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Recovery from Mental Illness: Understanding the Therapeutic Interventions of *Shifaa* Centres

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Abstract

This paper examines the therapeutic interventions of *Shifaa* centres in Garissa County, Kenya. *Shifaa* centres are becoming popular and significantly sought for mental health services. The aim of this inter-disciplinary research was to explain the therapeutic interventions of *Shifaa* centre. The study clarifies the inter-play of conventional psychiatric methods and spiritual/religious oriented techniques of offering mental health services. Data was gathered from two *Shifaa* centres in Garissa County-Kenya. In-depth interviews were conducted with two medical personnel, two psycho-social counsellors, one religious expert and one administrative staff working in two centres. The outcome reveals spirituality and religion as basis for mental recovery. Therapeutic interventions utilized in *Shifaa* centres were robust, hybrid and effective. *Shifaa* centres reported a significant number of clients having recovered from mental illness. However, there were some instances of relapse in substance induced psychotic patients after discharge. This blended approach need to be recognized, institutionalized and promoted because of its significant positive impact on mental health recovery and its value addition to human life. Further researches are recommended on larger samples and in other towns and studies of causes of relapse. Detailed research to unravel the concept of dealing with *Jinn* (unseen spirit possession) will add more value.

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Introduction

The issue on the interaction between religion and psychology has aroused considerable debate and research activities for decades. Psychologists have assisted mentally ill religious persons but have not contemplated how well religion can be utilized to offer mental health services (Thomas & Rebecca, 2015). Over centuries, people strived to understand conditions of human being and explain the nature of the soul. Different approaches of dealing with the soul and mental illness were practiced at different times. During the early times, it was believed that mental and emotional illness was as a result of possession by evil spirits. Modalities including myths, magic, belief in spirit and rituals were used to gain introspection of the soul and offer mental healing. Monotheistic religions also shaded light on the nature of the soul and hinted on avenues that offer mental health therapies. The Quran and the Old and New Testaments abound with examples of descriptions of the person and the soul which also gives insight on how to deal with the soul and emotions. Verses in the Quran that indicate spiritual healing are numerous. For example, the Quran Surah 17, verse 82 mentions the Quran a scripture

full of healing and it goes "*and we send down of the Quran that which is healing and a mercy to those who believe*". Thus, since time immemorial healing and introspection of the soul through the guide of the holy scriptures was offered in religious teachings.

The Renaissance in Europe and the advent of printing press ushered in modern psychology. Descartes (1596-1650) proposed that knowledge and truth come through deductive reasoning (Klee & College, 1997). This was the onset of modern science therefore by 1800 modern psychology took its grip on helping professions and on mental healing therapy (Corey, 2013). Psychology, a phenomenon which is described as empirical, reductionist, materialistic and rational could not easily accept religious concepts which is metaphysical and outside of human touch and experiences. Psychology therefore overlooked the influence of religion in human behaviour, growth and development. For many years, a sceptical attitude toward religious approaches in treating mental illness and emotions persisted. Mainstream psychology which deduces its approaches from scientific study and experimental evidences considered tradition interventions including magic, belief in spirits, ritualism, shamanism and other religious interventions as primitive and lacking evidence (Corey, 2013). Related to that, Wantini and Siyatno (2016) observe that with the development of paradigmatic scientific methods and civilization, religion is becoming a problem. However, one area of psychology – counselling psychology – narrowly accepted the concept of spiritually in the counselling approaches and integrated in the domain of multi-cultural counselling. In this article, religiosity is defined as adhering to practices, feelings and behaviours which are doctrinal and guided by reading scriptures which relate to God and through that transcendence and elevation of the soul is attained. Spirituality on the other hand is conceptualized as individual's inner positive feeling that may lead to elevation and has positive impact on one`s behaviour. Though spiritually and religiosity are independent of each other, the reciprocal influence is eminent. Religious practices are bound to improve spiritual feeling. This implies therefore that a religious person can be spiritual as well because religiosity will ultimately culminate to spirituality, while a person can be spiritual without influences of religion. In practice, both concepts have a common aim and that is to better the well-being of the person. For the purpose of this paper, spirituality and religiosity are interchangeably used to point to the same theme that is using religious/spiritual teachings to aid healing from mental illness. At this juncture, we can infer that the therapeutic practices of *Shifaa* centres is more of religious informed practices than spiritual interventions since there is numerous use of *Quranic* verses in the healing process. Mental health therapy offered in this contemporary *Shifaa* high rate of clients' recovery (80%) was reported making this approach successful.

To understand and guide mental health practice several theoretical frameworks were formulated: psychoanalysis by Sigmund Freund in 1900, client centred therapy by Carl Rogers 1951, Abraham Maslow`s Hierarchy of needs in 1954, rational emotive behaviour therapy (REBT) by Elbert Ellis in 1955, and cognitive behaviour therapy (CBT) by Aaron Beck in 1967 (Counselling tutor, 2025). These theories are either from preventing perspective (approaches focusing on avoiding negative outcomes and reducing risk behaviours) or from the promotive perspective (focus is on promoting well-being and enhancing capacity of the person in order to deal with challenges of life). in line on the objective of this study which is to explain and shed light on the therapeutic processes and practices utilized by *Shifaa* centres Kenya Hettler's multidimensional

model of wellness offers a suitable foundation framework for the study. According to this model wellness is self-conscious, self-directed and is a holistic process that comprises of emotional, physical, intellectual, occupational, spiritual, and social well-being (Wellness alliance, 2025). In this context, interventions employed by *Shifaa* centres are in the continuum of Hettler's model.

Religiosity, Physical and Psychological Health

The impact of religiosity and spiritually on general health and wellbeing is of interest to both academia and society. Being healthy is defined as attaining a state of complete physical, mental and social wellbeing (Baldwin, n.d.). A study examining the relationship between religion, spirituality and personal recovery affirms that religion and spirituality form basic frame-work for mental recovery (Glorney et al., 2019). Researches have indicated that religion-related activities such as attending churches have positive impact on physical and mental health, positive health practices, and healthy relationship (Batson, 1996; McCullough et. al., 2000). A study examining associations of adolescence wellbeing and religiosity conducted on 1000 German adolescent high school students revealed strong connection between religiosity, physical and psychological health (Kirkcaldy & Siefen, 2003). The study reported that participants who regularly attended church services adopted a healthier life-style and had less suicidal idealization. A longitudinal study conducted by Strawbridge et al. (1997) revealed that continuous attending of church activities increases life-span and reduces mortality rate. Involvement in religious activities are also associated with improvement in several health measures including reduction of blood pressure (Levin & Vanderpool, 1987), therapy for cancer patients (Jarvis & Northcott, 1987) remedy for heart diseases (Friedlander et al., 1986). In addition, Idler (1987) observes that religious activities are used to reduce high risk behaviours such as smoking and drinking alcohol.

Mental Health Status in Kenya

There is global concern about the rise of mental health status. A report published by Kenya National Commission in Human Rights on commemoration of world mental health day (Kenya National Commission on Human Rights, 2024) observes that there has been a 13% rise in mental health conditions and substance use disorders in the last decade, where 1 person in every 8 people are reported to have been living with a mental health condition as of 2019. Thus, WHO declared mental health as a public health priority. Therefore, it was advised that nations should plan and allocate budgetary resources for mental health services.

As part of the global world, Kenya also struggles with a surge of mental health issues. A large number of Kenyans specifically the youthful population grapple with mental health issues knowingly or unknowingly. According to a panel discussion on Citizen TV on Thursday, 29th May 2025 about mental health awareness the panellists reported that mental health issues account for 13% of disease burden in Kenya (Safin, 2024). Conversely the budgetary allocation for mental health services is very meagre (less 0.1%) (Safin, 2024) compared to allocations for other sectors. Mental health disorders on surge include depression, anxiety, suicidal cases, substance induced psychotic disorders, bipolar disorder, schizophrenia, alcoholism and other psychoses (Ministry of Health, Kenya, 2020). Alcoholism is posing a serious threat among Kenyan societies. It is slowly finding its way into regions that were not known for excessive sell

and consumption of alcohol, such as location of the current study – Garissa County. The danger of alcoholism is vividly described by Ann Njeri Mathu (2011, pg.1) a reformist from alcohol addiction in her book titled 'Sober again, How I beat alcoholism after 20 years of persistent drinking' and she proclaimed "*alcoholism is like cancer, which if not checked and monitored closely, has the power to ruin human being and that surrounds him or her*" (Mathu, 2011). The report on task force on mental health status in Kenya depicts a disturbing picture and asserts *"images of young men loitering the streets of urban centres in states of advanced intoxication with drugs and alcohol continue to prick our collective conscience. The situation in rural areas is no better as evidenced by images of chiefs making gallant but futile attempts to deal with what is commonly referred to as the alcohol and drug menace".* (Ministry of health, 2020. pg.10). The report laments that alcoholism and substance abuse is a ticking time bomb Kenyans are sitting on. Besides adverse effects of alcoholism on mental health and on economic and production, it is also becoming a major source of divorce and family break up (Kenya National Commission in Human rights, 2024).

The cases of mental illness in workplace is also on the rise. The report of the national task force on mental health reveals that an estimated 15% of the global working population has at least one mental health condition (Ministry of health, 2020). This report further asserts that about 3.7 million of the 24.9 million workforce in Kenya might be living with a mental health condition. The consequence of this on economy and productivity is severe. According to the Ministry of Health's Mental Health Investment Case 2021 the burden of mental health conditions is at 62.2B annually (0.6 of the GDP) due to loss of productivity capacities (Kenya National Commission Human Rights, 2023).

Current Study

This research focuses on understanding mental health healing processes and interventions utilized by the contemporary unconventional mental health service providers also known as "*Shifaa centres*". Recently, the number of such centres had increased in towns mostly inhabited by Muslim majority in Kenya. There is influx of mental health seekers toward such institutions and several success stories had been reported. Practices and process of offering mental health services in *Shifaa* centres are not well studied and documented. The purpose of this research is to shed light on the therapeutic processes and practices utilized by *Shifaa* centres in Garissa County Kenya. The research closely looked into the interplay of conventional mental health service practices and spiritual-oriented interventions. Therefore, this research will attempt to answer the research questions:

1. What is therapeutic practices of *Shifaa* centres?
2. How do the conventional mental health treatments blend with religious teaching to offer mental health services?

Mental health healing processes in these centres heavily borrows from religious prescriptions as the name *Shifaa* suggest which is an Arabic word meaning healing. Findings from this transdisciplinary study will ultimately enhance integration of knowledge. It will also close the gap and erode the boundary established by the dichotomy of knowledge between the orthodox psychological models of dealing with mental illness and emerging spiritually infused mental healing practices of *Shifaa* centres.

Methodology

This research utilized a qualitative approach using phenomenological inquiry. Phenomenological design is naturalistic and useful to deeper understand, describe and interpret attributes of certain phenomena. Key qualities of phenomenological inquiry are description, reduction, essence and intentionality (Thomas & Keith, 2003). A phenomenologist researcher delves into experiences as it presents itself in order to catch the structure of meaning. Creswell (2009, pg.13) asserts that "*phenomenological research is a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by the participants"* (Creswell, 2009). This inquiry is suitable for this research in order to gain insight into the therapeutic process and interventions of *Shifaa* centres from the perspective of the practitioners. Data was gathered from two *Shifaa* centres in Garissa town in Kenya. The instrument of gathering data was in-depth interview which is the most suitable data collection instrument to understand very complex phenomena (Creswell, 2009). Interviews were conducted with two medical practitioners, two counsellors and one spiritual staff (*Sheikh)* and an administrator. Resulting data was analysed using interpretive phenomenological analysis and conceptual analysis. Conceptual analysis as explained by Jonathan Furner (2006) is a technique that "*defines the meaning of a given concept by identifying and specifying the conditions under which any entity or phenomenon is (or could be) classified under the concept in question*" (Furner, 2006). Outcomes of this study are expected to enrich and broaden psychological intervention to mental recovery. The processes and practices of religious psychological interventions are important for integration and expansion of knowledge.

Results

Results were arrived at through analysis of data gathered from in-depth interviews with medical practitioners, counsellors, spiritual leader and administrative worker in *Shifaa* centre. Data was thematically and conceptually analysed to arrive at themes. Results are presented in chorological sequence starting from admission of client to recovery and discharge.

Admission Process

Mentally ill patients are brought either by relatives or good Samaritans. Majority of patients are brought involuntarily except a few. This is due to the fact that many people view rehabilitation centres as places of mentally ill people. Patients brought in by well-wishers are described to be in pathetic condition and are in poor hygiene, and also malnourished. Some of the requirements during admission are (i) a client should be 18 years and above (ii) should poses valid identification documents such as national identity card or passport in case a patient is not a Kenyan citizen and (iii) there shall be an active phone contact and address of next of kin. A file is opened for every patient where relevant documents, progress reports and a recent file photo are placed. During admission, a status photo of the patient is purposely taken in order to compare status of patients before and after recovery. This structured admission process makes *Shifaa* centres appear advanced and professional in receiving and handling of patients.

Therapeutic Process

Patients received in *Shifaa* centres are classified into three categories (1) behavioural maladaptive patients (2) substance induced psychotic disorder patients (3) psychotic patients. Placement into these categories is achieved after conducting assessment including lab test, behavioural observational assessment and verbal interviewing of clients. The intervention process is multidimensional and interactive. It is a hybrid triangular interactive process of medical diagnosis and treatment, psycho-social support and counselling and spiritual development and therapy, as depicted in Figure. 1.

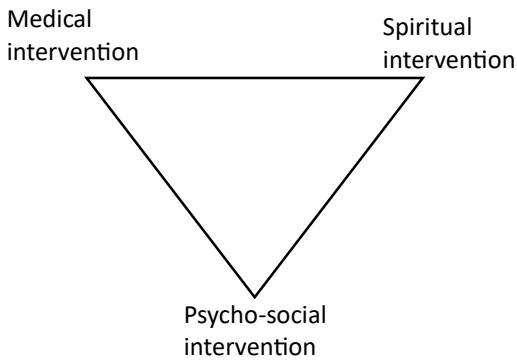

Figure1: *Shifaa* therapeutic intervention model

(1) Behavioural Maladaptive Patients

According to medical practitioners interviewed, behavioural maladaptive clients exhibit problematic behaviour in the society such as being aggressive, abusive and non-compliance with social norms and standards. Some clients were brought in by parents because of constant quarrelling with family members and trouble making. Other patients put in this group are those with anxiety, stress disorder and those with mild depression. These clients are restless, moody and are argumentative. According to practitioners, because members of this group are mentally functioning, they perceive *Shifaa* centres as places of psychotic people and therefore they argue they are wrongly and forcefully placed in such rehabilitative centres. They are the most resistant group to receive and undergo therapy. Positive behavioural change in such clients is paramount and behaviour change appears to have benefit on mental health (Dale, Brassington, & King, 2014). To restore their mood and relax their nerves the psychiatric doctor prescribes antidepressant drugs in order to attain mood relaxation of the client. Antidepressants controls excessive activity of the nerve cells in the brain (My dawa, 2025). Once the patient settles, psycho-education therapy is provided by the counsellor. The counsellor engages the patient using talk therapy in order to achieve cognitive restructuring in the process of correcting maladaptive behaviour. One of the counsellors proclaimed "*many problematic behaviour clients are resistant and resist admission at Shifaa centres but after one or two days of settling their brain they recognize their wrong behaviours and that is start of recovery*".

(2) Substance-induced Psychiatric Disorders and Alcoholism

The second category are patients who have adverse effects due to substance use and alcoholism. Symptoms exhibited are depression, psychosis, anxiety, neuro-cognitive disorders and hallucinations. This category makes a significant portion of patients in these centres contributing about more than 60% of clients. Members of this category are usually brought in by parents or other relatives and are the largest group in *Shifaa* centres. During admission, information given by the next of kin regarding drug and substance abuse is crucial and forms part of the basic assessment. Lab test is performed on the urine of such a client. Positive results of COT urine test are indication of substance abuse. The test further suggests the nature and severity of substance induced. Substances abused usually reported include *khaat* (miraa), cigarettes, tobacco, marijuana (bang), cannabis and high alcohol uptake and irregular use of medicinal drugs like diazepam. Management of such patients starts with relaxation and attaining tranquillity. Detoxification process begins after the patient is relaxed. Visiting psychiatric doctors after thorough assessment prescribes medication for substance abuse disorder. The process of detoxification takes in the second phase after attaining relative calmness in patients. According to medical professionals working in *Shifaa* centres some medicines are prescribed for detoxification and administered to act against alcohol withdrawal effect. Alcohol withdrawal are symptoms resulting when a person addicted to alcohol abruptly stops or decreases alcohol intake or halt substance use. These discomforts include muscle twitching, mood disorder, sleep changes and fatigue (Cleveland clinic, 2025). Unlike the other two categories, substance induced patients are monitored against relapse on drugs. Visiting relatives and friends are closely monitored to not smuggle drug into the centres. Visit is usually done once in a week and meeting is conducted with presence of staff from the centres. According to a counsellor in one of the centres, this group is the largest (60%) and also with highest recovery rate of patients. Clients admitted due to chronic smoking are provided with nicotine gum as supplementary to cigarettes in the process of gradually quitting smoking. The success cases of recovery from substance abuse are many however the rate of relapse is also high after discharge. Unfortunately, these *Shifaa* centres have poor mechanisms of monitory and follow-up of clients after discharge apart from making a few phone calls.

(3) Psychotic Patients

This category are patients who are delusional and hallucinating and are out of touch with reality. Patients of bipolar, schizophrenia and acute psychosis disorders are put into this category. Some patients are admitted by relatives while others are brought in by well-wishers who sympathize with the horrible conditions of such persons. Some of them are violent and in poor hygiene and, also malnourished. Persons possessed by *Jinn* are also put under this category. *Jinn* as described in the Quran are creation similar to humans created of fire and are expected to offer submission to God just like humans. *Jinns* can see, impact and influence human behaviour while humans cannot see them. Individuals who are admitted by well-wishers are also assisted by the *Shifaa* centres by giving discounts since there is no person to cater for their cost of services. In anticipation of rogue and aggressive psychosis patients, *Shifaa* centres employ strong personnel to control and maintain order in the centres. Violent clients are also administered with relaxation drugs. Upon receiving psychotic patients, mental assessment is performed by

psychiatric consultants to determine the mental status of the client. However, there was no evidence of utilizing and adhering to DSMV-IV and use of standardized tests during diagnosis and placement into categories. DSMV-IV stands for Diagnostic and Statistical Manual of Mental Disorders which is a standard manual used to diagnose mental health conditions. According to a practicing nurse working in one of the *Shifaa* centres, a consultant psychiatric doctor prescribes relaxing drugs for psychotic patients to make them sleep and relax their brains. Recovery process of this category is slow and may take longer period (3-6 months) unlike the other two categories like substance induced disorders which may take 3-6 weeks for recovery. Psychiatric doctors make weekly visit to assess and monitor progress of psychotic patients. An average therapy of 3-6 months will achieve a considerable recovery.

Spiritual Interventions

Shifaa centres are unique for their eclectic therapeutic interventions which appeals to many Muslim societies in Kenya. As indicated above, the process starts with conventional mode of treatment and later blended with spiritual/religious interventions. Mental recovery through spiritual therapy is conducted at individual level and also through group therapy. Quran is the first source of Islamic law (*sharia*) and it forms the basis for healing. Reading of the Quran on patients happen in two modes (i) congregation mode -where all patients are gathered in an open arena and Quran is read in chorus and also listening is made through speakers (ii) reading of Quran on specific clients, and this happens upon arrangement with patient`s parents or guidance. All clients are recruited to Quranic classes once relative calmness and mental stability is attained. It is reported that some clients memorized a significant portion of Quran during their stay in *Shifaa* centres. Whether voluntary or involuntary, all clients are made to observe the five daily prayers in congregation. Some of the techniques used to assess whether there is *Jinn* or spirit possession include is administering of herbal combination to the patients. Responses from clients is an indication of *Jinn* possessiveness. According to a practitioner in one of the *Shifaa* centres, patients who are possessed by *Jinn* react severely upon administering of the herbal materials and become extremely irritated. Another evidence of *Jiin*/spirit clients with spirit possession can be identified. During recitation of Quran therapy possessed patients become wild, rogue, cry and resist recitation of Quran. This an indication that a client is possessed by *Jinn* or spirit of evil eye. Though all patients receive dosage of reading of Quran on them, those possessed by *Jinn* and those hit by evil eye receive specific selection of Quran reading.

Other Supportive Programmes

Approaches employed *by Shifaa* centres are hybrid and are advanced in handling mental patients. Practitioners interviewed reported other supportive activities such as group therapy, family therapy and engaging clients in games and recreational activities. Clients with similar mental conditions like substance-induced patients are put into group therapy and are educated on negative effects of drug abuse. Group therapy is a very effective form of psychotherapy (Yalom & Leszc, 2005) and within groups, individuals get supported in dealing with a common problem such as overcoming drug addiction. Other recreational activities include playing football, playing chase and ludo. Though the space is limited some patients enjoy extra curricula activities. However, there

are some good number of patients who do not participate in this recreational activities due to unstable mental status and prolonged social isolation before admission.

Another important therapy practiced by *Shifaa* centres is family therapy. Family therapy is a psychotherapy intervention that conjoin family members and relatives to the therapeutic process to nurture change and development. Family members are allowed to make weekly visits and receive briefing about the progress of their patients. They are allowed to sit, chat and make stories with their kin. They bring some foods and refreshment. This offers psychological uplift to patients and makes them feel appreciated and connected to their families.

Conclusion

Mental health therapy offered in *Shifaa* Centres are unique of its kind. Approaches of treating mental health patients is hybrid, eclectic and robust. They combine medical intervention, spiritual nourishments and psycho-social support intervention to treat mental patients. According to respondent working in one of the centres many people seek mental health services and recovery rate is commendable. There is growing trend where people are preferring mental health services in *Shifaa* centres more than the conventional mental health hospitals. Despite attaining recovery from mental illness patients discharged from *Shifaa* centres also return while spiritually elevated, morally nourished and also gained some knowledge of their religion. This well-grounded comprehensive intervention should be appreciated, enhanced, funded and the techniques institutionalized. This hybrid mental health intervention model practiced in *Shifaa* centres deserve promotion, documentation and recognition. Services offered in *Shifaa* centre are effective and adding value to human life.

Practical Implications and Recommendations

Religion/spirituality shape purpose and meaning of life. Religion makes part of multi-cultural approach to psychology and counselling. Infusing religion/spirituality in mental health therapeutic processes is essential in achieving holistic recovery and growth of mental patients. This study was limited on *Shifaa* centres in Garissa County in Kenya. This study offers following recommendations:

1. Extending similar studies in other towns inhibited by Muslim societies
2. Documenting in details the concept of *Jinn* and spirit possessions and therapy
3. Explaining causes of relapse specifically in substance induced patients and longitudinal studies on life and recovery.
4. Suggesting framework for monitory and evaluation of clients after discharge.

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