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Experience of religiosity in caregiving for persons with serious mental illness: a qualitative study using interpretative phenomenological analysis from India

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ABSTRACT

Background Persons with serious mental illness (SMI) continue to be largely taken care of by their families in India. Religion-based explanatory models of illness and religious coping methods are commonly employed by caregivers to deal with the burden of caregiving. While there is evidence to support the positive impact of religiosity on caregiving, there are no qualitative studies that have explored these beliefs.

Objective This study aims to examine the experience of religiosity and coping among primary caregivers of persons with SMI.

Study design This study applied a qualitative study design using interpretative phenomenological analysis through face-to-face interviews.

Setting The study was conducted between June 2022 and October 2023 at the Occupational Therapy Unit of the Department of Psychiatry at a tertiary care centre in South India.

Participants 24 primary caregivers of persons with SMI who provided written informed consent participated in the study.

Results All participants had religion-based explanations for their relatives' mental illness. These explanations influenced perceptions about the role of healthcare professionals and the need to seek medical treatment for mental illness. Many participants simultaneously believed in medical, religious and social models of mental illness. Religious models of mental illness often led to fears of stigma, preventing participants from seeking support or healthcare services.

Conclusion The findings of our study demonstrate how religious beliefs of caregivers influence attributions to the cause and mode of treatment of mental illness. In order to optimise care for persons with mental illness, healthcare professionals need to involve themselves in dialogues regarding religious beliefs, formulate psychoeducation and care plans which incorporate these beliefs.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The study included participants from various religious and sociocultural backgrounds, thus providing rich descriptions of their personal experience.
⇒ To the best of our knowledge, this is among the few qualitative studies which have explored how religious beliefs modify the experience of caregiving.
⇒ This study was done among participants who had the awareness and resources to seek allopathic healthcare; we do not have narratives from those who sought alternative forms of healthcare.
⇒ We were unable to interview participants who identified as atheists, agnostics or rationalists, which could have added other dimensions to the data.

INTRODUCTION

Religion has been traditionally understood to be a doctrinal, formal, institutional set of beliefs, while spirituality refers to the more subjective, introspective aspect of religious experience. Contemporary thinking views both constructs as complementary rather than divergent since the search for the sacred, irrespective of the various names given for it, often takes place in the context of larger religious systems.[1] Religion and psychiatry have a tumultuous history; however, over the years there has been increasing acceptance of both positive and negative aspects of religion on coping.[2–4] The positive patterns of religious coping include seeking spiritual support and religious forgiveness, while negative patterns are characterised by spiritual discontent. When dealing with major life stressors, people tend to use several of these methods in different combinations.[5 6] Positive religious coping has been associated with reduced psychological distress and enhanced quality of life among persons with mental illness as well as their caregivers.[3 5 7–10] On the other hand, negative religious coping strategies are believed to result in emotional distress, callousness towards others and a poorer quality of life.[2 3 8 10–13]

Studies have also found differences in coping styles based on religion-specific beliefs about suffering. Hinduism

advocates detachment from the material world and belief in *karma,* the moral law of the universe. Additionally, *karma* is encompassed by God or The Ultimate, who can be embodied as individual deities. Since *karma* is an effect of past actions, this facilitates acceptance of the illness as beyond one's control, and suffering is reframed as something good that will enable liberation (*moksha*) from past deeds. *Yoga* and meditation help detach the mind, see beyond one's suffering and focus on The Ultimate.[14–16] Buddhism also has a detachment-based approach to suffering but with a non-theistic philosophy. Suffering is considered inevitable and is to be accepted, with a here-and-now focus. Meditative practices, finding meaning, ego-transcendence, doing good *karma* and non-attachment are coping strategies prescribed by Buddhism.[17–19] Christianity has evolved ideologically from an initial collectivistic focus to a more individualistic focus, where the individual takes personal responsibility for their sin, and salvation is gained through a personal relationship with God. Subsequently, coping with life stressors is an intrapersonal process through strengthening faith in God, solace seeking through personal prayers, reading scriptures and attending religious and collective worship services.[20 21] Islam is believed to retain a collectivistic orientation, with tenets encouraging social cohesiveness and self-sacrifice. Illness is attributed to *kismet* or destiny, thus externalising the locus of control. Coping through family and social support, and seeking religious healing is a common method of coping by Muslims.[21]

Studies have also reported differing coping styles based on cultural specificity—those with emphasis on individualism and independence versus cultures focusing on collectivism and interdependence. Coping in collectivistic societies tends to focus more on interpersonal dependence and culturally shaped emotional and cognitive coping styles. Asian cultures are traditionally more collectivistic in nature. Indian families were traditionally large, patriarchal, collectivistic, joint families; with increasing urbanisation, extended or nuclear families are becoming the norm. However, persons with severe mental illness continue to be largely taken care of by their families. The chronic nature of these illnesses and the associated disability leads to much caregiver burden.[22] Religion-based explanatory models of illness and religious coping methods have been commonly found to be employed by Indian caregivers to deal with stress.[23 24] While there are studies that support the positive impact of religiosity on caregiving, there are no qualitative studies that have explored how these beliefs modify the experience of caregiving. Hence, we aimed to fill this lacuna by examining the role of religiosity in caregiving for persons with serious mental illness (SMI). For the sake of simplicity, we use the term religiosity as an overarching concept that includes the spiritual aspects of a person's religious experiences.

METHODS

Study design

This is a descriptive qualitative study design based on the interpretative phenomenological analysis which encourages a non-linear, dynamic approach to data analysis.[25] This method was chosen as it would allow the researchers to focus ideographically on each participant as the experiential expert, while also attempting comparative analysis to bring out the diversity of participant experiences. We used face-to-face interviews as it would enable in-depth exploration of personal experiences.

Setting

The study was conducted at the inpatient occupational therapy unit of the Department of Psychiatry at a tertiary care centre in South India between June 2022 and October 2023. This is a 122-bed inpatient, as well as outpatient facility catering to a daily average of 500 patients. This is one of the few such centres in India; hence, the majority of the patients, hailing from different religious and cultural backgrounds, travel from all over the country to access care. This Christian faith-based institution has a long-standing commitment to providing quality, subsidised healthcare to the marginalised.

Participants

The participants were recruited from the residential care facility, which mandates family-mediated care, where persons with mental illness stay with their families for a few weeks to receive psychosocial rehabilitation. The authors are occupational therapists who oversee this rehabilitation process, hence would work closely with the patients and families for the length of their stay at the hospital. We approached primary caregivers around 2 weeks into their admission, which provided us adequate time for understanding the overall family context. Caregivers of mostly persons diagnosed with schizophrenia or bipolar affective disorder, aged 18–60 years, who were literate, were approached for written informed consent. We excluded caregivers who had clinically diagnosed mental illness. We used purposive, maximum variability sampling to include caregivers from different religions and relationships with patients. We also included caregivers with differing educational, economic and cultural backgrounds. Face-to-face in-depth interviews were conducted for caregivers who consented. Out of the 24 participants approached, none refused consent, and follow-up interviews were conducted with 2 participants for clarification of interview content. They were each assigned a code to ensure anonymity.

Quality assurance

We took care to ensure the trustworthiness of the study by focusing on credibility, dependability, conformability, transferability and authenticity as suggested by Lincoln

and Guba.[26] We used open-ended, unstructured questions which were developed after discussion with two caregivers as a critical reference group. We believe our inclusion criteria allowed for recruitment of caregivers best suited to answer the research question. After the first few interviews, all authors started preliminary analysis and explored the initial themes in subsequent interviews, until there was consensus about data saturation. The authors were mindful of their religious ideas and used reflexivity during regular discussions to ensure that personal bias did not influence the confirmability of the analysis.

Data collection

We interviewed 24 participants in their vernacular language—Tamil, Hindi, Bengali, Malayalam or English. Since the authors hail from different parts of India, each author conducted interviews in languages they were proficient in. The participants were familiar with the interviewers for at least a week before being approached for consent. The interviews were conducted in a therapy room with only the participant and interviewer present. The interviews typically lasted from 45 min to 1 hour. The interviews were audio-recorded, and the interviewer also took field notes on non-verbal aspects of the interview. Follow-up interviews were conducted with two participants for deeper clarifications. The interviews were transcribed and translated into English digitally using a word processor by each interviewer.

The interview guide was reviewed by all authors and consisted initially of five open-ended questions as given in the interview guide (table 1). Additional questions and probes were incorporated into subsequent interviews as various themes emerged. Data saturation was agreed by the authors to be achieved after 20 interviews when no new narratives seemed forthcoming. Four more interviews were conducted until thematic saturation was ensured.

Data analysis

We used the Consolidated Criteria for Reporting Qualitative Research checklist to guide the reporting of the methodology and results.[27] Thematic analysis was done using Braun and Clarke's six-step approach, with both inductive and deductive coding procedures.[28] Each author listened to the audio recordings, read the transcripts and inductively developed the codes separately based on preliminary themes that emerged from the transcripts. The codes were organised into categories and semantic themes using Microsoft Excel sheets. In the next cycle of analysis, the authors together reviewed the codes and themes and grouped them into over-arching or latent themes. The authors also discussed commonalities and differences across participant experiences, highlighted illustrative quotes and noted themes that elicited significant emotional displays during interviews.

Patient and public involvement

The questions of the initial interview guide were finalised after discussion and feedback from two caregivers before the initiation of the study. As the study was conducted in a Christian faith-based institution, one question in the interview guide focused on this experience, so that the feedback from the caregivers could be subsequently used to sensitise the professionals about caregivers' religious-based needs.

Table 1 Interview guide

S. no	Initial questions
1	Do you consider yourself religious? Please elaborate.
2	How has being religious influenced your coping with your relatives' illness?
3	What are the common rituals that you follow as part of your religion? In what ways do these activities help you cope?
4	What support do you receive in dealing with your relative's illness from your religious group?
5	How have your religious beliefs changed over the course of the illness?
	Additional questions
6	How would you describe your personal connection/experience with God?
7	According to you, how much is the role of medical care and how much is the role of God in healing?
8	According to your religious beliefs, what is the reason for your relative getting this illness?
9	Can you describe any religious measures you have tried to make your relative's illness better?
10	According to you, is being religious the same as believing in God? Please elaborate.
11	You have admitted your relative in a 'Christian' faith-based institution. How has this influenced your healthcare experience?

RESULTS

Table 2 provides demographic details about the study participants.

The key themes identified included general beliefs concerning God, religion and suffering; religious beliefs related to mental illness; blurred boundaries between religion and science; and religious models of mental illness and stigma.

Theme 1: general beliefs concerning God, religion and suffering

For most participants, belief in God developed early in life through their family or friends. As young children, they used to imitate elders, and as they grew older, most of them continued the same practices. Few changed their belief systems or converted to another religion, secondary to life experiences or marriage.

Most participants believed that despite the various names used in different religions, there is only one supreme power, God. Each person could worship the deity they were used to worshipping from childhood. Few

Table 2 Demographic characteristics of the study participants (n=24)

Participant ID	Age range	Gender	Religious affiliation	Relationship to patient	Sociocultural background	Patient diagnosis	Duration of illness (years)
P1	60–65	Male	Hindu	Father	Rural Tamil Nadu (South India)	Bipolar Affective disorder	10
P2	50–55	Female	Christian	Mother	Urban Tamil Nadu (South India)	Severe depression	4
P3	50–55	Female	Hindu	Mother	Urban Tamil Nadu (South India)	Schizophrenia	10
P4	55–60	Female	Muslim	Mother	Urban Kerala (South India)	Bipolar affective disorder	12
P5	60–65	Male	Hindu	Father	Rural Tamil Nadu (South India)	Schizophrenia	5
P6	40–45	Female	Hindu	Wife	Rural Tamil Nadu (South India)	Bipolar affective disorder	20
P7	60–65	Male	Hindu	Father	Rural Tamil Nadu (South India)	Schizophrenia	5
P8	60–65	Female	Hindu	Mother	Rural Tamil Nadu (South India)	Schizophrenia	20
P9	55–60	Female	Buddhist	Mother	Urban Mizoram (North-east India)	Delusional disorder	4
P10	60–65	Male	Muslim	Father	Urban Tamil Nadu (South India)	Schizophrenia	3
P11	30–35	Male	Hindu	Son	Urban Tamil Nadu (South India)	Bipolar affective disorder	20
P12	25–30	Female	Hindu	Sister	Urban Tamil Nadu (South India)	Schizophrenia	4
P13	30–35	Male	Hindu	Brother	Rural Tamil Nadu (South India)	Severe depression	4
P14	55–60	Male	Buddhist	Father	Urban Mizoram (North-east India)	Delusional disorder	4
P15	55–60	Female	Hindu	Mother	Urban Tamil Nadu (South India)	Schizophrenia	3
P16	65–70	Female	Hindu	Mother	Rural Tamil Nadu (South India)	Schizophrenia	15
P17	50–55	Female	Hindu	Mother	Rural Tamil Nadu (South India)	Schizophrenia	4
P18	50–55	Female	Christian	Mother	Urban Kerala (South India)	Schizophrenia	10
P19	50–55	Female	Hindu	Mother	Urban Tamil Nadu (South India)	Schizophrenia	3
P20	30–35	Female	Hindu	Wife	Rural Tamil Nadu (South India)	Schizophrenia	7
P21	30–35	Female	Hindu	Wife	Rural Kerala (South India)	Schizophrenia	4
P22	25–30	Female	Hindu	Wife	Urban West Bengal (East India)	Schizophrenia	7
P23	55–60	Female	Hindu	Mother	Urban Tamil Nadu (South India)	Schizophrenia	10
P24	45–50	Female	Hindu	Wife	Urban Tamil Nadu (South India)	Schizophrenia	15

felt that their deity was superior to deities of other religions. For most participants, the reason to worship God was to have their various needs met by Him. According to P4 (mother), "God is power, whenever we have any difficulties or worries, we go to Him only, there are no boundaries such as caste or religion, everyone calls on God. If we call to Him, He'll always answer us someday."

For most participants, a personal connection with God was made through prayers, rituals or mantras. Few mentioned dreams where God talked to them, or experiences which they took as a sign that God is communicating to them. As recounted by P22 (wife), "I don't know many prayers and mantras. I talk to God personally only. Even if I am sitting at home, alone or with others, I talk to Him, saying, God, do this and that for me."

All of them found a personal meaning as they experienced difficult times. Participants who identified as Christians and Muslims felt that it was a test from God to bring them closer to Him, or to strengthen them. Participants who identified as Hindus or Buddhists mostly attributed suffering to *karma*, which is loosely translated as the sum of a person's actions in current and previous births. As P24 (wife) put it,

> Karma, ours or our ancestors' karma, it's our birth's purpose. Like how parents' properties reach the children after their death, similarly, the deeds we do will reach our children. What we did in our past lives we don't know, karma's consequence will be there, that is what our religion teaches. That's why I pray to God, whatever deeds I did in my past life, I did not do it intentionally, so I'll ask for forgiveness, only then I ask Him for something.

Overall, the participants in our study reported a range of positive religious coping styles like benevolent religious reappraisal, collaborative religious coping, seeking religious support, seeking religious connection and religious purification. The negative religious coping styles included punishing God reappraisal, spiritual discontent, self-directing religious coping and interpersonal religious discontent.[29] Table 3 provides detailed quotes on themes related to general beliefs about God, religion and suffering.

Theme 2: religious beliefs related to mental illness

Most participants reported feeling anger towards God at some point during their relatives' illness. The anger was related to their perception that God was not making the person better in spite of continued prayers. Many also reported feeling helpless and tearful when they did not get the positive treatment outcomes they prayed for. However, for all participants, these feelings were transient, and sooner or later, they found peace by believing that things would get better. Many also felt that it was not their place to get angry with God, and subsequently felt guilty.

Even when participants did not believe in a specific entity, they still expressed faith in a larger scheme of things and meaning for their experiences. As expressed by P19 (mother),

> I don't believe in one single God or one single universal power, but I feel that there is some universal network of things. I strongly believe that each one has a path of life; we are not the deciding authorities for our lives. I'm sure that my son also will have unseen hands just helping his way through life. So I'm just doing what I can do at this moment, and I'm just leaving the rest to destiny.

Even when she believed in the medical model of illness, simultaneously, she also wanted to hope and believe in religious forms of cure.

> See, sometimes I was told to chant a few mantras, in difficult situations I did that, I wanted to believe that these things would give some result. If not immediate, but later. The kind of hope that it gave me, was helping me through the tough times because when there is nothing to hold onto, that's (faith) the biggest thing to hold onto.

The belief that mental illness was caused due to evil spirits or black magic was shared by many participants in the study. Like P12 (sister), even those who did not personally believe in religious forms of treatment, had at some point in the course of the relative's illness, adhered to the wishes of the family or neighbours and resorted to religious practices specifically for curing mental illness. There was also a generational difference among our participants, the younger relatives identified symptoms as part of an illness and the older participants were more oriented to religious causation. According to P11 (son),

> My mother and mother-in-law took him to a temple for healing. They don't believe that he has a psychiatric problem. They feel that somebody has done black magic to him. The healer asked us to come again, but I didn't take him.

Theme 3: blurred boundaries between religion and science

Many participants simultaneously believed in medical, religious and social models of mental illness, and were at times confused by the symptoms exhibited by their relatives. P11 was not sure whether it was a problem when his father, a devotee of *Saibaba* (an Indian sage), started reporting the sage appearing before him. P16, whose son has compulsions to hold a Bible constantly in his hand, attributed this behaviour to God blessing him. P17, whose daughter used to hear the voice of a goddess, took her daughter to a temple dedicated to the goddess and made an offering of her daughter's hair. P19, whose son experiences delusions, had read about an ancient Indian religious saint who had become famous despite reportedly experiencing psychosis. She wished that her son could also be helped through religious means, but felt a lack of guidance.

Table 3 Themes and illustrative quotes of general beliefs about God, religion and suffering

Theme	Categories	Illustrative quotes
Relationship between God and religion	– God and religion are same – Personal choice of which God to worship	Jesus Christ, Allah, Maariyatha, Perumal, everyone is the same. It's who we like. Some eat rice, some eat roti, some eat meat, some eat fruits … like that. (P1, father)
	– Different Gods for each religion – Preferable to stick to own religion, but unity is important	We can't say all religions are the same. We are Hindus, we can't go and read Bible or Quran. Just like some people speak only Tamil, others speak Hindi. Like that each religion should follow their God … but all should live in unity. (P5, father)
	– God and religion are different	God is a personal feeling. But religion is manipulated by many. In church, people say "saitane po" (go away, Satan!). Where is Satan? I don't believe in religion, I believe in God. (P12, sister)
Omnipresence of God	– Doing good deeds implies belief in God	There are some people who do not believe in God at all, but still they do good deeds, so this means believing in God. Because ultimately all religions teach us to love each other. (P9, mother)
	– God is present, irrespective of personal actions	Some people believe in God and go to places of worship, but don't do good deeds. But still inside him God is present, right? (P9, mother)
	– God is present in all living beings	God is one and the soul is one. Even an insect or an ant has a soul. (P11, son)
Importance of religious rituals and regulations	– Rituals need to be followed even if you don't believe in God	Religious rituals and traditions must be followed even if you don't believe, because it is part of the system, system is discipline, and without discipline no one can move forward. (P9, mother)
	– Belief in God a pre-requisite for following rules of a religion	If I have faith in Allah I will follow rules and regulations given in the book Quran. First faith, then religion. (P10, father)
Dependence on God vs personal responsibility	– Onus on God for personal actions	God only controls everything. Before doing any work, we have to tell God, right? If God is not there, then we will do wrong things. (P14, father)
	– Onus on self as well as God	I do believe in God, but we can't leave everything to God. If I say I will become a doctor, then do puja, but do not study, I won't become a doctor. So, there are things I also have to do. (P22, wife)
Reason for suffering	– To get closer to God	God has a purpose, which is why He has allowed this. So that when we come out of this problem, we can be a witness for God. (P2, mother)
	– As a test of faith	God is testing us, He is checking if we hate God when we are tested. (P6, wife)

Continued

Table 3 Continued

Theme	Categories	Illustrative quotes
	– As part of life balance	In life both happiness and sadness should be there. When problems come, we should face them and accept sadness. Then only life cycle will be complete. We should adapt and live. (P5, father)
	– As a punishment for own deeds	It is because of our wrong deeds. We hurt others and we are punished by Allah. (P10, father)
	– As a punishment for others' deeds	He is suffering for his father's bad deeds. Or maybe because of something I have done in the past. (P20, wife)
	– Unknown, but beneficial reason	I have always heard that whatever God does is always good. Maybe He gave my husband the illness for some unknown good, I don't know. (P22, wife)

> I've read a lot about people having such (psychotic) experiences, unfortunately, we don't have any (religious) support system to take them through that journey in a structured way. We end up in psychiatry. I strongly feel that both (healthcare and religion) are important. But I really wonder about the expertise we have on the other religious path. Medicine is real fact and science very rational stuff. But on the other side, it's a very vague system. And things are very commercialised in that area (religious-based healing), so you never know.

P24 (wife) illustrated alternative perspectives to causation of mental illness as

> There are no evil spirits, I believe, but there is karma. In the hospital, they ask if there is anyone in your family with similar illness, isn't that karma? Scientifically, if we see, it's genes but it is karma if we look at it from a religious point of view.

P22 talked about how as a wife she felt responsible for ensuring her husband's health through prayers.

> When I feel upset, I pray to Lord Shiva. All married women are supposed to pray to Him, for their husband's well-being. When my husband becomes unwell, I pour water on Lord Shiva's head (as part of a ritual), and fast on Mondays.

These multiple attributional styles also influenced how participants viewed the mental healthcare system and the role of professionals. All of them resoundingly stated that healthcare professionals were agents of God or an Unknown entity. Unless God's hand was at work, medicines and healthcare would not be beneficial. In an analogy given by P10 (father),

> Do you know Moses, the prophet? He was having stomach ache, and he prayed. Allah sent a messenger and told him to go to a tree and eat its leaves. He ate and his stomach ache was gone. Then, again he had a stomach ache. This time, he directly went to the tree and ate the leaves. His stomach ache increased. The medicine is like the plant leaves, they don't have healing power in themselves. Power is given by Allah.

God also used many others to give them not just psychological support, but also social and economic support as per their need. P7, P8 and P16 (parents) talked about how religious groups would offer them support and prayers to deal with the illness. Monetary help, assistance to access healthcare services, accompanying sick persons during admission and ensuring employment of ill persons within religious premises also were reported by participants. A few participants had also converted to religions where these supports were easily available.

P24 (wife) believed that God worked through a stranger when her husband had refused to come with her to the hospital.

> I was trying to bring him to hospital, it was a big struggle. That time there was an auto rickshaw driver; he talked to my husband tactfully and made him sit inside the car. I arranged so many people, they did help, but, the driver, he is the one who was sent from the power above. Whoever helped, they are all reflections of God. God will not come in His form to the world; he will come in human form only.

Table 4 provides detailed categories and illustrated quotes related to religion-based explanatory models and healing practices.

Theme 4: religious models of mental illness and stigma

Religious and social models of mental illness often led to fears of stigma, preventing participants from seeking support or healthcare services. P21's mother-in-law tried

Table 4 Themes and illustrative quotes of religious beliefs related to mental illness

Theme	Categories	Illustrative quotes
Explanatory models of mental illness	– Demon possession	They told us that my son is possessed by an evil spirit and told us to stay in a temple for 48 days. We went to the temple, but didn't stop the medicines. (P3, mother)
		In prayer meetings they call schizophrenia as *tharkolaiyin aavi* (spirit of suicide). (P12, sister)
	– Black magic	It is because of black magic, by friends, relatives or neighbours. My family has been asking me to do one *parihaaram* (religious remedy) after another. (P1, father)
	– Lunar cycle	For three days during *amavasai* (new moon) and *pournami* (full moon), she will talk more and get angry. After that, she will become like a child. Those days, I will stay away from her. (P17, mother)
	– Moral law of universe	It is *karma*, if you commit some sin in previous birth and you suddenly die without taking the punishment, you should complete the *karma* and live this birth, that's the balancing of the *karma*. (P11, son)
	– Exchanging one religious model for another	We believed in black magic before becoming Christians. Then, the pastor told us that God will destroy all black magic and we believe that. (P7, father)
	– Social and environmental factors	During COVID, she had to stay inside the house, she could not go out, there was no one to talk to. She was abroad and could not come to us in India. (P5, father)
		They thought he was on drugs, having bad friends, that his character is bad. (P4, mother)
Religion-based healing practices	– Providing free food as service	Some days we did *annadanam*—buying food and giving it to those in need by my son's hand. He also performed *gomatha pooja*—he fed a cow and the calf with bananas for 21 days on Friday mornings. (P3, mother)
	– Using talismans	We keep images of God under his pillow and apply *thiruneer* (sacred ash) and *kungumam* (red turmeric powder) on his face. It is a belief that these will guard him. (P20, wife)
	– Changing religious beliefs – Providing service	I worshiped all Gods, did all sort of rituals, but it didn't help my son get better. Then I thought, let me see whether *Yesuappa* (Jesus) will help. So, I cut firewood and helped with construction work in the church. (P23, mother)
	– Faith healing	The nuns told him to call on Jesus, believe in him, He will not leave you. He accepted Jesus in his heart. Then he got better and came home. (P6, wife)

Continued

Table 4 Continued

Theme	Categories	Illustrative quotes
	– Religious leaders referring to doctors	I took him to the *imam* in the mosque and did *manthiram oodhuradhu* (healing prayer) thrice. Then, the *imam* said, your son is fine. It must be due to family issues. Next time, take him to a doctor. (P10, father)
	– Prayer more important for mental rather than physical illness	To remain physically fit you need to take medicines but for mental illness, medicines alone are not enough. You need to pray and meditate as well. (P9, mother)
	– Economic factors influencing the decision to access religious vs medical care	The problem is, treatment is expensive. Many do not have the money for that. They try to leave it in God's hands. Others, who have the capacity, will pray to God as well as do treatment. (P22, wife)

various religious methods of treatment until her sister-in-law forced her husband to see a psychiatrist.

> I personally don't have a problem (telling others about illness). But his father, and mother, said don't tell anyone else. That is the reason my husband became so bad; we covered up the illness for 6 years. I was not allowed to speak to my family about this; in-laws said it would be considered bad if they knew.

Stigma was also a future concern for relatives like P19 (mother), who worried about explaining the illness to family and friends after discharge from the hospital.

> Now, we understand that it has to be termed as a mental illness which is very hard to digest even now because this is not a one-line statement that you can tell anyone and make them understand, right? The diagnosis if you tell them, people may completely misunderstand and, it's going to be tough.

Belief in God could be a double-edged sword with respect to the stigma of mental illness. P4 and P8, both mothers, were able to talk about how God helped them deal with the stigma, while P24 believed that accompanying her ill husband for hospital admission was a punishment from God. The details of this theme are given in table 5.

DISCUSSION

Our study provides various insights into the experience of religiosity and its impact on caregiving in a collectivistic society. The narratives from our participants demonstrate how much religion permeates their lives. Our participants had differing religious-based attributions for mental illness in alignment with their religious beliefs, but beyond these apparent differences, found comfort and meaning for their suffering in religion. Most of our participants identified as Hindus, whose explanatory model for mental illness included attributions caused by possessions, magical rituals and changing lunar cycles. We were also able to elicit a range of faith healing practices, usage of talismans and provision of charity as restitution, across religions. An overview of the main themes and subthemes is presented in figure 1.

Religious coping has been categorised as positive and negative, with negative strategies believed to be associated with more emotional distress.[2] The experiences of our participants show that even if they hold negative religious appraisals, these beliefs provide persons with acceptable narratives to find meaning in their suffering and are hence helpful.[30] This finding also aligns with the transactional model of coping, which categorises caregiver appraisals as positive, neutral or negative; depending on the unique interaction between personal resources to deal with the stress, spiritual meaning attached to the situation and the resources available in the environment.[31 32] Our conclusion that caregivers use a range of religious-based coping mechanisms and that there is scope to incorporate discussions on religious models into routine mental healthcare has been echoed by other studies from India.[24 33 34]

In collectivistic societies like India, persons with mental illness get the most emotional, social and economic support from their families.[35] Within the patriarchal, joint family settings to which most patients belong, the older, often male members of the family drive major decisions regarding access to care and adherence to medical and alternative modes of treatment for persons with mental illness.[35] When these members hold a religious model for causation as well as treatment for mental illness, this influences the perceived role of mental healthcare professionals and pathways.

At a personal level, religious beliefs help caregivers make sense of the sufferings of their ill family members. For chronic mental illnesses, despite years of medical treatment, patients continue to have residual symptoms, are ostracised by society and have difficulty holding jobs or forming new relationships. Formulation of disability arising from mental illness using a purely biomedical perspective is reductionist when social and

Table 5 Themes and illustrative quotes related to stigma

Theme	Categories	Illustrative quotes
Religious influence in experience of stigma	– God's hand in finding supportive spouses – Illness better after marriage	There were many marriage proposals, but when they came to know about her illness, there was a problem. Then someone came forward to marry, knowing all this. We didn't consider whether he is wealthy or not, he is of good character. Only her husband knows about her condition. If his family knew, not sure whether she could have got this life. We feel it's God's blessing. She's improved and her life is better after marriage. God gave her such a good person (as a husband). (P4, mother)
	– God comforts even when others stigmatise	That we should not mind. They don't know about illness and my God's strength. God's worship is like taste of honey, only people who know that taste can feel His presence. I don't mind such people or situations. (P8, mother)
	– God/karma influences need to seek healthcare	What we have done in the past (lives) is what decides if we set foot in a hospital in this life. It is bad for any illness. But this disease- mental illness, it's a horrible illness. Others see those with mental illness and a person who comes out of jail the same way. I don't know if this is a punishment from God to the patient or to people around the patient. I have these doubts, who is He punishing? (P24, wife)

environmental factors mediate a major part of the experience. Religious models provide the explanations that biomedical models fall short of, for the personal suffering and livelihood issues experienced by patients and their families. They deliver personalised coping mechanisms and act as 'psychological crutches' as caregivers negotiate the uncertainties of taking care of a person with mental illness. There is an urgent need to rethink how we view explanatory models as biomedical vs alternate models and develop a common, integrated language for culturally accepted explanatory models. The presence of psychiatric pluralism; the coexistence of multiple explanatory models for mental illness at institutional, cognitive and structural levels, has been reported in various studies from India.[23 24 34 36] Mental health professionals should focus on providing more caregiver-centric, nuanced and custom-tailored psychoeducation instead of opting for the standard biomedical formats usually employed, so that caregivers are empowered to cope better. In addition to this, there is a need for eliciting the useful religious coping mechanisms that caregivers use, adapting them and disseminating them for wider use in mental healthcare settings.[30]

At a social level, belonging to a religious group provides psychological, social and economic benefits for persons with mental illness and their families. However, stigma related to mental illness can be a major barrier for caregivers to seek support from others in their socio-religious circle.[24] Our participants felt that stigma related to mental illness was qualitatively different from that of other illnesses. Other studies have also reported that stigma influences external coping mechanisms and social identity.[30 37] Alternatively, stigma can prevent caregivers from seeking mental health services and instead opt for religious resources.[38] Either way, there is under-utilisation of available medical, religious and social support for caregivers and subsequently, persons with mental illness. A few of our participants reported how they were referred to mental health services through religious healers or groups. The National Alliance on Mental Illness includes the Family-to-Family Education Program, the Faith Communities Education Project and FaithNet. This grassroots organisation based in the USA focuses on providing resources for faith-based communities which are involved in the care of persons with mental illness.[39 40] There is scope for more such partnerships between medical services and faith-based services to improve knowledge of mental illness, promote effective coping and encourage peer support programmes.[34 41 42]

At a systemic level, mental healthcare delivery needs to incorporate family members, especially those with decision-making agency, from the time of initial contact.

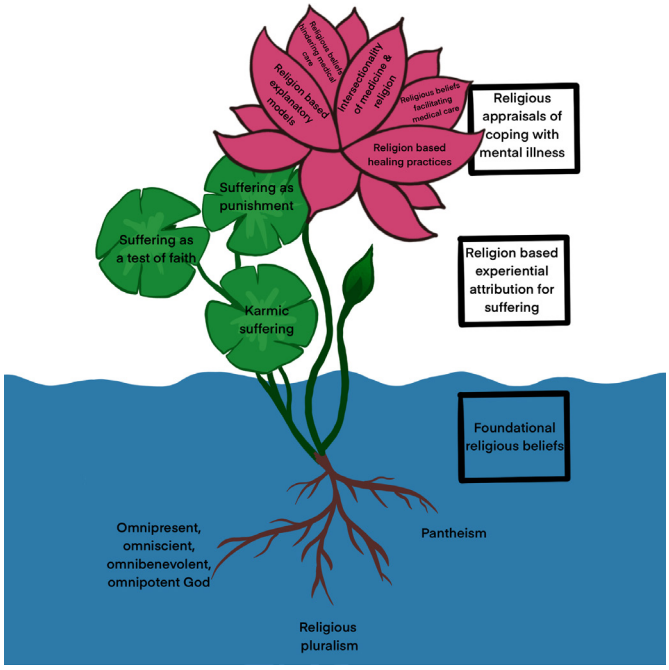

Figure 1 Thematic map representing the role of religiosity in caregiving for persons with serious mental illness. The lotus is a symbol of spiritual growth and enlightenment in Indian culture. Its growth from the mud to the surface reflects resilience despite adversity. The roots represent the deep foundations of religious beliefs. The stem represents the religious beliefs that are acquired through life experiences. They connect the core beliefs to practical action in times of suffering. The flower symbolises transcendence through suffering and finding a deeper sense of purpose.

The religious explanatory models they believe in need to be elicited, along with the range of alternate help-seeking behaviours in the past and present. The inter-generational differences and heterogeneity within the families on religious beliefs, with younger generations being more open to medical models, as found in our study also need to be considered. Clinicians can develop care plans that integrate religious healing practices that the family believes in, which was a felt need expressed by our participants, while not compromising on medication adherence and other treatment modalities. Discounting personal belief systems and insisting on families accepting the biomedical model of illness that is often provided as a part of psychoeducation might alienate the family and lead to treatment drop-outs.[30] This is especially true for an economy where medical treatment is still viewed as one of the many options available for persons with mental illness, and the decision to seek medical treatment is based more on the accessibility, affordability and availability of healers rather than on the explanatory models held by the family.[36]

LIMITATIONS

We do not have perspectives from persons identifying as atheists or agnostics, although we did not specifically plan to exclude them, it so happened that no one approached for consent identified as such. This study was done in a tertiary care centre among participants who had the awareness and resources to seek mental healthcare. Their experiences could be different to those who did not have similar access. The sample size was relatively small, with predominance of caregivers who identified as Hindus, and majorly women participants; both of which could lead to biased narratives. Since the interviews were done in the vernacular languages, some context-specific content may have changed during translation.

CONCLUSION

The results from our study reveal the entwined nature of religious beliefs and caregiver attributions to the cause and mode of treatment of mental illness. Religion-based explanatory models often drive decisions regarding the need for seeking and continuing with mental health services. In order to optimise care for persons with mental illness, healthcare professionals need to elicit the multiple explanatory models and religious coping methods used by caregivers, formulate psychoeducation and care plans which incorporate these beliefs, and explore partnerships with faith-based services to offer ongoing support for patients and their families.

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