflexive measures during the analysis process of this study. This is because, during the meetings, my supervisors assessed and checked the whole process of my

research, the chosen methodologies, and the analysis of the results, so they have helped me resolve any problems or concerns raised during the research process. My supervisors have evaluated and checked the generated themes and codes to ensure they are justifiable and applicable to my research focus. One of the advantages and the positive elements of this study is that my two academic supervisors were the same, so they accompanied me during the entire research.

Reflexivity is crucial mainly in qualitative research to enhance validity (Darawsheh, 2014). During the whole process of my research, I have always considered the positive linkage between validity and reflexivity. It has been argued in the current healthcare studies that quantitative methods are deemed to be the optimum way of achieving validity (Newton, 2009). This is because, in qualitative research, the association between the input and the output are often not straightforward and understandable (Trueit, 2008). Therefore, qualitative research is often disregarded and sometimes rejected from being included in practical fieldwork because of the insufficient validity measures (Newton, 2009). Yet, qualitative studies are considered helpful in demonstrating the participants' experience, which is often absent in the health guidelines and policies (Newton, 2009). Huberman and Miles (1998) supported establishing a proper reflexive process in qualitative studies by presenting constant detailed reflective notes on all the issues that could have impacted the research outcome to ensure obtaining the appropriate quality of research and to satisfy validity and reliability requirements.

The researcher is then supposed to perceive themselves as part of the research process, so they should not manipulate the research tools in creating theory from the data (Hammersley and Atkinson, 1983). In qualitative studies, validity is achieved when the researcher is investigating and exploring what they are supposed to be investigating and exploring (Mason, 2002). Miles and Huberman (1994) have recommended 13 strategies to reduce and eliminate bias and enhance the reliability of the research's findings. Some of these strategies are examining the generated codes to ensure being representative of the obtained data, looking for any unusual actions by the researchers during the interviews that provoke individual responses from the participants, and examining the unique inputs that don't correlate well with the most of remaining inputs, tracing the unexpected outcomes to ensure the accuracy, applying someone to test the fieldwork notes to search for any opposing evidence. Moreover,

the obtained evidence must be backed and supported by referenced quotes from the participants (Mays and Pope, 1995).

I believe that I followed such a process in my research, mainly when I conducted the thematic analysis. Indeed, I have shown and demonstrated all the steps applied in my thematic analysis: familiarising myself with the data, producing initial codes, classifying the themes, and formulating thematic structure by integrating the themes and interpreting the outcome. The thematic analysis is a flexible process that permits various themes to be formed and later reduces the numbers to include only those that can help accomplish the research aim. I was thinking reflexively while performing the coding and sorting the relevant codes by recognising and controlling my values, opinions, and presumptions about my research topic. This has been achieved by repeatedly reviewing the codes and adjusting them several times to reach the final refined codes. My reflective field notes, gathered during the interviews, helped make the coding process devoid of any potential bias. Also, the entire thematic analysis was completed under the supervision of my two experienced supervisors, so their given advice when required and their participatory efforts were vital to testing and scrutinising the analysis process and the interpretation of data.

#### **9.4 Learning From This PhD Process**

I believe that my research has succeeded in fulfilling its target by finding satisfactory answers to the main research questions and sub-questions. Accordingly, I can state undoubtedly that my study has achieved its goal of providing new knowledge to the mental health field, which is currently a field where a paucity of research has been carried out. Indeed, the unique contribution of this study can be recognised by the exceptional inclusion of the study groups (faith healers and psychiatrists) in the context of Kuwait, which has not been investigated before. The development of an overarching model for establishing the collaboration process between psychiatrists and faith healers is considered a unique contribution of this study. After investigating and analysing this research's results, the recommended collaborative model helped accomplish the research goal. This research provided a novel comprehension of the perspectives of faith healers and mental health professionals in Kuwait about mental treatment methods and mental health theories by the co-construction of the respondents' contributions and the outcome of the conducted analysis. This study demonstrated that a

multi-faced reality could exist about a single explicit element and people tend to view reality from a one-dimensional perspective or stand. Thus, our understanding of this reality could be primarily subjective. Indeed, the participants' different opinions and the various views that have been collected from their contributions to this study provide more profound descriptions and enriched understandings of the mental health values and treatment assumptions that exist in the Kuwaiti community. Thus, I have learned from my study that every thought matters in this life as the strength of this study principally derived from the various contributions and information of my participants, which enhanced the richness of the obtained results.

Moreover, the engagement with this study and the direct contact with the study population (faith healers and psychiatrist) has promoted my work skills and abilities since it broadened my horizons of thinking by acknowledging the role of culture in mental health and acquiring additional recognition of the connection between cultural beliefs and the suitable treatment options. Thus, in the future, I will always consider critically assessing my patients' religious and cultural beliefs in my medical practices. Also, I hope the result of my research can benefit mental health practitioners in better understanding the faith healing practices and their relationship with mental healthcare.

Moreover, this study has affected me significantly in terms of increasing my motivations to remove the widespread misunderstandings of psychiatric illness and enhanced my aspirations to discover the optimum solutions to advance the delivery of mental health services in Kuwait. My study has established a great willingness and an elevated sense of responsibility to improve the mental health situation in Kuwait. The close contact with my participants stimulated a profound desire to improve mental health in Kuwait. I was frustrated when both groups identified the obstacles they have faced and the struggle they encountered with treating their patients because of the pervasive stigma toward mental illness in Kuwait. Therefore, I am very eager to utilise what I have learnt in this study and apply it in my clinical work and to look for further progression in this field by incorporating more studies with a more extensive study population of the community.

Furthermore, my communication skills and capabilities have been significantly improved at the personal and professional levels. This is due to the acquired benefits of the negotiation with the participants. I developed new diplomatic ways of dealing with new people, so I am now more confident in building new relationships. These experiences have shaped my personality to become more open-minded in accepting opposing opinions and views. Thus, I

believe I can work effectively with other medical specialists and maintain satisfactory networks and relationships with them. Therefore, moving forward, I will attempt to create an open-hearted environment that accepts different points of view and halt the idea of working separately. Moreover, reflecting on my PhD journey and transferring across the various stages of this study, I have attained a more profound recognition and appreciation of the difficulties, obstructions, and frustrations encountering all professionals in different sectors which could occur within the process of achieving a sizeable exhaustive project in any field.

It is crucial to highlight that after my initial meeting and discussions with my supervisors, I realised that at each stage during my PhD programme, there must be some skills and knowledge that I should learn and acquire as they are essential to completing my research successfully. Therefore, various training courses and modules at the University of York have been attended to ensure and strengthen my capabilities in accomplishing my study. Attending these training courses, particularly searching the literature, allowed me to access and obtain a wide range of literature articles which ultimately helped me better understand my topic. Also, a Qualitative Health Research module has benefited me to get further knowledge and to be up to date with qualitative research methods, methodologies, and research analysis. Likewise, I believe applying phenomenology and its methods followed in this research is a significant methodology to be adapted to create reliable data and achieve profound and complex understanding in studies. Finally, I realised how essential to share knowledge and experience with colleagues and supervisors as I was gaining further clarification and understanding of my concerns during each phase of my PhD, so I learned to seek advice and information from the people around me actively and to be actively involved in discussions with them when needed. More importantly, having a good rapport with them is fundamental and necessary for adequate mental and physical support.

## **9.5 Conclusion**

Reflection on the researcher's position and role in the research design, data collection, data analysis, and all the different steps in conducting the study was emphasised in this chapter and employed to increase the study's credibility. Thinking reflexively will reduce the chance of my assumptions and experiences unintentionally interfering with interpreting the study's results. Measures undertaken during the process of conducting this study to minimise this from happening have been described in this chapter. This chapter outlined all the reflexive steps carried out during the entire process of completing this study, from the introduction to

the conclusion, to achieve the proper level of reliability and validity. I believe the transparency was relatively high in all the stages of this study, thus enabling the reader to make accurate judgments about the trustworthiness, applicability, and significance of this research. I was honest with all my study participants about my medical background, which enhanced this study's transparency. It encouraged the participants to openly engage with the research and share their knowledge without restrictions, contributing to a more in-depth understanding of the research topic. I developed a good rapport with my participants, allowing sufficient input from them. Optimistically, I think this study has provided an intensive and thorough description and analysis of the investigated phenomenon, thereby adding new valuable knowledge to the clinical mental practice.

Since I have faced several challenges and struggles to accomplish my study, I realised how difficult academic work is and recognised the high demands of academia. It was not a simple task to arrange and conduct the interviews, particularly with the faith healers. I relied on personal communications to reach them, which took a considerably long time, and some arrangements failed. In the beginning, I was quite apprehensive of what was appearing that the research may benefit from only limited participation. Yet, I desired to obtain a profound understanding of my research to help people with mental health problems in Kuwait. So, after believing in my capabilities and building trust and confidence with my participants, I was content with the number of respondents at the final stages. I was able to collect sufficient beneficial data from their contributions.

The final concluding message of this research is that faith healing practice is commonly accessed in Kuwait. However, the biomedical model of health and illness is still the dominant component of mental healthcare plans and policies. Optimistically, the outcome of this research has delivered a practical and valuable examination of the faith healing approaches and illuminated the vagueness of their position in the health system and their potential to contribute to people's mental health. Accordingly, the obtained findings of this study would facilitate the inclusion of cultural and religious elements in the mental healthcare system. Indeed, this study has made a start and has developed a framework to guide a collaboration initiative.

## **Chapter 10**

### **Conclusion**

#### **10.1 Introduction**

This concluding chapter will underscore the chief conclusions drawn from this dissertation. Prior research emphasised and concentrated on understanding the different faith healing practices and their role in providing mental healthcare services, rather than focusing on bringing their approaches to the medical field and working closely in one system. Consequently, this has produced a noticeable gap in the available literature. Therefore, research that can explore the relationship between the two sides and the opportunity to establish collaboration between them is needed to fill the identified gap. Therefore, this thesis has focused on addressing this gap. Based on the recognised gap in the available literature and my prior working experience in the healthcare services in Kuwait, I had a high enthusiasm and powerful determination to conduct this study to explore the opportunity to establish collaboration between mental health professionals and faith healers. Remarkable and motivating results were found in this study using the perspectives of psychiatrists and faith healers that displayed a clear interest from both sides in improving mental healthcare provision. The participants of my research provided various thoughts. They were involved in fruitful discussions via interviews with me about the potential interventions they have suggested to help improve the mental health status in Kuwait.

One of the most critical deductions that have been extracted from interpreting the results of this study is that most faith healers in Kuwait are cognizant of the significance and the importance of psychiatric management of people with mental health problems; yet, they revealed a lack of communication channels with the psychiatric hospital. Another crucial finding is that psychiatrists were healers reluctant to accept the collaborative mental healthcare system with the inclusion of faith, despite their belief that every sector should participate in maintaining the positive mental health status of the patients. Nevertheless, faith healers' and psychiatrists' mental health values and opinions are not expected to be permanently fixed and unchanged. On the contrary, the lack of trust and the hesitancy to collaborate might no longer be anticipated behaviour among psychiatrists. The previous findings demonstrate the potential obstacles to establishing shared mental healthcare services and provide a clear image of the mental health situation in Kuwait between the two leading



providers. Once this situation is recognised correctly, the mental healthcare workers will be obliged to share the responsibility with the faith healers to provide mutually organised mental healthcare.

The patients must be reassured that their mental help-seeking behaviours, including accessing faith practices, will not be perceived as an undesirable and unfavourable approach by their healthcare professionals. This will create an excellent and trustworthy connection between the patients and the health practitioners and promote the patients' mental and physical health. Despite the obstacles and hindrances to forming a collaborative healthcare system between the two sides, this study showed positive and successful examples of joint work between different treatment modalities. The differences between the two treatment approaches can produce a more efficient integrative healthcare system by providing a more comprehensive understanding of mental illnesses. This study has succeeded in developing a framework of treatment that incorporates the cultural and religious factors in managing mental illnesses in Kuwait and can be utilised by psychiatrists and faith healers.

The obtained findings and learned knowledge of this study will hopefully be applied in Kuwait's practical world and clinical field of mental health services by incorporating its acquired lessons in delivering mental healthcare. The present research has illuminated the differences as well as the similarities between the two treatment modalities; thus, the earned lessons can be employed by integrating Islamic faith healing practices into the formal mental healthcare system, and on the other hand, by applying the learned lessons from the biomedical model in the faith healing approaches. For instance, mindful meditation is currently an approved practice as a psychotherapeutic approach to managing different psychiatric illnesses. The basic knowledge and ideas of mindful meditation are brought from ancient Eastern philosophy (Walsh and Shapiro, 2006).

Therefore, decision makers and healthcare planners must implement a group of health policies and plans that organise the shared work between healthcare professionals and faith healers and adjust the healthcare system accordingly. Indeed, the present study advocated for the inclusion of the various existed mental healthcare providers in the state of Kuwait to satisfy the mental health needs of the Kuwaiti population. Integrative healthcare must educate all mental healthcare providers about the shared cultural beliefs within the Kuwaiti society concerning mental illness and faith healing practices since a considerable number of Kuwaiti patients first access faith healers. This study supports the consideration of cultural and

religious values in the mental healthcare plan as these values influence the treatment expectations and the response to the provided health services. Optimistically, this study has raised awareness of the role of religious and cultural beliefs in managing mental health problems among Kuwaiti patients. Moreover, the obtained findings would help psychiatrists to employ more culturally sensitive treatment approaches and to provide more holistic healthcare. This study advised proactive measures by modifying mental health service provision to become more culturally accepted. Hence, the Kuwaiti Ministry of Health should review and adjust the existed mental health laws and regulations to generate a new modified mental health act that permits the collaboration with faith healers and permit refereeing cases to them when it is projected that faith healing practices might add other beneficial healthcare to the referred patients.

## **10.2 Contribution of the Research**

This study was the first to explore the opportunity to establish collaboration between mental health professionals and faith healers in providing mental healthcare in the context of Kuwait. This study adds novel knowledge by exploring in depth the perspectives and perceptions of faith healers and mental healthcare practitioners about formulating cooperation to provide more holistic mental healthcare services. From an empirical and conceptual standpoint, this study helps comprehend the perceptions and perspectives of mental health workers and faith healers regarding collaboration. This research has empirically examined the gap concerning the relationship and the interactions between mental health professionals and faith healers and the role they play in providing and maintaining satisfactory mental healthcare services. The scoping review conducted in this study was the first narrative review that offers an understanding of the challenges that might face collaboration and provides different mechanisms to establish a feasible collaboration project. The scoping review indicated and highlighted that the partnership between the two mental healthcare providers could be found, which may result in improved mental healthcare provision. Moreover, from a methodological standpoint, this research has benefited from employing a combination of different qualitative methods. I attempted to obtain insights into potential collaboration by conducting interviews with mental healthcare professionals and faith healers and then linking and associating the findings from the interviews with autoethnographic methods. The autoethnographic section has permitted me to visualise an accurate picture of the interactions between mental healthcare professionals and faith healers.

Moreover, I developed a practical framework in this study to establish the collaboration between mental health professionals and faith healers, presented and analysed in the recommendations chapter (Chapter 8). It was found that such a framework is considered a pragmatic solution that will help adapt an integrated approach of collaboration between the two leading mental healthcare providers in Kuwait. This contributes to accomplishing the aim and objectives of this study by developing a framework for establishing the collaboration between psychiatrists and faith healers in Kuwait. The proposed framework contains several elements representing the critical steps to forming the partnership between the two leading mental health providers in Kuwait. The elements of the proposed framework are as the following: the multi-sectoral partnership between the Ministry of Health and the Ministry of Islamic Affairs; a collaborative plan through mutual agreement; training, education and awareness for faith healers; education and awareness for healthcare workers; developing guidelines, procedures, and protocols; development of a multisectoral and collaborative platform; implementation of collaborative activities and referral pathways; monitoring and evaluation for quality assurance; and annual education training and awareness.

The proposed framework is closely connected to the location and the actual situation of the study, making it a distinctive contribution to this research. The framework has superior and convincing characteristics facilitate its practicality and applicability in real work. The proposed framework's valuable and practical features are essential in the medical field as it will help understand the reasons for the preferred treatment plans of people who hold religious and cultural beliefs about their mental illness. It will also offer mental health professionals reasonable justifications for including faith healing treatments as a component of care provided to patients with mental illness. This is crucial in the medical field since it optimises the delivery of the proper mental healthcare to improve the health and well-being of individuals with mental health disorders. Thus, this thesis, with the emerging framework, produced a novel mental treatment approach and theory that fostered and improved the delivery of mental illness management in clinical practice.

Optimistically, the suggested framework would help improve Kuwait's mental health situation. Therefore, demanding collaboration between faith healers and the medical sector is an accurate decision to be endorsed in the current healthcare system. Thus, advocates for the collaboration programme should look for the appropriate approaches mutually suitable for the two sides to support collaboration by appreciating the significant role of each treatment way

in enhancing the utilisation of mental health services. It is hoped that the proposed framework will encourage decision makers to develop a roadmap strategy to foster collaboration by offering equivalent opportunities for all the existing sources of mental healthcare.

Talking about the practical part of the contribution of this research, a summary outlining the main findings from this research will be presented to the Ministry of Health in Kuwait via official explanatory presentations, and a complete dissertation will be handed in if requested. Through pre-arranged meetings, the Ministry of Education and the Ministry of Media will also be given an executive summary of the essential findings and recommendations in hard copies and soft copies. Moreover, hard and soft copies of the dissertation will be distributed to Kuwait University and other colleges and libraries in the country. Email conferences, seminars, and workshops will provide healthcare providers with detailed findings and recommendations. Likewise, faith healers and community leaders will receive key results from community meetings and media campaigns. Lastly, the researcher has a great intention to work on publishing several articles in various journals.

### **10.3 The Way Forward**

- It is recommended that future research initiatives be concentrated and more oriented on the region of the Middle East and Kuwait in particular since there is insufficient research on the mental health issues in Kuwait and the Middle East region.
- Further research is necessary to understand Kuwait's mental health situation better and to accurately account for the prevalence of psychiatric illness in the country because data is insufficient. This study provided several research areas that represent apparent gaps in the current literature, such as how pervasive faith healing practices are, thus offering various options for future research that can investigate different ways of improving the mental healthcare services in Kuwait.
- Future research should focus more on examining the exact role of faith healers in providing mental healthcare by scrutinising their practices and evaluating the usefulness and efficiency of their treatment methods.
- Future research initiatives must focus on acquiring a deeper understanding of the faith healing approaches to identify the similarities and common areas between the two treatment traditions: faith healing and psychiatry.

- Future research should be conducted to formulate and design a newly updated psychosocial mental healthcare model that derives from the context of Islamic faith practice.
- Examining the literature should prevent the possible bias after looking for the evidence primarily from the medical sources since faith healing literature is available mainly in ethnographic, qualitative, and other social science literature.
- The future recommended programmes for establishing collaboration with mental health professionals must adapt a reformed Islamic type of cognitive therapy by adding particular elements based on Islamic principles.
- It would be valuable and helpful to conduct studies with the same focus in different locations to compare other countries, cultures and religions with the obtained findings of this study, as that would be of additional benefit.
- Future research is needed to investigate the role of various factors in determining the mental help-seeking behaviour among Kuwaiti people and to evaluate the interactions between these different factors. Studies can accomplish this with a large sample of participants, which are appropriately evaluated by quantitative methods that could incorporate questionnaires or other numerical methods to assess the correlations between the different variables.
- Future research can be done by utilising different research methodological frameworks, including quantitative or experimental methods, to obtain extra insights and to accurately verify the cultural effect on mental health service delivery in the Kuwaiti context.
- Examining different groups of participants by including participants with various demographic characteristics, such as gender, age, ethnicity, level of education, and social class, might produce more profound insights into the investigated topic and allow further exploration. Particular groups of people with a higher possibility of approaching faith healers could facilitate more direct preventive efforts. Due to the diversity within the Muslim community in general, and the Kuwaiti community in particular, it is required to conduct specific studies on different generation groups and levels of education to understand the society's mental health needs further.
- Future research must assess the role of the various medical care specialists, such as primary healthcare workers and social care services since they are involved in working with the faith healers. Indeed, further research should consider the

perspectives of the different health professionals that provide mental healthcare as they might reveal valuable insights and additional knowledge since the ultimate aim is to reach a collaborative system with the participation of all involved healthcare providers.

- The perspectives of the patients who suffer from mental health problems about the collaboration should be examined to understand their views of the collaboration, as they represent a crucial factor for delivering a culturally appropriate healthcare service.
- This study followed the constructivist phenomenological research methodology, which is appropriate to accomplish the aim of this study to explore the opportunity to establish collaboration between the two leading mental health providers in Kuwait. Therefore, considering and applying other methodological research approaches by concentrating on and targeting different angles of this topic might produce different understandings of such phenomenon.
- Further studies could be conducted by choosing the observation method. This is because the observation methods can help obtain the actual vision of what happened in reality in practice, providing knowledge that interviews cannot reveal since they can collect data on aspects that are not easily articulated. Observation is a method used to capture the practical and theoretical reality of a particular event in this world to confirm the actual presence of such event or aspect (Jorgensen, 2011). Non-participant observation is achieved by permitting the researcher to only observe a specific event without any contributions to that event. Indeed, in non-participant observation, the researcher can remain proximate to the investigated practice or event. However, they must not be involved or participate in the observed practice or subjects and stay only as an outside observer (Jorgensen, 2011). This kind of observation is mainly chosen to observe a recognised and prominent reality from a new standpoint that can be applied to our study since it examines a well-known fact (faith healing practice) from a new perspective (healthcare perspective). The reason behind not choosing the observation in this study, as illustrated in the methodology chapter (Chapter 3), is because of the situation of COVID-19 in Kuwait and the impact of the related restrictions and precautions.

- Similarly, focus group discussions (FGD) methods are other choices to be applied for future research. Including FGD with in-depth semi-structured interviews will obtain a different interpretative account of the research focus.
- Follow-up research must be conducted in the future to strengthen the new model of healthcare that advocates for establishing an equivalent relationship between health and faith in sustaining stable well-being.
- A follow-on study can discover further if the recommended framework can be effectively managed to improve Kuwait's mental healthcare delivery system. Further research is needed to determine whether the framework can reduce the morbidity and mortality of mental illness. Further investigation will either support and advocate or disprove and invalidate the proposed framework's theoretical ideas.
- A further conceptual and theoretical examination is essential to review and appraise the proposed framework for establishing the collaboration process that could lead to a modified and enhanced framework.
- The results of this study provide a thoughtful perception of understanding Kuwaiti cultural values and beliefs about mental health issues and treatment preferences. These results produce some valuable practices that are worth supplementary explorative researches which could establish theory-based programmes and appropriate mental healthcare policies that facilitate the delivery of culturally sensitive healthcare facilities for the population of Kuwait.

## **10.4 Conclusion**

Faith healers in Kuwait offer very beneficial healthcare and social services to society. This study emphasises the undeniable important role of faith healers in delivering culturally appropriate and socially accepted healthcare to society. However, faith healers are not considered legal health providers in Kuwait since there are no legislations that regulate and supervise the work of faith healers in Kuwait. Faith healers can play a significant role in tackling the stigma attached to mental illness because of the high acceptance and the reliability of their approaches among the people who seek mental help from them. This study asserted the notable influence of stigma on hampering the utilisation of mental healthcare services since both psychiatrists and faith healers coincided and agreed on the stigma towards psychiatric disorders in Kuwaiti society. On the other side, accessing faith or religious healers is accepted behaviour as their places lack the stigma attached to psychiatric settings.

Therefore, their role can be significantly promoted if they receive adequate training and education and collaborate with psychiatrists.

This study demonstrated that most faith healers in Kuwait are willing to collaborate with mental healthcare professionals and work closely with them. Indeed, they admitted that the referral to the medical sector must be maintained to achieve optimum mental healthcare. Such an integrative healthcare system will improve mental healthcare and management in Kuwait. The collaboration programme will facilitate the provision of more holistic healthcare so that convenient healthcare services will be available for those patients who hold and attribute cultural and religious beliefs to their mental illness.

The findings of this study confirmed that patients access several formal and informal healthcare providers to receive mental treatments and help. Therefore, psychiatrists must cooperate with faith healers since they represent many patients' first contact line. Patients often receive medicines from both sides simultaneously, causing a lot of resource waste. To obtain a successful collaboration, the faith healers must view this collaboration as an egalitarian partnership, and their practices must be perceived as beneficial. Faith healers can refer their patients to receive medical help if their approaches are ineffective. This acts as a complementary help to their interventions. On the other side, psychiatrists can acquire knowledge about the fundamentals of faith healing so they can refer patients to faith healers when applicable. Establishing the reciprocal partnership between psychiatrists and faith healers might produce a more comprehensive and efficient healthcare system, and enhance the utilisation of mental health services, thereby reducing the burden of psychiatric illness on patients and the whole community. Thus, it is crucial to develop an evidence-based model to establish the collaboration that ascribes equivalent power to both sides and promotes a respectful relationship. It was found that the stable and adjacent connection has contributed to building solid and respectful associations between the two sides and enhanced the working environment in the two sectors. This indicates that the current prevailing explanatory model of mental illness needs to include faith and religion, which might add further strength to the model by making the health practitioners more culturally sensitive and socially accepted.

Based on the obtained findings from this study, it is evident that faith healers must receive adequate training and education, and the validity and usefulness of faith healing practices need to be investigated and proved. Yet it is challenging to evaluate the effectiveness of such methods. Also, the results of this study suggest that most psychiatrists are not satisfied with



governmental financial support for the mental health sector, and they think the policymakers do not grant mental health satisfactory priorities in Kuwait. Consequently, this has contributed to the low utilisation of mental health services in Kuwait. Indeed, the inadequate funding and unsatisfactory prioritisation of mental healthcare services in Kuwait were identified as barriers to mental health policy implementation in Kuwait. Various solutions have been suggested by the participants of this study to tackle the multiple obstacles hampering the collaboration between the two leading mental health providers in Kuwait. All the proposed solutions require operational policy planning for actual and operative implementation. Accordingly, decision makers initially need to appreciate and comprehend the various participatory influencing factors that shape the mental healthcare delivery system. Political will is a vital contributor to enhancing the delivery of mental healthcare services in Kuwait and promoting the cooperative healthcare system between the leading two mental healthcare providers. Thus, healthcare providers must continuously lobby to change the current situation by forcing the powerful authorities to accept the collaboration project. Civil society and human rights organisations can help exert high pressure on the governmental sector. Indeed, the policymakers must put the improvement of mental healthcare in its priorities. Although these recommendations are applicable and can be adopted in the context of Kuwait, it is noteworthy to understand that it usually takes a long time for formal authorities to adopt the recommendations.

## Appendix 1: Data Charting Summary

Author, Date of Publication, Location	Aim of Study	study design; participant population	Interventions or Topic	Main Findings
Ae-Ngibise et al., 2010 Ghana	The first aim of this study was to explore the reasons underpinning the widespread appeal of traditional/faith healers in Ghana. This formed a backdrop for the second objective, to identify what barriers or enabling factors may exist for forming bi-sectoral partnerships	Eighty-one semi-structured interviews and seven focus group discussions were held with policy makers, health professionals, users of psychiatric services, teachers, police officers, academics, and religious (Christian and Islamic) and traditional healers drawn from five of the ten regions in Ghana. The interviews and focus group discussions were conducted with 122 respondents	debate by looking critically at the role of traditional and faith healers in Ghana, and the possible barriers to, and enabling factors for, intersectoral cooperation	A number of barriers hindering collaboration, including human rights and safety concerns, scepticism around the effectiveness of 'conventional' treatments, and traditional healer solidarity were identified. Mutual respect and bi-directional conversations surfaced as the key ingredients for successful partnerships. Collaboration is not as easy as commonly assumed, given paradigmatic disjuncture and widespread scepticism between different treatment modalities
Akol et al., 2018, Uganda	To explore traditional healers' views on their collaboration with biomedical health systems so as to inform the implementation of strategies to improve access to mental health services	In-depth interviews with 20 purposively selected traditional healers were conducted	Discussion on the importance of establishing collaboration between traditional healers and biomedical health systems for improving access to mental health services in Uganda	Traditional healers expressed distrust in biomedical health systems and believed their treatments were superior to medical therapies in alleviating mental suffering. They expressed willingness to collaborate with biomedical providers. However, traditional healers believe clinicians disregard them and would not be willing to collaborate with them.
Allay and Laher, 2007 South Africa	To explore Muslim Faith Healers perceptions of mental and spiritual illness in terms of their- understanding of the distinctions between the two, the aetiologies and the treatments	Six Muslim Healers in the Johannesburg community were interviewed, and thematic content analysis was used to analyse the data	Discussion on the religious conceptualisations of mental illness in the understanding, aetiology and treatment of mental illness and mental illness like symptom.	the faith healers were aware of the distinction between mental and spiritual illnesses. Also, the cultural considerations in the evaluation and treatment of mental illness is important

Arias et al., 2016 Ghana	To examine the beliefs and practices of prayer camp staff and the perspective of biomedical care providers, with the goal of characterizing interest in—and potential for—intersectoral partnership between prayer camp staff and biomedical care providers	50 open-ended, semi-structured interviews were conducted with prophets and staff at nine Christian prayer camps in Ghana, and with staff within Ghana’s three public psychiatric hospitals.	Discussion on key areas of partnerships and collaboration in providing mental health care for prayer camp attenders.	Prayer camp staff expressed interest in collaboration with biomedical mental health care providers, particularly if partnerships could provide technical support Biomedical providers were skeptical about the spiritual interpretations of mental illness held by faith healers however, expressed interest in engaging with prayer camps to expand access to clinical care for patients residing in the camps
Bulbulia and Laher, 2013 Johannesburg, South Africa	To explore perceptions of mental illness, particularly in terms of the role of Islam in the understanding of mental illness among South African Muslim psychiatrists practising in Johannesburg	A qualitative design, semi-structured interviews were conducted with a convenience sample of 7 Muslim psychiatrists in the Johannesburg area	The interview includes issues such as: • contextual factors • the psychiatrist’s perceptions of mental illness • treatment of mental illness • collaboration between practitioners • cultural and religious factors and their influences on the conceptualisation of mental illness • the concept of spiritual illnesses	The findings of this study suggest that psychiatrists attempt to remain objective and to refrain from imposing their religious and cultural beliefs on their patients. However, their conceptualisation of mental illness is influenced by their religion and culture. Furthermore, psychiatrists indicated that they were open to collaboration with traditional healers and psychologists but that this was quite challenging.
Campbell-Hall et al., 2010 South Africa	To explore perceptions of service users and providers of current interactions between the two systems of care and ways in which collaboration could be improved in the provision of community mental health services	27 semi-structured interviews and 9 focus group discussions. <b>participants</b> : district mental health service providers within the formal health sector as well as in NGO settings, traditional practitioners and service users	Key issues explored in the interviews included: existing collaboration between traditional practitioners and healthcare practitioners; whether there should be collaboration between these practitioners with respect to mental health care; and what form the collaboration should take	The majority of service users held traditional explanatory models of illness and used dual systems of care, with shifting between treatment modalities reportedly causing problems with treatment adherence. Traditional healers expressed a lack of appreciation from Western health care practitioners but were open to training in Western biomedical approaches and establishing a collaborative relationship in the interests of improving patient care. Western biomedically trained practitioners were less interested in such an arrangement

January and Sodi, 2006 Zimbabwe	This study aimed to understand and interpret faith healers' explanations of the aetiology and treatment of diseases and to canvass their views regarding collaboration between Western trained health care professionals and faith healers	Fifteen female and six male faith healers from Apostolic churches in Marondera (Zimbabwe) were selected and interviewed	Discussion on the role and practices of a group of Zimbabwean faith healers in the treatment of mental health conditions and their views regarding collaboration between themselves and Western trained health care professionals.	The present study found most of the faith healers interviewed to be in favour of some form of collaboration between themselves and the biomedical health practitioners. faith healers use a variety of procedures like prayer, holy water, counselling and sacred stones during their healing sessions. Common ailments brought to the faith healers included mental disorders, infertility, substance abuse, sleep disorders, childhood problems and physical problems
Kpobi and Swartz, 2018 Ghana	To explore the diversity of different healers' perceptions of power, and the relationship between that power and the perceived power of biomedical approaches	a qualitative design where interviews conducted to thirty-six practitioners were interviewed, made up of 8 herbalists, 10 Islamic healers, 10 Pentecostal/charismatic Christian faith healers and 8 traditional shrine priests/medicine-men	Debates about collaboration amongst different sectors and the notions of power and positioning of different sorts of healers in relation to biomedicine	Through thematic analyses, differences in the notions about collaboration between the different categories of healers were identified. Their perceptions of whether collaboration would be beneficial seemed, from this study, to co-occur with their perceptions of their own power.
Musyimi et al., 2016 Kenya	To identify barriers and solutions for dialogue formation among the informal (faith and traditional healers) and formal health workers (clinicians) in enhancing community-based mental health in rural Kenya	Nine Focus Group Discussions each consisting of 8–10 participants: faith, traditional healers and formal health workers. Qualitative and quantitative data analysis was performed using thematic content analysis and Statistical Package Social Sciences (SPSS) software.	Discussion about four dominant themes such as; (i) basic understanding about mental illnesses, (ii) interaction and treatment skills of the respondents to mentally ill persons, (iii) referral gaps and mistrust among the practitioners and (iv) dialogue formation among the practitioners	Most participants had basic information on the causes and types of mental illness. Traditional and faith healers felt demeaned by the clinicians who disregarded their mode of treatment stereotyping them as “dirty”. After various discussions, majority of practitioners showed interest in collaborating with each other and stated that they had joined the dialogue in order interact with people committed to improving the lives of patients.

Osafo, 2016 Ghana	To provide a framework within which collaborative linkages between religious leaders (e.g., the clergy, traditional healers) and professional mental health workers can be established	A Review study based on secondary data.	The article begins with a brief overview of Ghana’s mental health landscape, followed by a description of the challenges that make collaboration a difficult task. Next, the need for a holistic view of health in Ghana is addressed by examining Engel’s biopsychosocial model and Twumasi’s work on the complementary role of traditional systems	The study ends by providing a three step approach—understanding, task shifting, and broadened curricula—as a model to guide any collaboration between religious leaders and health practitioners in Ghana
Rashid et al., 2012 United Kingdom (UK)	To examine the views of Muslims faith healers on symptoms and changes in behaviour commonly described as “psychosis” and “substance misuse”	Eight semi-structured interviews were conducted in UK with Muslim faith healers from various backgrounds	Discussions on issues such as knowledge and experience of psychosis and substance misuse, beliefs about the causes of these disorders, advice given to clients and a general view on religion and science	There were similarities and differences in the narratives given for psychosis and substance misuse. Healers expressed doubt towards other faith healers and the methods utilised by scientific means. The findings suggest a need for close collaboration between faith healers and mental health workers in order to achieve a culturally sensitive health care system
Robertson, 2006 South Africa	To investigate if the evidence support collaboration between psychiatry and traditional healers? Findings from three South African studies	A Review study based on secondary data. (three South African studies)	Discussion on the contribution of traditional healers in South Africa to mental health.	The author concludes that collaboration should be promoted, but further knowledge and debate is needed about the best way for mental health practitioners to collaborate with traditional healers, and on what basis it should be founded
Sabry and Vohra, 2018 Cairo, Egypt	The aim of this review article is to highlight the role of Islam in the management of different psychiatric disorders; and provide psychiatrists therapeutic modalities that are congruent with Islamic values	A Review study based on secondary data.	Focus on studies discussing the effectiveness of the integration of spirituality and religiosity into psychotherapy and how religious beliefs could affect the management plans	There is a huge impact of Islamic religion and spirituality within psychiatric clinical practice. Using Islamic values and beliefs can be beneficial in treatment of mentally ill Muslims, through incorporation of Islamic beliefs that help in drug adherence and modification of different psychotherapeutic techniques to suit Muslim patients.

Sorsdahl et al., 2010 South Africa	To gain an understanding of traditional healer referral practices of their patients with a mental illness	A qualitative design based on 3 focus groups with 24 traditional healers	Discussion on (a) views on collaboration with Western practitioners; (b) traditional healer knowledge of mental illness; (c) advantages and disadvantages of referring a mentally ill patient to a Western practitioner; (d) subjective norms (e) perceived behavioural control.	Results indicated that traditional healers possess a concept of mental illness, mainly referring to a patient behaving abnormally. Traditional healer referral to Western care is considered a temporary measure or a last resort. A majority of healers feel that allopathic physicians do not treat them with the respect that they feel their contribution to the health of the community warrants
Teuton et al., 2007 Uganda	1.To analyse the discourse of respondents from different parts of the healing system to establish how they view each other. 2.To examine the explanatory power of sociohistorical and social psychological perspectives in understanding these relationships	a two-phased qualitative study undertaken. In phase one: Case-vignettes of individuals with a diagnosis of a psychotic disorder were discussed by the healers (10 religious healers and 10 indigenous healers). In second phaser: a semi-structured interview was discussed by two psychiatrists and four Psychiatric Clinical Officers.	Debate about the integration and dialogue between all service providers delivering care for people with mental health problems	The healers varied in their attitudes towards other parts of the healing context. The healers varied in their attitudes towards other parts of the healing context. There appear to be opportunities for greater dialogue between indigenous and religious healers and allopathic doctors and this could contribute to a more integrative model of care for individuals with psychotic experiences in Uganda.
Thomas et al., 2015 UAE	To explores traditional healers' conceptualisations of mental health problems, discussing their perspectives on phenomenology, aetiology, intervention and outcome.	10 semi- structure telephone interviews were conducted to 10 traditional (faith) healers	Discussion on traditional healers' conceptualisations of mental health problems, and their perspectives on phenomenology, aetiology, intervention and outcome.	The traditional healers of the UAE (Mutawa) held a broad view concerning the aetiological factors implicated in what might be termed mental health problems or psychological complaints. Their views of causation extended from the metaphysical to the bio-psycho-social. Consequently, they saw the value of biomedical, psycho-social and traditional religious approaches to healing. All healers were positive about the idea of integrated services, and saw themselves as making avaluable contribution to the UAE's health-care sector

Uvais, 2018 Calicut, Kerala, India	To explore the belief among Muslim doctors regarding jinn and psychiatry.	Across-sectional study conducted among Muslim doctors using a study questionnaire. (30 participants)	The questionnaire concerned with views about whether jinn could cause possession and mental health problems in humans. Also, views on who they think are best to treat mental health problems attributed to Jinn affliction; doctors, religious figure, or both (working together)	Majority of the participants believed in the existence of jinn and a significant proportion of the sample believed in jinn possessing humans and jinn causing mental illness in humans and recommended treatment by doctor and religious figures together for jinn afflictions.
van der Watt et al., 2017 Ghana, Kenya, and Nigeria	To explore the views of biomedical providers, complementary alternative providers(CAPs), mental health service users and caregivers regarding the feasibility, boundaries of as well as perceived barriers and facilitators to such collaboration in three sub-Saharan African countries	A total of 25 semi-structured FGD were conducted in Ghana (9), Kenya (8), and Nigeria(8). Participants were faith healers, traditional healers, patients and caregivers, and biomedical care providers, respectively; with an average of seven participants per group	Discussion on perceived barriers and facilitators to collaboration, and possible pathways to collaboration between biomedical care providers and complementary alternative providers	A barrier to collaboration was distrust, influenced by factionalism, charlatanism, perceptions of superiority, limited roles, and responsibilities. Pathways to better collaboration were education, formal policy recognition and regulation, and acceptance of mutual responsibility
WAMBA and GROLEAU, 2012 Cameroon	to examine potential strategies of collaboration and exchange between traditional, religious, and biomedical practitioners.	Four different methods of qualitative data gathering: individual interviews, group interviews (focus group), self-confrontation, and confrontation. <b>Seven Participants:</b> two traditional healers, two biomedical practitioners, two exorcist priests, and one prophet	Discussion on collaborative processes emerged between traditional healers, prophets, priests, and biomedical practitioners	The study has revealed the existence of a true collaborative between traditional healers, prophets, and priests. As for biomedical practitioners, they are willing to engage in reciprocal exchange of health care services, but their willingness is limited by the corporatist standards of biomedicine and the conflict posed by its epistemology.

# Appendix 2: interview Guide

## Interview Guide: Faith Healers

### **A. Faith Healing Practices:**

The following questions will be asked to gather information about what constitute faith healing? And what is the role of faith healers in providing mental health care in Kuwait?

- 1. Open Question:** Could you please describe your work?
- 2. Closed question:** Tell me when you have started practicing faith healing? How do you become a faith healer?
- 3. Closed question:** How and where did you learn the faith healing approaches?
- 4. Closed question:** What motivated you to become a faith healer?
- 5. Open Question:** Could you please illustrate the practical side of your job?
- 6. Closed question:** What forms of treatment are used by faith healers?
- 7. Closed question:** What types of ailments do you treat? Does this include mental health problems/'madness'/emotional/ psychological distress?
- 8. Closed question:** What do you think the causes of mental problems? Can you tell me about these?
- 9. Open Question:** Generally, how can you describe the mental health care status in Kuwait? In other words, can you describe what care exists for people with mental health problems in Kuwait?
- 10. Closed Question:** Are you familiar with other sources of mental health care in Kuwait? If so, what are these?
- 11. Closed Question:** Why do think people might prefer to utilize different approaches?
- 12. Closed Question:** Do you think there are things might prevent people approaching mental care facilities – Faith healing services or psychiatry?
- 13. Open Question:** Is there a role of Islam in your understanding of mental illness as well as care and wellbeing? If so, in what way?
- 14. Closed Question:** Do you think there is relationship between Jinn and mental problems? If so, can you describe this?

### **B. The Relationship Between the Two Fields:**



The following questions are formulated to answer the next two research sub questions: what are the commonalities and differences in faith healing and professional mental health care? – what is the current interaction and relationship between faith healers and health professionals in Kuwait?

- 1. Open Question:** How does your Faith healing treatment differ from medical care treatment methods?
- 2. Closed question:** Is there any occasion where you have used medical treatments?
- 3. Closed question:** Do you utilise any medical care treatment methods in your practice?
- 4. Closed question:** Is there a danger of causing insult since you might be seen as being derogatory or demeaning? What do you think?
- 5. Open Question:** Generally, how can you describe your relationship with mental health professionals?
- 6. Closed question:** Have you ever experienced difficulties in handling any case before? What did you do for them?
- 7. Closed question:** Do have any previous experience or interaction with mental health professionals? Give examples please.
- 8. Closed question:** How do you communicate with health professionals?
- 9. Closed question:** In your past experience, have you ever referred patients to any health care facilities? If yes, how beneficial do you think was this referral?

### **C. Establishing Collaboration Between the Two Fields:**

The upcoming questions will be asked to seek answers for the following research sub questions: what mechanisms could be adapted to establish collaborations between official mental health services and faith healers? - What are the obstacles or enabling factors that could prevent or facilitate forming such collaboration?

- 1. Open Question:** Overall, do you consider it helpful or unhelpful for there to be more collaboration with health care professionals?
- 2. Closed question:** If so, do you have any ideas of ways to work closely with health professionals?
- 3. Closed question:** Do you think you need to receive medical training?
- 4. Closed question:** What are the motivations to collaborate with health care professionals?
- 5. Closed question:** From your perspective, what could hinder forming official collaboration between faith healers and health professionals?

- 6. Open Question:** Programmatically, what do you think the proper components of having such a programme of collaboration between faith healers and official health care system?
- 7. Closed question:** What could be the consequences of establishing the collaboration?

## **Interview Guide: Psychiatrists**

### **A. Mental Health Care in Kuwait:**

The following questions will be asked to gather information about what is the role of psychiatrists in providing mental health care?

- 1. Open Question:** Could you please describe your work?
- 2. Closed question:** Tell me when you have decided to become a psychiatrist?
- 3. Closed question:** What motivated you to become a psychiatrist?
- 4. Open Question:** Could you please illustrate the practical side of your job?
- 5. Closed question:** What forms of treatment do you usually follow in treating your patients?
- 6. Closed question:** What types of ailments do you treat?
- 7. Closed question:** What do you think the main causes of mental problems in Kuwait? Can you tell me about them?
- 8. Open Question:** Generally, how can you describe the mental health care status in Kuwait? In other words, can you describe what care exists for people with mental health problems in Kuwait?
- 9. Closed Question:** Are you familiar with other sources of mental health care in Kuwait? If so, what are these?
- 10. Closed Question:** Why do think people might prefer to utilize different approaches?
- 11. Closed Question:** What do you think might prevent people approaching mental care facilities?
- 12. Open Question:** Is there a role of Islam in your understanding of mental illness as well as care and wellbeing? If so, in what way?
- 13. Closed Question:** What is your belief regarding Jinn and its correlation with psychiatry?
- 14. Closed Question:** what is the influence of your culture in practicing mental health treatments?

## **B. The Relationship Between the Two Fields:**

The following questions are formulated to answer the next two research sub questions: what are the commonalities and differences in faith healing and professional mental health care? – what is the current interaction and relationship between faith healers and health professionals in Kuwait?

- 1. Open Question:** How does psychiatric treatment differ from faith healing approaches?  
Do think there is any sort of similarity between the two approaches?
- 2. Closed question:** Is there any occasion where you have used religious based treatments?
- 3. Closed question:** Have you ever advised your patients to use religious based treatments?
- 4. Closed question:** Have you found any ways to make your job more culturally accepted?
- 5. Open Question:** Generally, how can you describe your relationship with faith healers?
- 6. Closed question:** Have you ever experienced difficulties in handling any case before? What did you do for them?
- 7. Closed question:** Do have any previous experience or interaction with faith healers? Give examples please.
- 8. Closed question:** How do you communicate with health professionals?
- 9. Closed question:** In your past experience, have you ever referred patients to any faith healers? If yes, how beneficial do you think was this referral?

## **C. Establishing Collaboration Between the Two Fields:**

The upcoming questions will be asked to seek answers for the following research sub questions: what mechanisms could be adapted to establish collaborations between official mental health services and faith healers? - What are the obstacles or enabling factors that could prevent or facilitate forming such collaboration?

- 1. Open Question:** Overall, do you consider it helpful or unhelpful to collaborate with faith healers?
- 2. Closed question:** If so, do you have any ideas of ways to work closely with faith healers?
- 3. Closed question:** Do you think you need to receive training in faith healing practices?
- 4. Closed question:** What are the motivations to collaborate with faith healers?

5. **Closed question:** From your perspective, what could hinder forming official collaboration between faith healers and health professionals?
6. **Open Question:** Programmatically, what do you think the proper components of having such a programme of collaboration between faith healers and official health care system?
7. **Closed question:** What could be the consequences of establishing the collaboration?

## Arabic Version of the Interview Guide

### نموذج المقابلة الإرشادي المخصص لأطباء الصحة النفسية

#### أ. الرعاية الصحية النفسية في الكويت

الهدف من الأسئلة في هذا الجزء من المقابلة هو الحصول على المعلومات الكافية عن دور طبيب مستشفى الطب النفسي في توفير الرعاية المناسبة بمجال الصحة النفسية في الكويت.

1. سؤال مفتوح: هل من الممكن أن تشرح لي عن طبيعة عملك بشكل عام؟
2. سؤال مغلق: أخبرني كيف بدأت لديك فكرة العمل كطبيب في الصحة النفسية؟
3. سؤال مغلق: ما هو الدافع من وراء اختيارك مزاوله العمل في تخصص الصحة النفسية؟
4. سؤال مفتوح: هل من الممكن ان تشرح لي بإسهاب الجانب العملي من مهنتك كطبيب في الصحة النفسية؟
5. سؤال مغلق: ماهي الوسائل التي تتبعها غالبا في علاج المرضى الذين يعانون من مشاكل نفسية؟
6. سؤال مغلق: ماهي المشاكل النفسية التي تشرف على علاجها بشكل معتاد؟
7. سؤال مغلق: برأيك ماهي أهم مسببات للأمراض النفسية في الكويت؟ عدد لي بعض منها لو تكرمت
8. سؤال مفتوح: بشكل عام كيف يمكن أن تصف لي الوضع في الكويت في مجال الرعاية النفسية؟ بصيغة أخرى هل يمكن شرح الخدمات الصحية المتوفرة في الكويت في مجال الرعاية الصحية النفسية؟
9. سؤال مغلق: هل انت على دراية بطرق أخرى متوفرة في الكويت للعلاج النفسي؟ هل يمكنك ذكر بعضها ؟
10. سؤال مغلق: لماذا تعتقد بأن بعض المرضى الذين يعانون من الأمراض النفسية قد يلجئون لأكثر من وسيلة للعلاج؟
11. سؤال مغلق: هل تعتقد هناك موانع تعيق وصول بعض المرضى إلى مستشفى الطب النفسي؟
12. سؤال مفتوح: هل يلعب الدين الإسلامي دور في فهمك و تفسيرك للصحة النفسية للإنسان؟ اذا كنت تعتقد ذلك اشرح لي هذا الجانب؟
13. سؤال مغلق: ما هو اعتقادك تجاه قضية "تلبس الجن للإنسان" هل تؤمن بذلك؟ و ما مدى ارتباط هذا الأمر بالأمراض النفسية؟
14. سؤال مغلق: ما مدى تأثير ثقافتك و هويتك المجتمعية في مزاولتك لمهنة الطب في المجال النفسي؟

#### ب. العلاقة بين عملي الرعاية الصحية النفسية و المعالجين بالرقية الشرعية في الكويت

الأسئلة القادمة مخصصة للحصول على إجابات لأسئلة البحث التالية: ماهو وجه التشابه و الاختلاف بين عاملين الصحة النفسية و معاليجين الرقية الشرعية؟ وما هي طبيعة العلاقة بين الطرفين في الوقت الراهن؟

1. سؤال مفتوح: لأي مدى يختلف العلاج النفسي العلمي عن العلاج المتبع لدى معاليجين الرقية الشرعية؟ وهل يوجد أي تشابه يذكر بين الطريقتين المذكورتين؟
2. سؤال مغلق: هل قد استخدمت طرق ذات طابع ديني و روحاني في علاج مرضاكم النفسيين في السابق؟
3. سؤال مغلق: هل قدمت نصيحة بأي مناسبة سابقة لمرضاكم بإتباع علاج روحاني أو ديني؟
4. سؤال مغلق: هل حاولت في السابق بأن تستخدم طرق علاجية تناسب المجتمع الكويتي؟
5. سؤال مفتوح: بشكل عام, كيف ممكن أن تصف علاقتكم مع معاليجين الرقية الشرعية؟
6. سؤال مغلق: في السابق عندما تواجه صعوبات في علاج أحد المرضى ماذا تفعل بالعادة؟
7. سؤال مغلق: هل لديك أي تجربة سابقة بالتعامل مع معاليجي الرقية الشرعية؟ اذكر لي تفاصيل الحادثة ان وجدت
8. سؤال مغلق: برأيك كيف يمكنك بأن تتواصل مع معاليجي الرقية الشرعية؟
9. سؤال مغلق: خلال مزاولتك لمهنتك الحالية هل سبق بأن أوصيت مريض يعالج لديكم بالذهاب إلى مراكز العلاج بالرقية الشرعية؟ اذا كانت اجابتك بنعم, باعتقادك هل كانت هذه التوصية إيجابية النتيجة و مجدية للحصول على علاج أفضل؟

### ج. بناء تعاون مشترك بين طرق العلاج النفسي المختلفة

في هذا الجزء من المقابلة, الباحث يريد الحصول على إجابات لأسئلة البحث التالية: ماهي الآليات الممكن اتخاذها لبناء تعاون مشترك و مثمر بين طرق العلاج النفسي المختلفة؟ وماهي العوائق و المحفزات التي يمكن بأن تعيق أو تسهل إنشاء مثل هذا التعاون المشترك؟

1. سؤال مفتوح: بشكل عام, هل تعتقد بأن التعاون المشترك مع معاليجي الرقية الشرعية في علاج الأمراض النفسية أمر مجدي و يستحق العمل به؟
2. سؤال مغلق: هل لديك أدنى فكرة عن كيفية إنشاء آلية عمل مشترك مع معاليجي الرقية الشرعية؟
3. سؤال مغلق: هل تعتقد بأنه يتوجب عليك كطبيب للصحة النفسية بتلقي دورات في تعليم الرقية الشرعية؟
4. سؤال مغلق: ماهي باعتقادك المحفزات للعمل المشترك مع معاليجين الرقية الشرعية؟
5. سؤال مغلق: باعتقادك, ماهي المعوقات التي ممكن بأن تمنع الوصول إلى عمل مشترك بين الطرفين؟
6. سؤال مفتوح: إذا توفر الدعم لإنشاء برنامج للعمل المشترك بين الطرفين, باعتقادك ماهي أهم الخطوات و الركائز التي يجب اتباعها لإنجاح هذا البرنامج؟
7. سؤال مغلق: باعتقادك ماذا ممكن بأن تكون نتائج إنشاء عمل مشترك بين الطرفين المعنيين؟

### نموذج المقابلة الإرشادي المخصص لأطباء الصحة النفسية

ت. الرعاية الصحية النفسية في الكويت

الهدف من الأسئلة في هذا الجزء من المقابلة هو الحصول على المعلومات الكافية عن دور طبيب مستشفى الطب النفسي في توفير الرعاية المناسبة بمجال الصحة النفسية في الكويت.

15. سؤال مفتوح: هل من الممكن أن تشرح لي عن طبيعة عملك بشكل عام؟
16. سؤال مغلق: أخبرني كيف بدأت لديك فكرة العمل كمعالج بالرؤية الشرعية؟
17. سؤال مغلق: كيف و أين تعلمت الرؤية الشرعية؟
18. سؤال مغلق: ما هو الدافع من وراء اختيارك مزاوله العمل في الرؤية الشرعية؟
19. سؤال مفتوح: هل من الممكن ان تشرح لي بإسهاب الجانب العملي من مهنتك كقارىء شرعي؟
20. سؤال مغلق: ماهي الوسائل التي تتبعها غالبا في علاج المرضى الذين يعانون من مشاكل نفسية؟
21. سؤال مغلق: ماهي المشاكل النفسية التي تشرف على علاجها بشكل معتاد؟
22. سؤال مغلق: برأيك ماهي أهم مسببات للأمراض النفسية في الكويت؟ عدد لي بعض منها لو تكلمت
23. سؤال مفتوح: بشكل عام كيف يمكن أن تصف لي الوضع في الكويت في مجال الرعاية النفسية؟ بصيغة أخرى هل يمكن شرح الخدمات الصحية المتوفرة في الكويت في مجال الرعاية الصحية النفسية؟
24. سؤال مغلق: هل انت على دراية بطرق أخرى متوفرة في الكويت للعلاج النفسي؟ هل يمكنك ذكر بعضها ؟
25. سؤال مغلق: لماذا تعتقد بأن بعض المرضى الذين يعانون من الأمراض النفسية قد يلجئون لأكثر من وسيلة للعلاج؟
26. سؤال مغلق: هل تعتقد هناك موانع تعيق وصول بعض المرضى إلى مستشفى الطب النفسي؟
27. سؤال مفتوح: هل يلعب الدين الإسلامي دور في فهمك و تفسيرك للصحة النفسية للإنسان؟ اذا كنت تعتقد ذلك اشرح لي هذا الجانب؟
28. سؤال مغلق: ما هو اعتقادك تجاه قضية "تلبس الجن للإنسان" هل تؤمن بذلك؟ و ما مدى ارتباط هذا الأمر بالأمراض النفسية؟
29. سؤال مغلق: ما مدى تأثير ثقافتك و هويتك المجتمعية في مزاولتك لمهنتك؟

### ث. العلاقة بين عاملي الرعاية الصحية النفسية و المعالجين بالرؤية الشرعية في الكويت

- الأسئلة القادمة مخصصة للحصول على إجابات لأسئلة البحث التالية: ماهو وجه التشابه و الاختلاف بين عاملين الصحة النفسية و معالجيها بالرؤية الشرعية؟ وما هي طبيعة العلاقة بين الطرفين في الوقت الراهن؟
10. سؤال مفتوح: لأي مدى يختلف العلاج النفسي العلمي عن العلاج المتبع لدى معالجيها بالرؤية الشرعية؟ وهل يوجد أي تشابه يذكر بين الطريقتين المذكورتين؟
  11. سؤال مغلق: هل قد سبق واستخدمت علاج طبي علمي لأحد مرضاكم؟
  12. سؤال مغلق: هل قدمت نصيحة بأي مناسبة سابقة لمرضاكم بإتباع علاج طبي علمي؟
  13. سؤال مغلق: هل تشعر بأن هناك نظرة ازدراء لعماكم من قبل أطباء الصحة النفسية؟
  14. سؤال مفتوح: بشكل عام، كيف ممكن أن تصف علاقتكم مع أطباء الصحة النفسية؟
  15. سؤال مغلق: في السابق عندما تواجه صعوبات في علاج أحد المرضى ماذا تفعل بالعادة؟
  16. سؤال مغلق: هل لديك أي تجربة سابقة بالتعامل مع أطباء الصحة النفسية؟ اذكر لي تفاصيل الحادثة ان وجدت
  17. سؤال مغلق: برأيك كيف يمكنك بأن تتواصل مع أطباء الصحة النفسية؟

18. سؤال مغلق: خلال مزاولتك لمهنتك الحالية هل سبق بأن أوصيت مريض يعالج لديكم بالذهاب إلى مراكز الطب النفسي؟ إذا كانت اجابتك بنعم, باعتقادك هل كانت هذه التوصية إيجابية النتيجة و مجدية للحصول على علاج أفضل؟

### ج. بناء تعاون مشترك بين طرق العلاج النفسي المختلفة

في هذا الجزء من المقابلة, الباحث يريد الحصول على إجابات لأسئلة البحث التالية: ماهي الآليات الممكن اتخاذها لبناء تعاون مشترك و مثمر بين طرق العلاج النفسي المختلفة؟ وماهي العوائق و المحفزات التي يمكن بأن تعيق أو تسهل إنشاء مثل هذا التعاون المشترك؟

8. سؤال مفتوح: بشكل عام, هل تعتقد بأن التعاون المشترك مع أطباء الطب النفسي في علاج الأمراض النفسية أمر مجدي و يستحق العمل به؟

9. سؤال مغلق: هل لديك أدنى فكرة عن كيفية إنشاء آلية عمل مشترك مع أطباء الطب النفسي؟

10. سؤال مغلق: هل تعتقد بأنه يتوجب عليك كـمعالج بالرقبة الشرعية بتلقي دورات في تعلم الطب النفسي؟

11. سؤال مغلق: ماهي باعتقادك المحفزات للعمل المشترك مع أطباء الصحة النفسية؟

12. سؤال مغلق: باعتقادك, ماهي المعوقات التي ممكن بأن تمنع الوصول إلى عمل مشترك بين الطرفين؟

13. سؤال مفتوح: إذا توفر الدعم لإنشاء برنامج للعمل المشترك بين الطرفين, باعتقادك ماهي أهم الخطوات والركائز التي يجب اتباعها لإنجاح هذا البرنامج؟

## Appendix 3: Ethical approval from the Health Sciences Research Governance Committee from University of York



DEPARTMENT OF  
HEALTH SCIENCES

c/o Department of Philosophy  
Healington,  
York YO10 5DD

Telephone (01904) 323233  
Fax (01904) 321383  
E-mail [smh12@york.ac.uk](mailto:smh12@york.ac.uk)

Prof Stephen Holland  
Chair, Health Sciences Research  
Governance Committee

[www.york.ac.uk/healthsciences](http://www.york.ac.uk/healthsciences)

19 February 2020

Dr Meshal Almutairi  
University of York  
Department of Health Sciences  
York  
YO10 5DD

Dear Meshal

**HSRGC/2020/373/A: Potential Collaboration between Faith Healers and Mental Health Professionals in Kuwait**

Thank you for your email of 12 February, including more details on the process of recruiting participants (revised S12 of the submission form) and a summary of how you would respond were you to elicit professional misconduct on the part of Psychiatrists or potentially harmful faith healing practices.

I can now confirm by Chair's action that the interviews are approved.

Please bear in mind that you must send me KMOH approval when you have it; and that the Observations part of your study still requires HSRGC review.

Yours sincerely

A handwritten signature in blue ink that reads "S. Holland".

Stephen Holland  
Chair, HSRGC



## Appendix 4: Ethical Approval from Kuwait Ministry of Health



دولة الكويت  
وزارة الصحة  
وكيل الوزارة المساعد لشؤون التخطيط والجودة



المرجع : ٦٠٠  
التاريخ : ١٨/٩/٢٠٢٠ م  
المسيد الفاضل / د. وكيل الوزارة  
المحترم  
تحية طيبة وبعد،،،،

الموضوع / تسهيل مهمة الباحث / د. مشعل مطلق المطيري - طالب دكتوراه في  
جامعة (York) البريطانية  
(رقم البحث 1282 / 2020) تحت عنوان:

*Establishing A Potential Collaboration between Faith healers*  
*and Formal Mental Health system in Kuwait*

يرجى التفضل بالإحاطة بأن اللجنة الدائمة لتنسيق البحوث الطبية والصحية  
المشكلة بموجب القرار الوزاري رقم 207 لسنة 2012 قد أوصت بإجتماعها  
السادس والمستين (4 / 2020) الاجتماع عن بعد / بالتواصل الاجتماعي  
(VIRTUAL MEETING) بالموافقة على اجراء البحث رقم (1282 / 2020)  
المقدم من الباحث / د. مشعل مطلق المطيري - طالب دكتوراه في  
جامعة (York) البريطانية بتاريخ 2020/2/24 تحت عنوان:

*Establishing A Potential Collaboration between Faith healers*  
*and Formal Mental Health system in Kuwait*

وذلك بعد أن قامت اللجنة استنادا للقرار الوزاري رقم 207 لسنة 2012 والتعميم  
الصادر من السيد / وكيل الوزارة برقم 156 لسنة 2012 باستطلاع آراء الجهات  
ذات العلاقة بموضوع البحث حيث وافق السيد / وكيل الوزارة المساعد للشؤون  
القانونية بالكتاب الوارد برقم 229 بتاريخ 2020/4/19 كما رد السيد / د. رئيس مجلس  
السام الامراض الباطنية بالكتاب الوارد برقم 262 بتاريخ 2020/5/27.

المرجع : ويتم البحث من خلال اجراء مقابلات لجمع البيانات والمؤشرات من المستفيدين  
التاريخ : بالدراسة حسب بروتوكول البحث ( مدة البحث سنة واحدة ) .  
ولا يتضمن البحث اجراء اي تجارب طبية أو إعطاء أدوية أو أخذ عينات حيوية  
خارج اطار الخطط العلاجية .  
يرجاء التفضل بالاطلاع والتوجيه بما ترونه مناسباً نحو اعتماد توصية اللجنة  
والموافقة على مخاطبة الجهات ذات الصلة بموضوع البحث ( المسادة / مبراء  
المناطق الصحية والمستشفيات / السيد / د. رئيس مجلس أقسام الامراض  
الباطنية) بهذا الشأن للعمل على تسهيل مهمة الباحثين لإجراء البحث .  
مع مراعاة التزام الباحثين بالمحافظة على حقوق المشاركين بالبحث  
بالخصوصية وسرية المعلومات وعدم تناولها خارج اطار البحث وتقديم متابعة  
تقارير دورية Progress Reports للجنة الدائمة لتنسيق البحوث الطبية  
والصحية عن مدي التقدم في سير الدراسة ومدى تحقيقها للأهداف المرجوة من  
إجرائها والتنسيق مع رؤساء الأقسام التي ستجري بها الدراسة وفقاً للضوابط  
المنظمة لذلك .

وتفضلوا بقبول فائق الاحترام،،،،،

الدكتور / محمد جاسم الخشتي  
الوكيل المساعد لشئون التخطيط والجودة  
رئيس اللجنة الدائمة لتنسيق البحوث الطبية والصحية

يعتمد،،

حسب النظم

وكيل وزارة الصحة

  
وكيل الوزارة المساعد لشئون  
التخطيط والجودة



وكيل الوزارة المساعد لشئون  
التخطيط والجودة

## **Appendix 5: Information Sheet (Interviews-Faith healers)**

**UNIVERSITY *of* York**  
**The Department of Health Sciences**

[ESTABLISHING A POTENTIAL COLLABORATION BETWEEN FAITH HEALERS AND HEALTH PROFESSIONALS TO PROVIDE MENTAL HEALTH CARE: THE CASE OF KUWAIT]

### **Participant Information Sheet**

#### **[Interviews \_Faith Healers]**

We would like to invite you to take part in the above named study but before you decide whether to participate or not please read the following information carefully. If there is anything unclear or you need further information, feel free to ask. Take your time while reading this information sheet and thank you for sparing your time to read this.

#### **What is the purpose of this study?**

This study about faith healing practices in Kuwait and its relationship with the formal health system. The study is attempting to explore and examine the opportunities for faith healers and mental health professionals to collaborate to provide care in the context of Kuwait.

#### **Who is doing the study?**

My name is Meshal Almutairi, and I am doing this study to obtain my PhD degree as I am currently a PhD student at University of York. This study is under supervision of my supervisors at University of York: Dr Janaka Jayawickrama, and Mr Jerome Wright. I am sponsored student as being granted a scholarship by The Government of the State of Kuwait to do my current PhD programme.

#### **Why have I been asked to participate?**

You are selected to participate in this study because you are a faith healer practicing faith healing in Kuwait for more than 2 years. So, you are eligible to give informative input to this study.

#### **Do I have to take part?**

Taking part in this study is entirely voluntary so it is up to you to accept or refuse participation in this study. If you accepted to take part in this study, you will be given an informed consent to sign before participation in this study. You will be able to withdraw from the study without giving any reason anytime during the study and even after the study up to two weeks and your information will be destroyed.

#### **What will be involved if I take part in this study?**

Once you agreed to participate, the researcher will arrange with you the suitable time and venue to conduct the interview. During the interview, firstly the researcher will give you the informed consent to sign, then the interview starts where you will be asked several questions, some are opened questions, others are closed ones. The interview will be audio recorded and will take approximately 45 minutes .

### **What are the advantages/benefits and disadvantages/risks of taking part?**

There are no particular direct benefits to you if you decided to participate, but it hopefully would be a positive experience for you as it might open your eyes for new aspects of your work. There will be indirect benefits to you as your contribution to this study will be added to the knowledge base, which ultimately would help to improve the mental health status in Kuwait. There are no expected harms or any disadvantages of your contribution to this study, other than taking 45 minutes from your time.

### **Can I withdraw from the study at any time?**

You will be able to withdraw from the study without giving any reason anytime during the study and even after the study and your information will be destroyed. However, after two weeks of your participation in this study, your data will be probably emerged in the analysis pool, so it will be impossible to withdraw after two weeks of your interview.

### **How will the information and personal data I give be handled?**

All the data that you will provide to this study will be anonymous. You will be given a code number that will be used instead of your name to label your data so it can be identified in case you decided to withdraw from the study. Moreover, all your contact details will be kept confidential and will not be shared. In line with the University of York Research Data Management Policy, your data will be kept for 10 years from the date of last requested access. Then, your data will be destroyed.

### **What will happen to the results of the study?**

The results of this study will be used in my PhD thesis and after accomplishing my PhD course successfully, this study could be published in peer-reviewed articles. Furthermore, the results will be disseminated through various ways, such as distributing summary documents of the results to WHO, KMOH, Psychological Medicine Hospital and all the general hospitals in Kuwait. In addition, the research findings will be presented in different conferences, workshops, seminars, and community forums.

### **Who has reviewed and approved this study?**

This study has been reviewed and ethically approved from both the University of York's Health Sciences Research Governance Committee and Kuwait Ministry of Health ethics Committee.

### **Who do I contact for more information about the study?**

To get more information about the study, you can contact me personally all my contact details can be found at the end of this information sheet, also you can contact the supervisors of this study Dr Janaka Jayawickrama, email: [janaka.jayawickrama@york.ac.uk](mailto:janaka.jayawickrama@york.ac.uk), and Mr Jerome Wright, email: [jerome.wright@york.ac.uk](mailto:jerome.wright@york.ac.uk)

### **Who do I contact in the event of a complaint?**

If you have any complaint concerning this study, you can firstly contact me, all my contact details can be found at the end of this information sheet. Alternatively, you can also contact the supervisors of this study Dr Janaka Jayawickrama from The University of York in UK at email: [janaka.jayawickrama@york.ac.uk](mailto:janaka.jayawickrama@york.ac.uk), and/or Dr. Manal Bouhaimed, from Kuwait University, Department of Community Medicine and Behavioural Sciences, email: [manalbouhaimed@gmail.com](mailto:manalbouhaimed@gmail.com). Tel: 0096597878634.

Additionally, if you are unhappy with the way your personal data has been handled, you have the right to complain to the University's Data Protection Officer at

[dataprotection@york.ac.uk](mailto:dataprotection@york.ac.uk); if they are still unsatisfied, you have the right to report concerns to the Information Commissioner's Office at [www.ico.org.uk/concerns](http://www.ico.org.uk/concerns).

***1.1.1 Contact for Further Information***

If you have any query about this study, please feel free to contact:

Name of the Researcher: Meshal Almutairi.

Contact details: Tel: +965 65997676 / +44(0) 7397321166 email: [ma1486@york.ac.uk](mailto:ma1486@york.ac.uk).

*Thank you for taking the time to read this information sheet.*

## Appendix 6: Consent Form Interviews

UNIVERSITY *of York*

The Department of Health Sciences

Participant Consent Form  
Interviews

Title of Study:

ESTABLISHING A POTENTIAL COLLABORATION BETWEEN FAITH HEALERS AND HEALTH PROFESSIONALS TO PROVIDE MENTAL HEALTH CARE: THE CASE OF KUWAIT	Please confirm agreement to each <u>statements</u> by putting your initials in the boxes below
I have read and understood the participant information sheet [date ..., version ...]	
I have had the opportunity to ask questions and discuss this study	
I have received satisfactory answers to all of my questions	
I have received enough information about the study	
I understand my participation in the study is voluntary and that I am free to withdraw from the <u>study</u> :- 1 At any time/up to two weeks post-interview 2 Without having to give a reason for withdrawing	
I understand that my interview will be audio-recorded.	
I understand that any information I provide, including personal data, will be kept confidential, stored securely and only accessed by those carrying out the study.	
I understand that any information I give may be included in published documents but all information will be anonymised.	
I agree to take part in this study	
Participant Signature .....	Date
Name of Participant	
Researcher Signature .....	Date
Name of Researcher	

## **Appendix 7: Information Sheet (interviews-Psychiatrists)**

**UNIVERSITY *of York***  
**The Department of Health Sciences**

[ESTABLISHING A POTENTIAL COLLABORATION BETWEEN FAITH HEALERS AND  
HEALTH PROFESSIONALS TO PROVIDE MENTAL HEALTH CARE: THE CASE OF  
KUWAIT]

### **Participant Information Sheet**

#### **[Interviews\_ psychiatrists]**

We would like to invite you to take part in the above named study but before you decide whether to participate or not please read the following information carefully. If there is anything unclear or you need further information, feel free to ask. Take your time while reading this information sheet and thank you for sparing your time to read this.

#### **What is the purpose of this study?**

This study about faith healing practices in Kuwait and its relationship with the formal health system. The study is attempting to explore and examine the opportunities for faith healers and mental health professionals to collaborate to provide care in the context of Kuwait.

#### **Who is doing the study?**

My name is Meshal Almutairi, and I am doing this study to obtain my PhD degree as I am currently a PhD student at University of York. This study is under supervision of my supervisors at University of York: Dr Janaka Jayawickrama, and Mr Jerome Wright. I am sponsored student as being granted a scholarship by The Government of the State of Kuwait to do my current PhD programme.

#### **Why have I been asked to participate?**

You are selected to participate in this study because you are a psychiatrist working in Kuwait psychiatric hospital for more than 2 years. So, you are eligible to give informative input to this study.

#### **Do I have to take part?**

Taking part in this study is entirely voluntary so it is up to you to accept or refuse participation in this study. If you accepted to take part in this study, you will be given an informed consent to sign before participation in this study. You will be able to withdraw from the study without giving any reason anytime during the study and even after the study up to two weeks and your information will be destroyed.

#### **What will be involved if I take part in this study?**

Once you agreed to participate, the researcher will arrange with you the suitable time and venue to conduct the interview. During the interview, firstly the researcher will give you the informed consent to sign, then the interview starts where you will be asked several questions, some are opened questions, others are closed ones. The interview will be audio recorded and will take approximately 45 minutes .

#### **What are the advantages/benefits and disadvantages/risks of taking part?**

There are no particular direct benefits to you if you decided to participate, but it hopefully would be a positive experience for you as it might open your eyes for new aspects of your work. There will be indirect benefits to you as your contribution to this study will be added to the knowledge base, which ultimately would help to improve the mental health status in Kuwait. There are no expected harms or any disadvantages of your contribution to this study, other than taking 45 minutes from your time.

### **Can I withdraw from the study at any time?**

You will be able to withdraw from the study without giving any reason anytime during the study and even after the study and your information will be destroyed. However, after two weeks of your participation in this study, your data will be probably emerged in the analysis pool, so it will be impossible to withdraw after two weeks of your interview.

### **How will the information and personal data I give be handled?**

All the data that you will provide to this study will be anonymous. You will be given a code number that will be used instead of your name to label your data so it can be identified in case you decided to withdraw from the study. Moreover, all your contact details will be kept confidential and will not be shared. In line with the University of York Research Data Management Policy, your data will be kept for 10 years from the date of last requested access. Then, your data will be destroyed.

### **What will happen to the results of the study?**

The results of this study will be used in my PhD thesis and after accomplishing my PhD course successfully, this study could be published in peer-reviewed articles. Furthermore, the results will be disseminated through various ways, such as distributing summary documents of the results to WHO, KMOH, Psychological Medicine Hospital and all the general hospitals in Kuwait. In addition, the research findings will be presented in different conferences, workshops, seminars, and community forums.

### **Who has reviewed and approved this study?**

This study has been reviewed and ethically approved from both the University of York's Health Sciences Research Governance Committee and Kuwait Ministry of Health ethics Committee.

### **Who do I contact for more information about the study?**

To get more information about the study, you can contact me personally all my contact details can be found at the end of this information sheet, also you can contact the supervisors of this study Dr Janaka Jayawickrama, email: [janaka.jayawickrama@york.ac.uk](mailto:janaka.jayawickrama@york.ac.uk), and Mr Jerome Wright, email: [jerome.wright@york.ac.uk](mailto:jerome.wright@york.ac.uk)

### **Who do I contact in the event of a complaint?**

If you have any complaint concerning this study, you can firstly contact me, all my contact details can be found at the end of this information sheet. Alternatively, you can also contact the supervisors of this study Dr Janaka Jayawickrama from The University of York in UK at email: [janaka.jayawickrama@york.ac.uk](mailto:janaka.jayawickrama@york.ac.uk), and/or Dr Manal Bouhaimed, from Kuwait University, Department of Community Medicine and Behavioural Sciences, email: [manalbouhaimed@gmail.com](mailto:manalbouhaimed@gmail.com). Tel: 0096597878634.



Additionally, if you are unhappy with the way your personal data has been handled, you have the right to complain to the University's Data Protection Officer at [dataprotection@york.ac.uk](mailto:dataprotection@york.ac.uk); if they are still unsatisfied, you have the right to report concerns to the Information Commissioner's Office at [www.ico.org.uk/concerns](http://www.ico.org.uk/concerns).

### ***1.1.2 Contact for Further Information***

If you have any query about this study, please feel free to contact:

Name of the Researcher: Meshal Almutairi.

Contact details: Tel: +965 65997676 / +44(0) 7397321166 email: ma1486@york.ac.uk.

*Thank you for taking the time to read this information sheet.*

## Abbreviations/ Acronyms

ADB	Asian Development Bank
AD	Anno Domini
AFDB	African Development Bank
AYUSH	Ayurveda, Yoga and naturopathy, Unani, Siddha, Sowa-Rigpa, and homoeopathy
BC	Before Christ
BCE	Before Christian Era
CAM	Complementary and Alternative Medicine
CCIM	Central Council for Indian Medicine
CE	Common Era
COVID-19	Coronavirus Disease 2019
DFL	Doctors for Life
DSMMD	Diagnostic and Statistical Manual of Mental Disorders
Dr	Doctor
ECT	Electroconvulsive Therapy
ENT	Ear, Nose and Throat
FGD	focus group discussions
FHs	Faith Healers
GCC	Gulf Cooperation Council
GDP	Gross Domestic Product
GP	General Practitioner
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HSRGC	Health Sciences Research Governance Committee
KCCC	Kuwait Centre for Cancer Control
Km	Kilometre
LMIC	Low- and Middle-Income Countries
mhGA P-IG	mental health Global Action Programme Intervention Guide

MOH	Ministry of Health
NABH	National Accreditation Board for Hospitals and Health care Providers
NHS	The National Health Service
OCD	obsessive-compulsive disorders
PBUH	Peace Be Upon Him
PHC	Primary Health Care
PhD	Doctor of Philosophy
TCM	Traditional Chinese Medicine
UAE	United Arab Emirates
UK	United Kingdom
UN	United Nations
USA	United States of America
US	United States
USAID	United States Agency for International Development
WHO	World Health Organisation

## References

- Abbo, C. (2011). Profiles and outcome of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda. *Global Health Action*, 4(1), 7-17.
- Abdel-Khalek, A. (2011). Islam and mental health: A few speculations. *Mental Health, Religion & Culture*, 14(2), 87-92.
- Abdelmaaboud, H. (2015). The undersecretary of Health announced the extension and increase in the numbers of psychiatric clinics in the primary health care to reach up to 15 in the next upcoming months. *Alanba*. [online]. [Accessed 25 May 2021]. Available from: <http://www.alanba.com.kw/ar/kuwait-news/health/601266/13-11-2015>.
- Abdullah, K., Mohamed Saini, S., Sharip, S. and Shaharom, M. (2016). Seeking help at an Islamic spiritual healing centre: Malaysia's perspective. *Mental Health, Religion & Culture*, 19(7), 742-751.
- Ae-Ngibise, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., Doku, V. and The MHaPP Research Programme Consor. (2010). 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry*, 22(6), 558-567.
- Agbor, A. and Naidoo, S. (2011). Knowledge and practice of traditional healers in oral health in the Bui Division, Cameroon. *Journal of Ethnobiology and Ethnomedicine*, 7(1), 6-14.
- Ahmad, M. and Khan, S. (2015). A Model of Spirituality for Ageing Muslims. *Journal of Religion and Health*, 55(3), 830-843.
- Ahmed W., Choudhry A., Alam A. and Kaisar F. (2007). Muslims Patients Perceptions of Faith-Based and Religious Inclination of Treating Physicians. *Pakistan Heart Journal*, 40(3)
- Akol, A., Moland, K., Babirye, J. and Engebretsen, I. (2018). "We are like co-wives": Traditional healers' views on collaborating with the formal Child and Adolescent Mental Health System in Uganda. *BMC Health Services Research*, 18(258).

Ali, T. and Gul, S. (2018). Community mental health services in Pakistan: Review study from Muslim world 2000-2015. *Psychology, Community & Health*, 7(1), 57-71.

Ally, Y. and Laher, S. (2007). South African Muslim Faith Healers Perceptions of Mental Illness: Understanding, Aetiology and Treatment. *Journal of Religion and Health*, 47(1), 45-56.

Aladwani, M. (2015). The impact of purchaser-provider split on health systems performance: lessons for Kuwait, Master's Degree. Thesis. University of Leeds.

Al-Ansari, E., El-Hilu, S., El-Hihi, M. and Hassan, K. (1990). Patterns of psychiatric consultations in Kuwait general hospitals. *General Hospital Psychiatry*, 12(4), 257-263.

Al-Busaidi, Z. (2008). Qualitative Research and its Uses in Health Care. *Sultan Qaboos University Medical Journal*, 8(1), 11-19.

Al-Dhafiri, H. (2011). Closure of Faith healing (Ruqyah) centres in Jahra area in Kuwait. *Alanba Newspapers*. [Online]. [Accessed 10 November 2022]. Available from: <https://www.alanba.com.kw/ar/kuwait-news/incidents-issues/162817/08-01-2011>

Al-Habeeb, T. A. (2003). A pilot study of faith healers' views on evil eye, jinn possession, and magic in the kingdom of Saudi Arabia. *Journal of Family and Community Medicine*, 10(3), 31-38

Alkhadhari, S., Alsabbri, A., Mohammad, I., Atwan, A., Alqudaihi, F. and Zahid, M. (2016). Prevalence of psychiatric morbidity in the primary health clinic attendees in Kuwait. *Journal of Affective Disorders*, 195(1), 15-20.

Al-Krenawi, A. and Graham, J. (2000). Culturally Sensitive Social Work Practice with Arab Clients in Mental Health Settings. *Health & Social Work*, 25(1), 9-22.

Al-Janfawi F. (2022). Ministry of Islamic Affairs: 200 Centres for teaching Qur'an and the Islamic literature in Morning and Evening shifts. *Alrai Newspapers* [Online]. [Accessed 7 November 2022]. Available from: <https://www-alraimedia-com.translate.goog/article/1584222>

Al-Jarallah, K., Moussa, M. and Al-Khanfar, K. (2009). The Physicians workforce in Kuwait to the year 2020. *International Journal of Health Planning and Management*, 25(1), 49-62.

- Almazeedi, H. and Alsuwaidan, M. (2014). "Integrating Kuwait's Mental Health System to end stigma: a call to action". *Journal of Mental Health*, 23(1), 1-3.
- Almutairi, A. (2015). Mental illness in Saudi Arabia: an overview. *Psychology Research and Behavior Management*. 3(8), 47-49.
- Alosaimi, F., Alshehri, Y., Alfrah, I., Alghamdi, A., Aldahash, S., Alkhuzayem, H. and Al-Beeshi, H. (2015). Psychosocial correlates of using faith healing services in Riyadh, Saudi Arabia: a comparative cross-sectional study. *International Journal of Mental Health System*, 9(8), 91-98.
- Aloud, N. (2004). *Factors affecting attitudes toward seeking and using formal mental health and psychological services among Arab-Muslims population*. Ph.D. thesis. Ohio State University.
- Al Riyami, A., Al Adawi, S., Al Kharusi, H., Morsi, M., and Jaju, S. (2009). Health services utilization by school going Omani adolescents and youths with DSM IV mental disorders and barriers to service use. *International Journal of Mental Health Systems*, 3(1), 22-33.
- Al-Rowais, N., Al-Faris, E., Mohammad, A., Al-Rukban, M. and Abdulghani, H. (2010). Traditional Healers in Riyadh Region: Reasons and Health Problems for Seeking Their Advice. A Household Survey. *The Journal of Alternative and Complementary Medicine*, 16(2), 199-204.
- Alsalmah H. (2017). Faith healing is prohibited. Alqabas Newspapers [Online]. [Accessed 7 June 2019]. Available from: <https://alqabas.com/460255/>
- Alsanea R. (2010). Faith healing\_\_\_\_\_ Between permitting or criminalizing. Alanba Newspapers. [Online]. [Accessed 7 June 2019]. Available from: <https://www.alanba.com.kw/kottab/riyad-halsanea/155923>
- Al-Shari, M. Al-Khenaizan, A. (2005). Al-Palliative Care for Muslim Patients. *The Journal of Supportive Oncology*, (3), 432-436
- Andrews, M., Lyne, P. and Riley, E. (1996). Validity in qualitative health care research: an exploration of the impact of individual researcher perspectives within collaborative enquiry. *Journal of Advanced Nursing*, 23(3), 441-447.

- Angen, M. (2000). Evaluating Interpretive Inquiry: Reviewing the Validity Debate and Opening the Dialogue. *Qualitative Health Research*, 10(3), 378-395.
- Appelbaum, D., Kligler, B., Barrett, B., Frenkel, M., Guerrera, M., Kondwani, K., Lee, B. and Tattelman, E. (2006). Natural and Traditional Medicine in Cuba: Lessons for U.S. Medical Education. *Academic Medicine*, 81(12), 1098-1103.
- Arksey, H. and O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8(1), 19-32.
- Arias, D., Taylor, L., Ofori-Atta, A. and Bradley, E. (2016). Prayer Camps and Biomedical Care in Ghana: Is Collaboration in Mental Health Care Possible. *PLOS ONE*, 11(9),
- Arseculeratne, S. (2002). Interactions between Traditional Medicine and 'Western' Medicine in Sri Lanka. *Social Scientist*, 30(5), 4-17
- Ateeq M, Jehan S, Mehmood R. (2014). Faith healing; modern health care. *Professional Medical Journal*, 21(2), 295-301
- Babbie, E. (2005). The basics of social research (3rd ed), Thomson: Wadsworth.
- Bahceci, B., Bagcioglu, E., Ozturk, A., Bulbul, F., Sahiner, I., Tuncer, B., Guzel, H. and Hocaoglu, C. (2013). Complementary and alternative medicine use in patients with mental disorders in Turkey. *Complementary Therapies in Clinical Practice*, 19(4), 221-226.
- Bale, R. (2000). A project to develop quality improvements in the Kuwait mental health service. *Psychiatric Bulletin*, 24(3), 111 -112.
- Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? *British Medical Journal*, 322(7294), 1115-1117.
- Bathla, M., Bathla, J., Kaloija, G. and Chandna, S. (2011). Seeking Help of Faith Healers in Modern Psychiatric Practice: Results of a 4 Years Study in Northern India. *Asian Journal of Psychiatry*, 18(1), 48-52.
- Bayer RS, Shunaigat WM. (2002). Sociodemographic and clinical characteristics of possessive disorder in Jordan. *Neurosciences (Riyadh)*, 7(1), 46-9.

- Birhan, W., Giday, M. and Teklehaymanot, T. (2011). The contribution of traditional healers' clinics to public health care system in Addis Ababa, Ethiopia: a cross-sectional study. *Journal of Ethnobiology Ethnomedicine*, 7(1), 39-46.
- Booyesen, M., Chikwanha, T., Chikwasha, V. and January, J. (2016). Knowledge and conceptualisation of mental illness among the Muslim population in Harare, Zimbabwe. *Mental Health, Religion & Culture*, 19(10), 1086-1093.
- Borras, L., Mohr, S., Brandt, P., Gillieron, C., Eytan, A. and Huguelet, P. (2007). Religious Beliefs in Schizophrenia: Their Relevance for Adherence to Treatment. *Schizophrenia Bulletin*. 33(5), 1238-1246.
- Bothello, J. and Roulet, T. (2018). The Imposter Syndrome, or the Mis-Representation of Self in Academic Life. *Journal of Management Studies*, 56(4), 854-861.
- Bracken, P. (2014). Towards a hermeneutic shift in psychiatry. *World Psychiatry*, 13(3), 241-243.
- Bradley, E., Curry, L. and Devers, K. (2007). Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory. *Health Services Research*, 42(4), 1758-1772.
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, (3), 77-101.
- Braun, V. and Clarke, V. (2013). Successful Qualitative Research: A Practical Guide for Beginners, London: SAGE, CHAPTER 5
- Bryman, A. (1988). Quantity and quality in social research, Boston: Unwin Hyman Publications, London.
- Bryman, A. (2001). Social Research Methods, Oxford University Press, Oxford.
- Bryman, A. (2012). Social research methods. 4th ed. Oxford: Oxford University Press.
- Bulbulia, T. and Laher, S. (2013). Exploring the role of Islam in perceptions of mental illness in a sample of Muslim psychiatrists based in Johannesburg. *South African Journal of Psychiatry*, 19(2), 3-5.



- Burns, J. and Tomita, A. (2014). Traditional and religious healers in the pathway to care for people with mental disorders in Africa: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*, 50(6), 867-877.
- Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V. and Flisher, A. (2010). Collaboration Between Traditional Practitioners and Primary Health Care Staff in South Africa: Developing a Workable Partnership for Community Mental Health Services. *Transcultural Psychiatry*, 47(4), 610-628.
- Canel Çınarbaş, D., Tuna, E. and Ar-Karci, Y. (2019). Turkish Muslim Healers: A Qualitative Investigation of Hocas and Their Methods. *Journal of Religion and Health*, 59(5), 2397-2413.
- Carpenter, C.M. and Suto, M. (2008). *Qualitative research for occupational and physical therapists: a practical guide*. Wiley, Oxford.  
<http://eu.wiley.com/WileyCDA/WileyTitle/productCd-1405144351.html>
- Carulla, L. S., Reed, G. M., VAEZ-AZIZI, L. M., COOPER, S. A., LEAL, R., Bertelli, M. and Girimaji, S. C. (2011). Intellectual developmental disorders: towards a new name, definition and framework for “mental retardation/intellectual disability”. *World Psychiatry*, 10(3), 175-180.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: Sage.
- Chilale, H. K., Sulungwe, N. D., Gondwe, S., and Masulani- Mwale, C. (2017). Clients and carers perception of mental illness and factors that influence help-seeking: Where they go first and why. *International Journal of Social Psychiatry*, 63(5), 418- 425.
- Coverdale, J., Nairn, R., and Claasen, D. (2002). Depictions of mental illness in print media: A prospective national sample. *Australian and New Zealand Journal of Psychiatry*, 36(5), 697-700.
- Cox, T. (1994). *Cultural Diversity in Organizations: Theory, Research and Practice* Berrett-Koehler Publishers.
- Creswell, J., Hanson, W., Clark Plano, V. and Morales, A. (2007). Qualitative Research Designs. *The Counseling Psychologist*, 35(2), 236-264.

- Creswell, J. W. (2012). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (4th ed.). Boston, MA: Pearson.
- Creswell, J.W. (2013). *Qualitative inquiry and research design: choosing among five approaches*. 3rd ed. Thousand Oaks, CA: Sage.
- Crosby, J. and Bossley, N., (2012). The religiosity gap: preferences for seeking help from religious advisors. *Mental Health, Religion & Culture*, 15(2), 141-159.
- Crotty, M. J. (1998). *The foundations of social research: Meaning and perspective in the research process*, Thousand Oaks, CA: Sage Publication.
- Daly, Kerry J. (2007). *Qualitative methods for family studies & human development / Kerry J. Daly* Sage Publications Thousand Oaks, Calif
- Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy & Rehabilitation*, 21(12), 560-568.
- Dein, S., Alexander, M. and Napier, A. (2008). Jinn, Psychiatry and Contested Notions of Misfortune among East London Bangladeshis. *Transcultural Psychiatry*, 45(1), 31-55.
- Devers, K. J., and Frankel, R. M. (2000). Study design in qualitative research--2: Sampling and data collection strategies. *Education for health*, 13(2), 263.
- Dresang, L., Brebrick, L., Murray, D., Shallue, A. and Sullivan-Vedder, L. (2005). Family Medicine in Cuba: Community-Oriented Primary Care and Complementary and Alternative Medicine. *The Journal of the American Board of Family Medicine*, 18(4), 297-303.
- Duckworth, K. (2013). *Mental Illness: What you Need to Know*. Arlington: National Alliance on Mental Illness.
- Ellis, C. (2004). *The ethnographic I. A Methodological Novel about Autoethnography*. Walnut Creek, CA: Altamira Press
- Eremnews. (2017). Why Kuwait prevents Faith healing practices. EremNews [Online]. [Accessed 7 June 2019]. Available from: <https://www.ereamnews.com/entertainment/society/1065997>

Fakhr El-Islam, M. (2008). Arab Culture and Mental Health Care. *Transcultural Psychiatry*, 45(4), 671-682.

Fakhr El-Islam, M. and Abu-Dagga, S. (1992). Lay Explanations of Symptoms of Mental Ill Health in Kuwait. *International Journal of Social Psychiatry*, 38(2), 150- 156.

Farooqi, Y. (2006). Traditional Healing Practices Sought by Muslim Psychiatric Patients in Lahore, Pakistan. *International Journal of Disability, Development and Education*, 53(4), 401-415.

Francis, J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. and Grimshaw, J. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology & Health*, 25(10), 1229-1245.

Gasson, S. (2004). Rigor in grounded theory research: An interpretive perspective on generating theory from qualitative field studies. In M. E. Whitman, & A. B. Woszczyński (Eds.), *The handbook of information systems research* (pp. 79–102). Hershey, PA: Idea Group.

Gelling, L. (2015). Qualitative research. *Nursing Standard*, 29 (30), pp. 43-47.

Gerrish, K. and Lacey, A. eds. (2006). *The research process in nursing*. 5th ed. Oxford: Blackwell.

Ghanizadeh A., Arkan N., Mohammadi M., Ghanizadeh-Zarchi M. (2008). Frequency of and barriers to utilization of mental health services in an Iranian population. *East Mediterranean Health Journal*, 14(2), 438-446.

Ghobary Bonab, B., Miner, M. and Proctor, M. (2013). Attachment to God in Islamic Spirituality. *Journal of Muslim Mental Health*, 7(2), 77-104

Glaser, B.G. (1978). *Theoretical sensitivity: advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.

Glaser, B.G. (1999). The future of grounded theory. *Qualitative Health Research*, 9(6), 836-845.

Green, J., and Thorogood, N. (2009). *Qualitative methods for health research*. Los Angeles, SAGE

Guarnaccia, P. J., and Rodriguez, O. (1996). Concepts of culture and their role in the development of culturally competent mental health services. *Hispanic Journal of Behavioral Sciences*, 18(4), 419–443.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *ECTJ*, 29(2), 75-91.

Gureje, O., Appiah-Poku, J., Bello, T., Kola, L., Araya, R., Chisholm, D., Esan, O., Harris, B., Makanjuola, V., Othieno, C., Price, L. and Seedat, S. (2020). Effect of collaborative care between traditional and faith healers and primary health-care workers on psychosis outcomes in Nigeria and Ghana (COSIMPO): a cluster randomised controlled trial. *The Lancet*, 396(10251), 612-622.

Hammersley, M. and Atkinson, P. (1983). *Ethnography: Principles in Practice*. London, Tavistock

Hancock, B. Windridge, K. and Ockleford E. (2007): *An Introduction to Qualitative Research*. Trent RDSU.

Hannah, M. and Halliday, M. (2002). *With Health in Mind: Improving mental health and wellbeing in Scotland*. Edinburgh: Scottish Public Mental Health Alliance

Hanneke, R., Asada, Y., Lieberman, L., Neubauer, L. and Fagen, M. (2017). The Scoping Review Method: Mapping the Literature in “Structural Change” Public Health Interventions. *SAGE Research Methods Cases*.

Haque, A. (2005). Mental health concepts and program development in Malaysia. *Journal of Mental Health*, 14(2), 183-195.

Hesse-Biber, S., and Nagy Leavy, P. (2011). *The Practice of Qualitative Research* (2nd ed.). New York: Sage

Jain, N., Gautam, S., Jain, S., Gupta, I., Batra, L., Sharma, R. and Singh, H. (2012). Pathway to psychiatric care in a tertiary mental health facility in Jaipur, India. *Asian Journal of Psychiatry*, 5(4), 303-308.

- Higginbottom, G. M., Pillay, J. J., and Boadu, N. Y. (2013). Guidance on Performing Focused Ethnographies with an Emphasis on Healthcare Research. *Th Qualitative Report*, 18(9), 1-6.
- Holloway, I. and Todres, L. (2006). Grounded theory. In: K. Gerrish and A. Lacey, eds. *The research process in nursing*. 5th ed. Oxford: Blackwell, 192-207
- Houghton, C., Hunter, A. and Meskell, P. (2012). "Linking Aims, Paradigms and Method in Nursing Research", *Nurse Researcher*, 20(2), 34-39.
- Huberman, A. M., and Lincoln, Y. S. (1998). Data management and analysis methods. In N.K. Denzin & Y. S. Lincoln (Eds), *Collecting and interpreting qualitative materials* (pp, 179-210). Thousand Oaks, CA: Sage Publications.
- Hughes, J. and Sharrock, W. (1997). *The Philosophy of Social Research*, 3rd edition, Pearson: Essex.
- Hughes, J. and Sharrock, W. (2007). *Theory and methods in sociology: an introduction to sociological thinking and practice*, Hampshire: Palgrave Macmillan.
- Hunter, A., Lusardi, P., Zucker, D., Jacelon, C. and Chandler, G. (2002). An exploration and advancement of the concept of trust. *Journal of Advanced Nursing*, 36 (2), 282-293
- Jack, E. P., and Raturi, A. S. (2006). Lessons learned from methodological triangulation in management research. *Management Research News*, 29(6), 345-357.
- Jack-Ide, I. and Uys, L. (2013). Barriers to mental health services utilization in the Niger Delta region of Nigeria: service users' perspectives. *Pan African Medical Journal*, 159(14). 159-197.
- Jain, N., Gautam, S., Jain, S., Gupta, I., Batra, L., Sharma, R. and Singh, H. (2012). Pathway to psychiatric care in a tertiary mental health facility in Jaipur, India. *Asian Journal of Psychiatry*, 5(4), 303-308.
- January, J. and Sodi, T. (2006). The Practices of Apostolic Faith Healers in Mental Health Care in Zimbabwe. *Journal of Psychology in Africa*, 16(2), 315-319.
- Jones, M. and Liyanage, C. (2018). Traditional Medicine and Primary Health Care in Sri Lanka: Policy, Perceptions, and Practice. *Asian Review of World Histories*, 6(1), 157-184.

Jorgensen, D. (2011). The Methodology of Participant Observation. *SAGE research methods*, 9(78), 12-25.

Kessler R. (2000). psychiatric epidemiology: selected recent advances and future directions. *Bulletin of World Health Organization*. 78(4)

Khoso, A., Soomro, R., Quraishy, A., Khan, H., Ismail, S., Nazaz, M., Younus, S. and Zainab, S. (2018). An insight into frequency and predictors leading psychiatric patients to visit faith healers: A hospital-based cross-sectional survey, Karachi, Pakistan. *International Journal of Social Psychiatry*, 64(3), 217-224.

Kleinman, A. M. (1977). Depression, somatization and the new cross-cultural psychiatry. *Social Science & Medicine*, 11(1), 3–10

Kleinman, A. (1980). Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry. Berkeley: University of California Press.

Kielmann, K. Cataldo, F. and SeeleyJ. (2011). Introduction to Qualitative Research Methodology DIFID

Kirmayer L.J. and, Ban L., (2013). Cultural Psychiatry: Research Strategies and Future Directions. *Adv Psychosom Med*. Basel, Karger, 33(9), 97-114

Kivunja, C. and Kuyini, A. (2017). Understanding and Applying Research Paradigms in Educational Contexts. *International Journal of Higher Education*, 6(5), 26.

Koch, T. and Harrington, A. (1998). "Reconceptualizing rigor: The case for reflexivity." *Journal of Advanced Nursing*, 28(4), 882-890.

Kpobi, L. and Swartz, L. (2018). Implications of healing power and positioning for collaboration between formal mental health services and traditional/alternative medicine: the case of Ghana. *Global Health Action*, 11(1), 1445333.

Kuna. (2020). Kuwait University: Accepting 8064 male and female students for the academic year 2020/2021. Kuwait News Agency (Kuna) [Online]. [Accessed 7 November 2022].

Available from: <https://www.kuna.net.kw/ArticleDetails.aspx?id=2935928&Language=ar#>

Kurihara, T., Kato, M., Reverger, R. and Tirta, I. (2006). Pathway to psychiatric care in Bali. *Psychiatry and Clinical Neurosciences*, 60(2), 204-210.

- Kuwait Central Statistical Bureau. (2014). Annual Statistical Abstract, 2014. Kuwait. [Online]. [Accessed 10 June 2019]. Available from: [http://www.csb.gov.kw/Socan\\_Statistic\\_EN.aspx?ID=18](http://www.csb.gov.kw/Socan_Statistic_EN.aspx?ID=18)
- Kuwait Government Online. (2020). Official Religion of Kuwait. Kuwait Government Online. State of Kuwait. [Online]. [Accessed 12 June 2020]. Available from: <https://www.e.gov.kw/sites/kgenglish/Pages/Visitors/AboutKuwait/CultureAndHeritageReligiousPractices.aspx>
- Lacey, A. (2015). Qualitative analysis In: K. Gerrish and J. Lathlean, eds. The research process in nursing. 7th ed. Chichester: Wiley.
- Lemelson, R. (2004). Traditional Healing and Its Discontents: Efficacy and Traditional Therapies of Neuropsychiatric Disorders in Bali. *Medical Anthropology Quarterly*, 18(1), 48-76.
- Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. *Critical Issues in Qualitative Research Methods*, 95-115.
- Lewis, S. (2015). Qualitative Inquiry and Research Design: Choosing Among Five Approaches. *Health Promotion Practice*, 16(4), 473-475.
- Lewis, J., and Ritchie, J. (2003). Generalising from qualitative research. *Qualitative research practice: A guide for social science students and researchers*
- Lewis, J., and Ritchie, J. (2003). Generalising from qualitative research. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 263-286). London: SAGE.
- Lincoln, Y.S. and Guba, E.G. (1985). *Naturalistic Enquiry*, Thousand Oaks, CA: Sage.
- Lu, W. and Lu, D. (2014). Impact of Chinese Herbal Medicine on American Society and Health Care System: Perspective and Concern. *Evidence-Based Complementary and Alternative Medicine*, 1-6.
- Macmillan P. (2016). "Kuwait". *The Statesman's Yearbook*. *The Statesman's Yearbook*: 727–731.
- Marcos, L. R. (1979). "Effects of interpreters on the evaluation of psychopathology in nonEnglish-speaking patients". *American Journal of Psychiatry*, 136(2), 171-174.

Marechal, G. (2010). "Autoethnography." In *Encyclopedia of Case Study Research*, edited by A. J. Mills, G. Durepos, and E. Weibe, 43–45. Thousand Oaks, CA: Sage.

Mason, J. (2002). *Qualitative Researching*. 2nd edition. London: Sage

Mathers C.D. and Loncar, D. (2006). Projections of Global Mortality and Burden of Disease from 2002 to 2030. *Public Library of Science Medicine*. 3(11). 442.

Mays, N. and Pope, C. (1995). Rigour and qualitative research. *British Medical Journal*, 311, 109-12

Mays, N., and Pope, C. (2000). Qualitative research in health care. Assessing quality in qualitative research. *BMJ (Clinical research ed.)*, 320(7226), 50–52.

McEvoy, P., and Richards, D. (2003). Critical realism: a way forward for evaluation research in nursing?. *Journal of advanced nursing*, 43(4), 411-420

Md. Sa'ad, R., Razali, Z., Sanip, S. and Mohd Rani, M. (2017). Knowledge and attitude of Malaysia's Muslim faith healers in dealing with the mentally ill. *Mental Health, Religion & Culture*, 20(10), 1015-1027.

Miller, W.R. (2010). Qualitative research findings as evidence: utility in nursing practice. *Clinical Nurse Specialist*, 24 (4), 191-193.

Miles, M.B. and Huberman, A.M. (1994). *Qualitative data analysis*. California: Sage.

MOH. (2013). *World Health Survey in Kuwait: Main report*. [Online]. Kuwait: Ministry of Health. [Accessed 25 June 2019]. Available from: <http://www.moh.gov.kw/>

Mohammad, Y., Al-Ahmari, A., Al-Dashash, F., Al-Hussain, F., Al-Masnour, F., Masoud, A. and Jradi, H. (2015). Pattern of traditional medicine use by adult Saudi patients with neurological disorders. *BioMed Central Complementary and Alternative Medicine*, 15(102).

Mruck, K., and Mey, G. (2007). Grounded theory and reflexivity. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 515-538). London: SAGE.

Munhall, P. L. (2007). The landscape of qualitative research in nursing. In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective* (pp. 3-36). Sudbury MA: Jones and Bartlett.



- Musyimi, C., Mutiso, V., Nandoya, E. and Ndetei, D. (2016). Forming a joint dialogue among faith healers, traditional healers and formal health workers in mental health in a Kenyan setting: towards common grounds. *Journal of Ethnobiology Ethnomedicine*, 12(4), 75-83.
- Neumann, J., Robson, A. and Sloan, D. (2018). Monitoring and evaluation of strategic change programme implementation—Lessons from a case analysis. *Evaluation and Program Planning*, 66, 120-132.
- Newton, L. (2009). Reflexivity, validity and roses. *Complicity: An International Journal of Complexity and Education*, 6(2), 104-112.
- Nightingale, D., and Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. London: McGraw-Hill Education
- Noble, H. and Smith, J. (2013). Qualitative data analysis: a practical example. *Evidence Based Nursing*, 17(1), 2-3.
- Nortje, G., Oladeji, B., Gureje, O. and Seedat, S. (2016). Effectiveness of traditional healers in treating mental disorders: a systematic review. *The Lancet Psychiatry*, 3(2), 154-170.
- O'Connell Davidson, J., and Layder, D. (1994). *Methods, Sex and Madness*. Hoboken: Routledge.
- Orlikowski, W. J., and Baroudi, J. J. (1991). Studying information technology in organizations: Research approaches and assumptions. *Information Systems Research*, 2(1), 1-28.
- Osafo, J. (2016). Seeking Paths for Collaboration between Religious Leaders and Mental Health Professionals in Ghana. *Pastoral Psychology*, 65(4), 493-508.
- Parahoo, K. (2014). *Nursing research: principles, process and issues*. 3rd ed. Basingstoke: Palgrave Macmillan.
- Patton, Michael, Q., and Michael, Q. P. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, Calif: Sage Publications

- Patton, M. (2008). *Utilization focused evaluation* (4th ed.). Thousand Oaks: Sage.
- Peters, M., Godfrey, C., Khalil, H., McInerney P., Parker, D., and Soares, C. (2015). Guidance for conducting systematic scoping reviews. *International Journal of Evidence-Based Healthcare*. 13, 141-146.
- Pham, T., Koirala, R., Wainberg, M. and Kohrt, B. (2020). Reassessing the Mental Health Treatment Gap: What Happens if We Include the Impact of Traditional Healing on Mental Illness?. *Community Mental Health Journal*, 57(4), 777-791.
- Pink, S. (2013). *Doing visual ethnography*. London: Sage.
- Pouchly, C. (2012). A narrative review: arguments for a collaborative approach in mental health between traditional healers and clinicians regarding spiritual beliefs. *Mental Health, Religion & Culture*, 15(1), 65-85.
- Pridmore, S. and Pasha, M. (2004). Psychiatry and Islam. *Australas Psychiatry*. 12(4), 380-5.
- Prince, M. Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M., and Rahman, A. (2007). No health without mental health from the Global mental health series. *The lancet*, 370(9590), 859-877.
- Pyett, P. (2003). Validation of Qualitative Research in the “Real World”. *Qualitative Health Research*, 13(8), 1170-1179.
- Raja, A. (2015). Ethical Considerations for Therapists Working with Demographically Similar Clients. *Ethics & Behavior*.
- Ramakrishnan, P., Rane, A., Dias, A., Bhat, J., Shukla, A., Lakshmi, S., Ansari, B., Ramaswamy, R., Reddy, R., Tribulato, A., Agarwal, A., SatyaPrasad, N., Mushtaq, A., Rao, P., Murthy, P. and Koenig, H. (2014). Indian Health Care Professionals’ Attitude Towards Spiritual Healing and Its Role in Alleviating Stigma of Psychiatric Services. *Journal of Religion and Health*, 53(6), 1800-1814.
- Rashid, S., Copello, A. and Birchwood, M. (2012). Muslim faith healers' views on substance misuse and psychosis. *Mental Health, Religion & Culture*, 15(6), 653-673.

Rashrash, M., Schommer, J., and Brown, L. (2017). Prevalence and Predictors of Herbal Medicine Use Among Adults in the United States. *Journal of Patient Experience*, 4(3), 108-113.

Razali, S. and Najib, M. (2000). Help-Seeking Pathways Among Malay Psychiatric Patients. *International Journal of Social Psychiatry*, 46(4), 281-289.

Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. (2013). n.d. *Qualitative research practice. A guide for Social Science Students and Researchers*.

Robert C. (2002). "Ubaid-period boat remains from As-Sabiyah: excavations by the British Archaeological Expedition to Kuwait". *Proceedings of the Seminar for Arabian Studies*, 32(1),13–30

Robert C. (2011). "The Neolithic origins of seafaring in the Arabian Gulf". *Archaeology International*, 24(3), 44.

Robertson, B. (2006). Does the evidence support collaboration between psychiatry and traditional healers? Findings from three South African studies. *African Journal of Psychiatry*, 9(2).

Robson, C. (2002). *Real world research*. 2nd ed. Oxford: Blackwell.

Sabry, W. and Vohra, A. (2013). Role of Islam in the management of Psychiatric disorders. *Indian Journal of Psychiatry*, 55(6), 205-210.

Saged, A., Mohd Yusoff, M., Abdul Latif, F., Hilmi, S., Al-Rahmi, W., Al-Samman, A., Alias, N. and Zeki, A. (2018). Impact of Quran in Treatment of the Psychological Disorder and Spiritual Illness. *Journal of Religion and Health*.

Sağlamer, G. (2013). The Mediterranean Sea: Cradle of civilization. *UN Chronicle*, 50(1), 41-41.

Sánchez, A. and Salmon, J. (2013). Overview of Complementary/Alternative Medicine in the Cuban Health System. *The International Journal of Healing and Caring*, 13(1).

Sandelowski, M. (1986). The problem of rigour in qualitative research. *Advances in Nursing Science* 8, 27-37

- Scull, N., Khullar, N., Al-Awadhi, N. and Erheim, R. (2014). A qualitative study of the perceptions of mental health care in Kuwait. *International Perspectives in Psychology: Research, Practice, Consultation*, 3(4), 284-299.
- Seale, C. (1999). Quality in Qualitative Research. *Qualitative Inquiry*, 5(4), 465-478.
- Shenton, A. (2004). "Strategies for ensuring trustworthiness in qualitative research projects", *Education for Information*, 22(1), 63–75.
- Shore, J., Richardson, W. Byron, B. and Manson, S. (2015). Traditional Healing Concepts and Psychiatry: Collaboration and Integration in Psychiatric Practice. *Psychiatric Times*, 30(6), 1 -4.
- Shrivastava, S., Shrivastava, P. and Ramasamy, J. (2015). Mainstreaming of Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy with the health care delivery system in India. *Journal of Traditional and Complementary Medicine*, 5(2), 116-118.
- Silverman, D. (2011). *Interpreting qualitative data: A guide to the principles of qualitative research*. London: SAGE.
- Skinner, D. (2004). Evaluation and change management: rhetoric and reality. *Human Resource Management Journal*, 14(3), 5-19.
- Sorketti, E., Zainal, N. and Habil, M. (2012). The treatment outcome of psychotic disorders by traditional healers in central Sudan. *International Journal of Social Psychiatry*, 59(4), 365-376.
- Sorsdahl, K., Stein, D. and Flisher, A. (2010). Traditional Healer Attitudes and Beliefs Regarding Referral of the Mentally Ill to Western Doctors in South Africa. *Transcultural Psychiatry*, 47(4), 591-609.
- Spradley, J. (1980). *Participant observation*. New York: Holt, 1980
- Sujatha, V. (2020). Globalisation of South Asian Medicines: Knowledge, Power, Structure and Sustainability. *Society and Culture in South Asia*, 6(1), 7–30.
- Summerfield, D. (2008). How Scientifically Valid Is the Knowledge Base of Global Mental Health? *British Medical Journal*, 336(7651), 992-994

- Stafford, B. 2005. "The Growing Evidence for 'Demonic Possession': What Should Psychiatry's Response Be?" *Journal of Religion and Health*, 44(1), 13–30,
- Stevenson, A. (2010). *The Oxford dictionary of English*. [Oxford]: [Oxford University Press].
- Teuton, J., Dowrick, C. and Bentall, R. (2007). How healers manage the pluralistic healing context: The perspective of indigenous, religious and allopathic healers in relation to psychosis in Uganda. *Social Science & Medicine*, 65(6), 1260-1273
- Thirhalli, J., Zhou, L., Kumar, K., Gao, J., Vaid, H., Liu, H., Hankey, A., Wang, G., Gangadhar, B., Nie, J. and Nichter, M. (2016). Traditional, complementary, and alternative medicine approaches to mental health care and psychological wellbeing in India and China. *The Lancet Psychiatry*, 3(7), 660-672.
- Thomas, J., Al-Qarni, N. and Furber, S. (2015). Conceptualising mental health in the United Arab Emirates: the perspective of traditional healers. *Mental Health, Religion & Culture*, 18(2), 134-145.
- Thorne, S. (2000). Data analysis in qualitative research. *Evidence-Based Nursing*, 3, 68-70.
- Thornicroft G, Rose D, Kassam A. (2007). Discrimination in health care against people with mental illness. *Int Rev Psychiatry*, 19(2):113-22.
- Todres, L. (2005). Clarifying the life-world: Descriptive phenomenology. *Qualitative Research in Health Care*.
- Trueit, D. (2008). Beyond simple order: Complexity and postmodern politics. *Journal of the Canadian Association for Curriculum Studies*, 6(1), 25-43.
- Tzeferakos, G. and Douzenis, A. (2017). Islam, mental health and law: a general overview. *Annals of General Psychiatry*, 16(1).
- UN World Population Prospects. (2019). Kuwait Population Growth. United Nations World Population Prospects 2019. [Online]. [Accessed 12 June 2020]. Available from: <https://worldpopulationreview.com/countries/kuwait-population/>
- Uvais, N. (2017). Jinn and psychiatry: Beliefs among (muslim) doctors. *Indian Journal of Social Psychiatry*, 33(1), p.47.

van der Watt, A., Nortje, G., Kola, L., Appiah-Poku, J., Othieno, C., Harris, B., Oladeji, B., Esan, O., Makanjuola, V., Price, L., Seedat, S. and Gureje, O. (2017). Collaboration Between Biomedical and Complementary and Alternative Care Providers: Barriers and Pathways. *Qualitative Health Research*, 27(14), 2177-2188

Vontress, CE. (2005). “Animism: Foundation of traditional healing in Sub-Saharan Africa”. In *Integrating traditional healing practices into counseling and psychotherapy*, Edited by: Moodley, R and West, W. 124–137. Thousand Oaks, CA: Sage Publications.

Walsh, R., and Shapiro, S. L. (2006). The meeting of meditative disciplines and Western psychology: a mutually enriching dialogue. *American Psychologist*, 61(3), 227-239.

Wamba, A. and Groleau, D. (2012). Constructing Collaborative Processes between Traditional, Religious and Biomedical Health Practitioners in Cameroon. *Noradic Journal of African Studies*. 12(2), 49-74.

Wang, P., Angermeyer, M., Borges, R., Chiu, W., Haro, J., Nakane, Y., Pennell, B., Chatterji, S., Kessler, R. and Ormel, J. (2007). Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization’s World Mental Health Survey Initiative. *World Psychiatry*, 62(6),177-185.

Warmoth, A. (2000). Social constructionist epistemology.

Warren, C. A. (2002). Qualitative interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 83-99). London: SAGE.

Weatherhead, S. and Daiches, A. (2010). Muslim views on mental health and psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 83(1), 75-89.

WHO. (2000). General guidelines for methodologies on research and evaluation of traditional medicine. [Online]. Geneva, Switzerland: World Health Organization. [Accessed 25 May 2021]. Available from: <http://www.who.int/>

WHO. (2002). *Traditional medicine strategy 2002-2005*. [online] available from [www.wpro.who.int/health\\_technology/book\\_who\\_traditional\\_medicine\\_strategy\\_2002\\_2005](http://www.wpro.who.int/health_technology/book_who_traditional_medicine_strategy_2002_2005)

[Accessed 2 February 2019].

WHO. (2003). Advocacy for Mental Health. [Online]. Geneva, Switzerland: World Health Organization. [Accessed 19 June 2020]. Available from: [www.who.int/](http://www.who.int/)

WHO. (2005). Promoting Mental Health. [Online]. Geneva, Switzerland: World Health Organization. [Accessed 19 June 2019]. Available from: <http://www.who.int>

WHO. (2006). Health Systems Profile- Kuwait. 2006. Regional Health Systems Observatory- EMRO. World Health Organization. [Online]. [Accessed January 29, 2019]. Available from: <http://apps.who.int/medicinedocs/en/d/Js17297e/>

WHO. (2006). Mental health in the Eastern Mediterranean Region: Reaching the unreached. [Online]. Geneva, Switzerland: World Health Organization. [Accessed 11 June 2019]. Available from: <http://www.who.int/>

WHO. (2008). Mental Health Gap Action Programme: Scaling up care for mental, neurological and substance use disorders. [Online]. Geneva, Switzerland: World Health Organization. [Accessed 12 June 2019]. Available from: <http://www.who.int/>

WHO. (2011). “*Mental Health Atlas: Kuwait*”. WHO publications. Geneva. [online] available from [www.who.int/mental\\_health/evidence/atlas/profiles/kwt\\_mh\\_profile.pdf?ua](http://www.who.int/mental_health/evidence/atlas/profiles/kwt_mh_profile.pdf?ua) [Accessed 5 February 2019].

WHO. (2013). Mental health action plan 2013-2020. [Online]. Geneva, Switzerland: World Health Organization. [Accessed May 2019]. Available from: <http://www.who.int/>

WHO. (2014a). Country Cooperation Strategy for WHO and Kuwait 2012 - 2016. [Online]. Geneva, Switzerland: World Health Organization. [Accessed 25 May 2019]. Available from: <http://www.who.int/>

WHO. (2014b). Mental health Atlas country profile 2014. [Online]. Geneva, Switzerland: World Health Organization. [Accessed 26 May 2019]. Available from: <http://www.who.int/>

WHO. (2021). Comprehensive Mental Health Action Plan 2013-2030. [Online]. Geneva, Switzerland: World Health Organization. [Accessed 10 November 2022]. Available from: <http://www.who.int/>

Willis, J. W. (2007). Foundations of qualitative research: Interpretive and critical approaches. SAGE Publications, Inc. <https://dx.doi.org/10.4135/9781452230108>

WorldAtlas. (2018). Religious Beliefs in Kuwait. World Atlas. [Online]. [Accessed 12 June 2020]. Available from: <https://www.worldatlas.com/articles/religious-beliefs-in-kuwait.html>

World Bank, (2016). Kuwait | Data. *Data.worldbank.org*. [Online]. [Accessed 10 June 2019]. Available from: <http://data.worldbank.org/country/kuwait>.

Wu, A.P., Burke, A., and LeBaron S. (2007). Use of traditional medicine by immigrant Chinese patients. *Family Medicine*, 39(3), 195-200.

Xu, J. and Yang, Y. (2009). Traditional Chinese medicine in the Chinese health care system. *Health Policy*, 90(2-3), 133-139.

Ypinazar, V. and Margolis, S. (2006). Delivering Culturally Sensitive Care: The Perceptions of Older Arabian Gulf Arabs Concerning Religion, Health, and Disease. *Qualitative Health Research*, 16(6), 773-787.

Ziebland, S. And McPherson, A. (2006). ‘Making sense of qualitative data analysis: an introduction with illustrations from DIPEX (personal experiences of health and illness)’, *Medical Education*, 40, 405–414