FAITH PRACTICES AND THE DURATION OF UNTREATED PSYCHOSIS (DUP) AMONG YOUTH IN SOUTHEASTERN NIGERIA

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Abstract

This study investigates how Pentecostal faith practices in Southeast Nigeria contribute to delayed psychiatric intervention for youths with psychosis. In Pentecostal settings, mental illness is often viewed as demonic possession, leading to prolonged spiritual warfare and neglect of clinical treatment. Such neglect increases the risk of psychiatric decline, sometimes causing irreversible damage. The study addresses the obstruction of timely mental healthcare caused by misguided religious interpretations in southeastern Nigeria. Using a mixed method design, it combines qualitative interviews, literature analysis, and digital media review with a quantitative descriptive survey of 600 respondents. Open and close ended interviews were used to collect data on belief patterns and health responses. The theoretical lens of Arthur Kleinman's 1978 explanatory models of illness guides the analysis, showing the strong influence of spiritual beliefs on treatment choices. Findings reveal that religious superstition delays psychiatric care. Recommendations include mental health education and dialogue with religious leaders.

Keywords: Faith Practices, Duration of Untreated Psychosis (DUP), Youth, Southeastern Nigeria, Pentecostal Churches

Introduction

Religion holds immense value, yet when taken to extremes, it can degenerate into superstition. Deeply religious individuals often attribute psychosis to evil forces and disregard medical explanations, seeking spiritual rather than clinical solutions with grave outcomes. Psychosis may result from brain disorders, infections, drug use, psychiatric illness, trauma, or stress (Mayo et al., 2017). While cultural and religious perspectives

influence understanding, they do not cause psychosis. Rejecting medical reasoning reflects a denial of scientific knowledge as a sacred gift, and even the educated may err without discernment (Setta & Shemie, 2015). Understanding psychosis and the duration of untreated psychosis (DUP)—the period between symptom onset and medical intervention—is vital, as DUP significantly affects prognosis, recovery, and overall outcomes (Zhang et al., 2021). This is particularly relevant among adolescents in Southeastern Nigeria, where faith, culture, and medicine closely interact.

Psychosis is a severe disorder marked by a loss of contact with reality, hallucinations, delusions, disorganisation, and social dysfunction (Lindhardt et al., 2022). Prolonged DUP is associated with poor clinical outcomes, slow recovery, and long-term impairment. Cultural and religious interpretations of mental illness strongly shape perception and help-seeking patterns across Africa. In Southeastern Nigeria, psychosis is often viewed as a spiritual or moral affliction rather than a biological one (Ran et al., 2021). Families typically consult traditional healers, prophets, or prayer houses before seeking psychiatric care, attributing symptoms to witchcraft, ancestral vengeance, or divine trial. Though these faith-based responses provide identity and comfort, they often prolong DUP and delay intervention. Even in urban and educated circles, religious practices and biomedical understanding remain unintegrated, perpetuating superstition (Murphy, 2020; Okore, 2025). The belief that psychiatric care reflects weak faith intensifies the conflict between spiritual and medical approaches.

Superstition also distorts health beliefs by linking illness to fate or unseen forces while dismissing scientific reasoning (Taher & Pashaeypoor et al., 2020). Such beliefs hinder treatment adherence and discourage evidence-based care. Traditional healers often depend on unverified practices, leading to severe complications and deaths (Uwayezu & Ntigura et al., 2022). Persistent faith in demonic causation of mental illness fuels prolonged spiritual warfare while medical intervention is neglected. In parts of Africa, including Nigeria, superstition continues to obstruct healthcare access and results in preventable deaths (Kosmin, 2022). Religious and cultural misinterpretations also prevent early psychiatric attention, particularly in societies where pastors or prophets act as the primary health authorities (Mauda & Mokwena et al., 2023).

Empirical evidence links superstition to poor health literacy and inadequate self-care. In Warri, Nigeria, superstition significantly weakened the relationship between literacy and self-care among diabetic patients (Ukpabi, 2021). Similar findings in Adun reveal superstition as a major barrier to diagnosis (Ojen, 2014). While traditional interpretations of illness may reflect cultural norms, substituting clinical treatment with superstition constitutes medical neglect. Religious leaders should encourage medical consultation alongside prayer to promote timely care (Salami & Kanmodi et al., 2023).

This study focused on youth psychosis in Southeast Nigeria, where recent evidence shows a growing prevalence. Many affected youths roam the streets without treatment as their

conditions deteriorate due to prolonged Duration of Untreated Psychosis (DUP), largely driven by superstitious beliefs that hinder timely medical care (Igweze et al., 2017; Okeke et al., 2023; Eneh & Eneh, 2024; I. Eze, I. Eluka, & K. Arize, personal communication, August 10, 2025).

This study investigates how Pentecostal beliefs influence or cause delays in responses to psychosis among youths in Southeast Nigeria. It raises critical questions: why do many Pentecostal churches and their leaders in this region continue to rely solely on prayer warfare in addressing youth psychosis, even when such delays increase the risk of prolonged Duration of Untreated Psychosis (DUP) and lead to severe or irreversible mental illness and death? Pentecostal doctrine affirms that “every good gift and every perfect gift is from above, and cometh down from the Father of lights” (James 1:17, KJV), yet there remains a marked reluctance to accept medical and clinical therapies as legitimate responses to mental illness. If these therapies are divine provisions, what explains the unwillingness of many Pentecostal leaders to embrace them? Why do superstitious beliefs that cause harm continue to shape public attitudes across communities in Southeast Nigeria? What role do Pentecostal teachings on spiritual warfare play in discouraging clinical treatment for psychosis, and to what extent do religious leaders influence public perceptions of psychiatric care in regions affected by untreated psychosis? This gap demands empirical research using Kleinman's explanatory model to determine how Pentecostal doctrine and pastoral authority prolong the duration of untreated psychosis among youths in Southeast Nigeria.

Literature Review on Youth Psychosis in Southeast, Nigeria

Nwokocha and Chinawa et al. (2017) examined somatisation disorder among 485 adolescents aged 10 to 19 years in four secondary schools in Southeast Nigeria using the Enugu Somatization Scale. Their results showed that 51.8 percent experienced head-related symptoms, 54.0 percent had body-related symptoms, and 62.5 percent reported either head or body symptoms, while 43.3 percent experienced both. There were notable age-related variations in symptom presentation, with slight gender differences as 51.3 percent of males and 52.2 percent of females reported head symptoms. Their findings indicate that psychosomatic conditions, often overlooked in paediatric care, are common and possibly increasing among adolescents in the region. Ogbonna et al. (2020) affirm that psychosis among youths is prevalent in Southeast Nigeria, particularly in Enugu, where schizophrenia spectrum and related disorders are the most frequent diagnoses. The condition is more common in males, though females record higher rates within categories such as schizophrenia and depression. Substance use and neurodevelopmental conditions appear more frequent among males. Older adolescents, especially those aged 18, show higher rates of mental illness, while those aged 15 report lower rates. The study underscores the urgency of early mental health services and targeted interventions.

Ughasoro and Onukwuli et al. (2022) reveal that adolescents in Southeast Nigeria experience high levels of violence, mostly within the home and often from relatives. Such

violence is strongly associated with mental illness, as more than half of affected youths show signs of psychological distress. Girls, particularly those not living with parents and those from poor households, are most at risk. The authors highlight violence as a key driver of adolescent mental health problems in the region. Mbanuzuru and Oriji (2022) link the growing use of methamphetamine among Southeast youths to rising incidents of violence and suspected psychosis. Easy access, supported by local production and global drug circulation, worsens the situation. Their analysis warns that the trend is alarming and calls for urgent attention.

Eneh and Eneh (2024) analysed three years of mental health hospital records in Southeast Nigeria, involving 380 index and 180 post-index cases. Of these patients, 55 percent were male, 65.27 percent had post-primary education, and the mean age was 39.87 years. Most were single and unemployed. Schizophrenia constituted 68.42 percent of diagnoses, with a relapse rate of 52.1 percent, mainly among males (61.62 percent), the unemployed (61.62 percent), traders (9.60 percent), and professionals (5.05 percent). Relapse was more frequent in those with illness duration of five years or more (52.02 percent) and in those with poor drug compliance (66.16 percent), with a mean relapse age of 34.23 years. Relapse correlated with age, marital status, education, and employment at p value 0.10. Patients whose illness exceeded three years were 1.17 times more likely to relapse, and early onset predicted 2.479 times more relapse. Employment and family support reduced relapse risk by 1.110 times. The authors call for better mental health services, education, and job opportunities for single, unemployed, and uneducated individuals below thirty-five years.

Umezurike (2025) asserts that psychosis among youths in Southeast Nigeria is increasingly associated with the abuse of substances such as “monkey tail,” a mixture of ogogoro and cannabis or opioids, “gutter water,” and “gegemu,” a fermented herbal drug often laced with unknown psychoactive elements. The United Nations Office on Drugs and Crime (UNODC) reports that over 14.3 million Nigerians aged 15 to 64 have used drugs, with cannabis as the most common. In urban and semi-urban areas, about 20 percent of youths have experimented with drugs, while over 10 percent are regular users (Umezurike, 2025). These substances are linked to rising cases of drug-induced psychosis, suicide, rape, imprisonment, assault, truancy, academic decline, and violence, particularly among school and street youths. Many Pentecostal churches and communities interpret psychosis as demonic possession, relying on prayer and spiritual warfare rather than medical care. This belief delays treatment, reflecting how Pentecostal teachings, stigma, and religious leadership influence health-seeking behaviour. The study addresses this gap by showing how such beliefs prolong access to psychiatric treatment.

The reviewed studies reveal significant evidence on the prevalence, causes, and clinical features of youth psychosis in Southeast Nigeria, yet they fail to address how Pentecostal belief systems shape responses to the condition. Most existing research focuses on epidemiological data, drug abuse, violence, and relapse patterns, with little attention to the

socio-religious dynamics that influence the duration of untreated psychosis. There is limited inquiry into how Pentecostal teachings on spiritual warfare, demonology, and divine healing obstruct timely psychiatric intervention. The gap lies in understanding the behavioural and theological mechanisms through which faith-based interpretations replace medical reasoning, especially among families who prioritise prayer houses over hospitals. This study therefore advances knowledge by examining how Pentecostal beliefs and practices contribute to delayed treatment, using Arthur Kleinman's Explanatory Model of Illness to explain how religious interpretations of psychosis shape help-seeking decisions and reinforce prolonged Duration of Untreated Psychosis among youths in Southeast Nigeria.

Theoretical Framework

Arthur Kleinman's 1978 Explanatory Model of Illness Theory is utilised in reinforcing this study's rationales. The model illustrates how patients understand sickness through cultural, religious, or personal beliefs that may differ from medical views. The model helps doctors ask clear questions, understand the patient's beliefs, and adjust treatment to match their needs and behaviour (Lynch & Medin, 2006; Hodson, 2025). According to Hallenbeck (2024), Arthur Kleinman said that understanding a patient's beliefs about their illness helps reveal the meaning they give to it, their treatment goals, and what they expect from care. Clinicians should always inquire to understand these beliefs.

A major criticism of Author Kleinman's Explanatory Model of Illness is that it oversimplifies complex health beliefs by reducing them to fixed cultural categories, ignoring individual variation and power dynamics in clinical settings. It also idealises mutual understanding between patient and clinician, despite the reality of institutional pressures and unequal relations that often hinder genuine dialogue (Dein, 2003; Good, 2012).

Despite its limitations, Kleinman's model remains relevant to this study as it reveals how local beliefs shape the understanding of illness and care. In Southeastern Nigeria, spiritual interpretations of psychosis often lead families of affected youths to delay medical treatment in favour of religious rituals. While the model may not account for every individual or power relation, it still provides a useful way to explain how belief systems hinder timely clinical intervention. Arthur Kleinman's Explanatory Model of Illness helps to show how people understand sickness within their culture. In this study, it explains why many Pentecostal pastors, citizens, and families of youth with psychosis in Anambra State see the condition as a spiritual attack rather than a medical issue. Some pastors believe evil forces cause psychosis and urge families to seek help in prayer houses instead of hospitals. The model also shows how pastors influence how people view illness. In some Pentecostal groups, they have strong control over their members and can easily direct them away from medical treatment. Many teach that psychosis is proof of demonic activity, leading people to choose deliverance instead of clinical care.

This belief causes delays in getting proper treatment, putting many youths at risk of long-term harm. Kleinman's model explains the clash between medical understanding and spiritual belief, which often results in poor response to early psychiatric care. Understanding what illness means to people in this setting is vital in planning mental health education. The model supports involving religious leaders in mental health awareness because they have strong influence in their communities. When they begin to see that prayer and medical care can work together, more families may seek early and effective help.

Methodology

The survey investigated the influence of Pentecostal beliefs on the management of psychosis and resistance to clinical treatment among adolescents in the region. The inquiry was conducted in metropolitan and semi-urban areas where Pentecostal groups exert strong social and spiritual influence. This study focused on youth psychosis in Southeast Nigeria, where recent evidence shows a growing prevalence. Many affected youths roam the streets without treatment as their conditions deteriorate due to prolonged Duration of Untreated Psychosis (DUP), largely driven by superstitious beliefs that hinder timely medical care (Igweze et al., 2017; Okeke et al., 2023; Eneh & Eneh, 2024; I. Eze, I. Eluka, & K. Arize, personal communication, August 10, 2025).

A mixed-method approach was employed, combining quantitative and qualitative methods to obtain a comprehensive understanding of the research problem. The quantitative aspect consisted of structured questionnaires distributed to 600 participants, while the qualitative aspect involved in-depth interviews designed to capture detailed personal experiences and theological explanations related to psychosis. The integration of both approaches allowed for convergence between numerical patterns and narrative depth. Quantitative data revealed trends and frequency distributions, while qualitative data illuminated the meanings and beliefs behind those patterns. The qualitative component has already been articulated and justified in this study to address the concern that the analysis relies heavily on figures. Thematic analysis, supported by quantitative findings, was therefore used to enrich the interpretation of results.

Purposive and stratified sampling ensured balanced representation of gender, age, education, and occupation among the 600 participants. The selection process involved identifying individuals across artisan groups, traders, educators, students, and clergy from Pentecostal backgrounds. Each category was represented in proportion to its population in the study area to ensure inclusivity. Recruitment challenges included reluctance among some clergy to discuss mental health due to spiritual sensitivity. However, this approach provided the benefit of obtaining insights from diverse social and religious perspectives.

Although the focus of the study was on youths, adults aged 15 to 65 were included to capture the views of parents, religious leaders, and caregivers who influence help-seeking behaviour. Their inclusion was justified as their opinions and decisions often determine

whether affected youths receive medical or spiritual treatment. Their insights enriched understanding of the societal and theological dynamics shaping youth psychosis management.

A systematic interview guide containing both open and closed questions was used to gather data on demographics, perceptions of prayer versus medical therapy, theological beliefs, superstitions, teachings on spiritual warfare, roles of religious leaders, and perspectives on integrating faith healing with medical intervention. Frequency counts and descriptive statistics were applied to the quantitative data to identify trends, while thematic analysis was used to interpret open-ended responses.

Recurring themes emerged from participants' accounts, including the spiritual interpretation of psychosis as a manifestation of demonic influence or sin, a strong preference for prayer and deliverance over medical care, scepticism towards psychiatry due to perceived conflicts with faith, advocacy for integrating faith and science, and community stigma that encourages secrecy and avoidance. These themes formed the analytical foundation for the discussion of how theological and cultural beliefs shape Pentecostal responses to psychosis and resistance to treatment.

The analysed survey data were organised thematically under categories such as superstition, spiritual warfare, religious leadership, and integration of treatment, with frequency distributions showing participants' responses across each variable as presented in the data table.

Ethical standards were observed throughout the study. Informed consent was obtained from all participants after clear explanation of the study objectives. Confidentiality and anonymity were maintained, and participation was voluntary. The research protocol received approval from an institutional ethics committee in line with international research ethics standards.

Understanding Duration of Untreated Psychosis (DUP)

Morré and Hancq (2023) explain that Duration of Untreated Psychosis (DUP) is the time between the first psychotic symptom and the start of proper treatment. They report that in the United States, the median DUP is about 74 weeks. Long DUP may harm the brain, worsen symptoms, and lower treatment success. According to Morré and Hancq, it is linked to reduced grey matter, altered brain structure, and chemical imbalance. They add that DUP can cause poor social functioning, worse symptoms, less insight, and increased substance use. Early treatment can prevent brain changes and improve recovery. Zoghbi et al. (2022) show that long DUP leads to poor clinical outcomes, weak treatment response, and low functioning. They note that only a few studies found clear brain changes, mostly in the temporal regions. Salazar de Pablo et al. (2022) state that there is no strong proof that untreated psychosis causes widespread brain damage, as limits in imaging may hide minor changes.

Marshall et al. (2005) found that delays in treatment after first symptoms result in worse outcomes such as higher symptom levels, poor functioning, and low remission. They stress that delay itself has a harmful effect, even after early life adjustment is considered. Their findings from comparisons between shorter and longer treatment delays show clear differences after six and twelve months (Marshall et al., 2005). This confirms the need for early detection and treatment of psychosis to improve recovery chances. When religious beliefs cause families to delay hospital care and seek prayer warfare instead, especially among youth in Southeast Nigeria, the illness becomes more severe.

Origins and Spiritual Emphasis of Nigerian Pentecostalism

The Pentecostal movement in Nigeria began in the early twentieth century when believers seeking deeper spiritual experiences separated from mission-established churches. Joseph Ayo Babalola's leadership led to the formation of the Christ Apostolic Church in 1941, while the Cherubim and Seraphim movement gained influence by mid-century (Afunugo, 2025). The call, "Come out from among them," from 2 Corinthians 6:17, symbolised a conscious rejection of traditional ecclesiastical structures (Afunugo, 2025). From the 1970s, Pentecostalism grew across Nigeria, building large congregations and contributing to education and social services. Afunugo (2025) observes that Pentecostals became a dominant force within Nigeria's Christian landscape, shaping politics and development.

Pentecostal spirituality in Nigeria centres on divine healing, deliverance, and miracles as expressions of authentic faith (Afunugo, 2025). Miracles are seen as proof of God's presence, while prayer, holiness, and faith are considered channels for supernatural intervention. G. Anaso, C. Ike, O. Emele, and K. Obidiegwu (personal communication, 30 June 2025) confirm that spiritual authenticity remains vital under leaders such as Bishop Francis Wale Oke. Nigerian Pentecostals interpret life through belief in an unseen spiritual realm that influences their political, moral, and cultural outlook (Wariboko, 2014). This conviction frames their engagement with society and affirms their sense of divine purpose.

Bachmann (2017) explains that Pentecostals regard witchcraft as a tangible expression of evil responsible for illness, misfortune, and family disorder. Drawing from testimonies and media narratives, Pentecostals link such forces to the devil and respond through prayer and deliverance (Bachmann, 2017). This perception sustains widespread fear and superstition within their ranks. I. Ofor, A. Anene, and I. Okafor (personal communication, 30 June 2025) state that in Southeast Nigeria, this belief system leads many Pentecostal leaders to interpret youth psychosis as demonic attack, often rejecting medical care in favour of spiritual intervention. Such delay in clinical response prolongs the Duration of Untreated Psychosis (DUP) and worsens its outcomes.

Evidence-Based Survey

Nigeria consists of six geopolitical zones: North Central, North East, North West, South West, South South and South East. The South East, which is mainly Igbo, includes Abia,

Anambra, Ebonyi, Enugu and Imo States (Daily Independent, 2014; European Union Agency for Asylum, 2024). Abuoma (2015) reveals that several Pentecostal churches in Southeast Nigeria interpret medical conditions such as sickle cell anaemia and psychotic symptoms as manifestations of demonic possession. Spirits such as Ogbanje and other traditional beliefs are often invoked as explanations. The author argues that deliverance sessions in which youths roll on the floor and claim deliverance from demons reflect superstition mistaken for spiritual discernment. Such practices obstruct access to medical care and contribute to the long Duration of Untreated Psychosis (DUP) among youths.

Ikwuka et al. (2016) conducted a study among 602 Igbo respondents across Southeastern Nigeria and found that more than half displayed authoritarian views and preferred primary social distance from people with mental illness. One third of the participants endorsed social restrictiveness, rejected community-based care, and supported secondary social distance. Negative attitudes were significantly predicted by older age, male gender, low education, Pentecostal affiliation, and lack of contact with persons with mental illness. The study identified cultural beliefs, stereotypes, spiritual explanations, and poor mental health knowledge as key mediators. Psychosis is thus viewed through a spiritual or moral lens rather than a medical one, showing that superstition strongly shapes stigma.

Ndu and Nwankwo (2018) discovered in Awka South Local Government Area of Anambra State that many people believe mental illness is punishment from the gods. This view is widespread among the lower class, where hardship and social pressures are also blamed. Their findings revealed that men were more likely than women to link mental illness to divine wrath. Families led by men who hold strong traditional and religious convictions often seek spiritual rather than medical remedies for psychosis. According to A. Ifemenam and P. Onunkwo (personal communication, July 5, 2025), many continue to rely on Pentecostal prayers and deliverance, convinced that spiritual warfare will bring healing. They stress that such dependence leads to prolonged suffering and delayed treatment, sometimes ending in death. They affirm that where healing seems to occur, it often happens after medical options have failed.

Further evidence from Ikwuka et al. (2024) shows that supernatural explanations dominate beliefs about schizophrenia among the Igbo. The study, which surveyed 200 participants through multi-stage sampling, found that older people and women were more inclined to hold supernatural views, while those with higher education and members of mission churches were more likely to endorse psychosocial or biological causes. The findings demonstrate that many Pentecostal leaders and members attribute psychosis to evil forces, rejecting clinical treatment in favour of warfare prayers, which prolongs DUP.

Okafor et al. (2025) reported similar findings in Anaocha and Idemili South Local Government Areas of Anambra State. Their interviews with ten males and ten females showed that beliefs in supernatural forces and traditional healing continue to define local

understanding of depression and psychosis. Symptoms are often linked to ancestral punishment or spiritual attacks rather than to medical conditions. These beliefs, combined with stigma and cultural expectations, discourage help-seeking and delay clinical intervention. Pentecostal practices and prayers are often preferred, reinforcing superstitious interpretations of youth psychosis.

According to I. Edeh, A. Eze, O. Nwankwo and O. Obodoeze (personal communication, June 30, 2025), many people in the Southeast depend on deliverance prayers, believing Pentecostal pastors understand youth psychosis. However, after prayer sessions, the affected youths fall under what is termed anointing while their condition remains unchanged. U. Umeh and N. Umeh (personal communication, July 2, 2025) narrated their experience of taking their son to a Pentecostal church in Awka on the advice of others. After years of repeated deliverance sessions, the psychosis worsened, and the boy later died. Similarly, E. Onu, K. Udeze and A. Mbamalu (personal communication, July 4, 2025) reported that a Pentecostal pastor demanded a seed of faith offering for the healing of their seventeen-year-old relative with psychosis. A subsequent medical report confirmed advanced paranoid schizophrenia. These experiences reveal how early reliance on spiritual remedies results in delayed treatment and chronic illness.

The evidence across these studies and communications demonstrates that superstition surrounding youth psychosis in Southeast Nigeria remains entrenched. Pentecostal leaders often interpret the condition as demonic and prescribe prayer warfare as the only solution. This belief system sustains prolonged DUP and worsens suffering among affected youths. Many families continue to rely on spiritual means rather than clinical care. While not all residents belong to Pentecostal churches, many regard their pastors as spiritually powerful and capable of addressing psychosis (A. Okafor, O. Ezichi and H. Iloh, personal communication, June 28, 2025). The influence of religious authority continues to shape help-seeking behaviour and limits access to medical intervention, particularly in poor communities.

Significant Causes of Youth Psychosis in Southeast Nigeria

The evidence-based findings and literature review of this study reveal that youth psychosis in Southeast Nigeria results from a combination of biological, psychological and social factors. Major causes include genetic vulnerability, substance use such as mkpulu mmiri, cannabis, methamphetamine and alcohol, childhood trauma and inadequate parental care (A. Okafor, O. Ezichi and H. Iloh, personal communication, June 28, 2025). Many young people also struggle with academic pressure, peer influence and social isolation, which undermine mental stability and may trigger early symptoms of psychosis if not addressed.

The ongoing economic hardship in Nigeria has intensified family stress in the Southeast. Many households face poverty, joblessness and increasing living expenses. Youths unable to meet personal or family needs often experience depression and anxiety, which can

progress to psychosis. Limited access to professional mental health services, together with stigma and poor awareness, worsens the problem as many cases remain untreated for long periods.

According to K. Chidume, C. Sam-Obi and U. Arize (personal communication, July 6, 2025), some Pentecostal pastors in the Southeast teach that demonic powers and evil forces are responsible for youth psychosis. This study, however, affirms that medical causes such as brain chemical imbalance, severe infections and untreated neurological disorders are well established. The spiritual dimension of illness may be recognised, yet superstition should never replace clinical diagnosis. Spiritual considerations are relevant only when comprehensive medical evaluation reveals no biological cause.

Dispelling Superstition through Faith-Inspired Mental Health Care

Many faith-based clerics and adherents have lost their lives, both in the past and in recent times, because of excessive dependence on fasting and warfare prayers while neglecting medical care (Fraser, 2019; Swan, 2020; Children's Health Care, 2025). This study affirms that human beings are not God and must value medicine as a divine gift. All medical insight and advancement come from God, who grants knowledge for human progress. God often leads humanity from the familiar to the unfamiliar. Rejecting modern discoveries such as mobile phones or digital devices would now mean isolation. In the same way, God continues to reveal Himself and meet human needs through scientific and technological developments, including medical therapy.

Pentecostal churches in Nigeria, particularly in the Southeast, use social media and digital platforms to share messages, advertise programmes and communicate with followers. It is therefore hypocritical to claim that youth psychosis is caused only by evil forces when evidence shows that many cases arise from stress, substance abuse, obsession and frustration. It is also deceptive to preach faith in public while privately taking one's family to the hospital for treatment.

This study does not deny the reality of miracles or the existence of evil, but it stresses that individuals must know when to seek help through legitimate means. Medical and psychological care should not be treated with suspicion, for such care is also a divine provision. As Dr. I. Emelummadu observes, “We treat, but God heals” (I. Emelummadu, personal communication, June 8, 2002). This view supports the research assertion: “strive as if everything depends on striving and pray as if everything depends on praying.” Healing in youth psychosis requires both psychological therapy and prayer (Afunugo, 2023; Afunugo, 2025). Therapy and medication restore the mind, while prayer and pastoral counselling strengthen the spirit. Together, they promote balanced recovery that meets emotional and spiritual needs.

Pastors and Pentecostal leaders should make conscious efforts to improve their knowledge

through formal education. They are encouraged to study theology, religion, psychology, medicine and related fields to enhance their understanding. Where necessary, they may seek sponsorship for such studies. Broader intellectual and spiritual formation is vital for freeing the mind from superstition and cultivating sound judgement and creativity in pastoral ministry.

Interview Summary Table

Section	Q.No	Summary
Demographic	1	Age: 15–65 years
Demographic	2	Gender: 250 males, 350 females
Demographic	3	Occupation: Teachers=50, Traders=100, Artisans=400, Pastors=50
Demographic	4	Education: No formal=200, Primary=100, Secondary=100, Tertiary=200
Demographic	5	Religion: Pentecostal=300, Catholic=100, Anglican=100, Traditional=100
Demographic	6	Church leaders: Yes=50, No=550
Demographic	7	Experience with psychosis: Yes=230, No=370
B: Prayer vs Clinical	8	First response to psychosis: Prayer=400, Hospital=100, Traditional=100
B: Prayer vs Clinical	9	Why prayer first: Spiritual belief=400, No knowledge=150, Routine=50
B: Prayer vs Clinical	10	Risks of delay: Worsening=550, God handles it=50
B: Prayer vs Clinical	11	Prayer alone heals: Strongly Agree=150, Agree=100, Disagree=100, Strongly Disagree=250
C: Theology & Therapy	12	Medical healing from God: Yes=550, No=50
C: Theology & Therapy	13	Church teaching on hospitals: Faith=550, Avoid hospitals=50
C: Theology & Therapy	14	Why pastors avoid hospitals: Role=400, Fear=150, Financial=50
C: Theology & Therapy	15	Take relative to hospital first: Yes=150, No=150, Depends=300
D: Superstition	16	Causes: Witchcraft=50, Spiritual=200, Drug=300, Medical=50
D: Superstition	17	Psychosis is spiritual: Yes=500, No=70, Not sure=30
D: Superstition	18	Effect of superstition: Poor treatment=550, Faith-based approach=50
D: Superstition	19	Improve belief: Awareness=400, Media=150, Retain faith=50
E: Spiritual Warfare	20	Heard of warfare: Yes
E: Spiritual Warfare	21	Teaching: Spiritual attack=400, Jealousy=150, Substance=50
E: Spiritual Warfare	22	Teaching stopped hospital: Yes=400, No=200
E: Spiritual Warfare	23	Warfare discourages treatment: Yes=500, No=100
F: Religious Leaders	24	Most trusted: Pastor=200, Doctor=100, Family=100, Traditional healer=200
F: Religious Leaders	25	Leaders' view: Encourage=200, Discourage=350, Neutral=50
F: Religious Leaders	26	Pastor influence: Very High=230, High=270, Low=70, None=30
F: Religious Leaders	27	What pastors should do: Inform=400, Educate=150, Divine tool=50
G: Final Thoughts	28	Church handling: Awareness=400, Collaborate=150, OK=50
G: Final Thoughts	29	Integrate treatment: Yes=400, No=200

Critical Discussion of Key Findings

1. **Demographic Structure**:
   i. The majority of respondents are artisans, and their degrees of education range from low to high. Two hundred of them have no formal education.
   ii. Pentecostalism is the religion that is the most common, accounting for 300 out of 600 people.
   iii. The majority of respondents (550) do not have relevant experience in church leadership, although they do have psychosis experience (230).
2. **Preference for Prayer over Clinical Treatment (RQ1)**:
   i. Four hundred of the respondents place an emphasis on prayer and delivery as the primary treatment.
   ii. The primary factors are the spiritual cause and the lack of awareness regarding

mental disease.
iii. In spite of the fact that 550 people acknowledge that delaying medical treatment can lead to an increase in psychosis, 250 people "strongly disagree" that prayer alone can heal it.

3. **Theological Beliefs vs. Medical Therapies (RQ2)**:
   i. There is a widespread conviction that receiving medical treatment is a blessing from God (550).
   ii. Theological teachings have a significant influence on behaviour, notably among leaders of the Pentecostal denomination.
   iii. There are approximately 300 individuals who would only go to the hospital if the circumstances demanded it, which indicates that they are hesitant.
4. **Superstition and Misattribution (RQ3)**:
   i. The most common causes that are stated are drug abuse and psychic powers, also known as witchcraft or spiritual attacks.
   ii. Over five hundred individuals have linked psychosis to spirituality, which is indicative of the widespread presence of superstition.
   iii. A total of 550 respondents identified superstition as a factor contributing to unfavourable results.
5. **Spiritual Warfare Teachings and Resistance (RQ4)**:
   i. The term "spiritual warfare" is well known to the majority of people.
   ii. It has been reported that these beliefs have hindered persons from receiving hospital care, as indicated by four hundred reports.
   iii. There is consensus among 500 individuals that spiritual warfare ideologies hinder clinical acceptance.
6. **Influence of Religious Leaders (RQ5)**:
   i. It is estimated that two hundred percent of people have faith in traditional healers, making them even more trusted than medical professionals.
   ii. According to the majority of respondents (350), pastors are believed to be opposed to the practice of mental therapy.
   iii. There are five hundred people who are of the opinion that pastors have a high to extremely high level of influence.
7. **Suggested Reforms (Final Thoughts)**:
   i. Four hundred of the respondents support expanded awareness, and one hundred and fifty of them recommend professional partnership.
   ii. On the other hand, 200 people believe that prayer is adequate on its own, and fifty people believe that pastors are already successful.
   iii. The results are improved, according to 400 people, when prayer and professional treatment are combined.

Summary

The findings reveal a strong relationship between faith, perception, and medical understanding in the treatment of psychosis among Pentecostal adherents in Southeast Nigeria. Most respondents were artisans, with Pentecostalism as the dominant faith, and

many relied on prayer and deliverance rather than clinical therapy. Their preference reflected beliefs in spiritual causation and poor awareness of mental illness within their communities. Although many participants recognised that delays in medical care worsen psychosis, superstitious beliefs and teachings on spiritual warfare often discouraged clinical intervention.

Pastors and traditional healers exerted notable influence on treatment choices. Their teachings shaped perceptions of illness, while several Pentecostal leaders expressed caution or resistance towards medical intervention. Such influence sustained faith-based interpretations that overshadowed psychiatric explanations. The dominance of religious authority over scientific knowledge reflected a persistent conflict between spirituality and medicine within mental health discourse.

These findings correspond with Exline and Wilt (2023), who observed that supernatural attributions delay treatment, and with Ahad et al. (2023), who linked delayed care to poor recovery outcomes. The themes of spiritual attribution, faith-over-medicine ideology, and pastoral dominance illustrate the complex relationship between religion and mental health. The study therefore recommends structured mental health education and collaboration between faith leaders and medical practitioners to align spiritual care with clinical intervention for sustainable recovery.

Conclusion

The study reveals a pressing need to close the gap between Pentecostal beliefs and clinical care for young people with psychosis in Southeast Nigeria, where many attribute mental illness to demonic causes. Such beliefs often delay treatment and worsen outcomes. While acknowledging the spiritual dimension of healing, the study cautions against replacing medical intervention with faith-based practices. Its analysis, though insightful, remains limited in scope and geographic focus, restricting its general applicability across Nigeria's varied regions and faith traditions.

The study's conclusions are also constrained by its limited attention to social and structural determinants such as poverty, stigma, and weak health systems, all of which shape mental health outcomes. A wider approach is needed to capture how these contextual elements interact with religion to influence care-seeking behaviour. Addressing these factors would enhance understanding of the broader socio-religious landscape that defines youth mental health in Nigeria.

Future research should explore comparative theological positions, rural–urban disparities, and the long-term effects of delayed treatment. Strengthening collaboration among church leaders, healthcare practitioners, and policymakers remains essential for advancing mental health awareness, improving service delivery, and encouraging early psychiatric

intervention for young people.

Recommendations

Based on the findings, the study suggests that:

1. Religious leaders should be trained to understand mental illness as both a medical and spiritual concern. Their sermons should promote early medical intervention alongside prayer to reduce the Duration of Untreated Psychosis (DUP).
2. Government health agencies and faith institutions should collaborate to create mental health education programmes within Pentecostal communities. This will correct misconceptions and encourage informed health-seeking behaviour.
3. Pentecostal churches should establish referral systems that link prayer houses with psychiatric hospitals to ensure prompt professional assessment of suspected psychosis cases.
4. The Ministry of Health should integrate faith-based mental health education into existing community health campaigns in Southeastern Nigeria to reach rural and urban populations.
5. The curriculum of theological seminaries should include courses on mental health awareness and pastoral counselling to equip ministers with scientific and compassionate approaches to mental illness.
6. Public enlightenment campaigns should address superstition and stigma through radio, social media, and community outreach, using testimonies of recovered patients to promote trust in medical care.
7. Health professionals should engage pastors in dialogue and joint workshops to develop culturally sensitive treatment models that respect faith but emphasise clinical care.
8. Policymakers should support legislation that recognises mental illness as a public health priority and funds collaborative programmes between churches and psychiatric institutions.
9. Families should receive community-based education on recognising early symptoms of psychosis and the dangers of prolonged spiritual warfare without clinical intervention.
10. Further research should explore comparative studies among different Christian denominations and regions to understand variations in faith influence on psychosis management and to strengthen the theoretical application of Kleinman's model within religious contexts.

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