

# RELIGIOUS BELIEFS AND DURATION OF UNTREATED PSYCHOSIS (DUP) AMONG YOUNG ADULTS IN IGBO COMMUNITIES, NIGERIA

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## Abstract

*This study investigates how Pentecostal religious beliefs in Igbo communities in Nigeria contribute to delayed psychiatric intervention for young adults aged 18 to 35 years with psychosis. In many Pentecostal settings, mental illness is often perceived as a spiritual condition rather than a medical disorder. Such interpretations can delay timely access to mental health care. Arthur Kleinman's 1978 explanatory models of illness guide the analysis. Mental illness is frequently understood as demonic possession. This view encourages prolonged spiritual interventions and limits engagement with clinical treatment. A qualitative approach was adopted. Data were obtained through personal communication and a review of extant literature. Narratives from participants and documented sources show the strong influence of spiritual beliefs on help seeking behaviour. Findings indicate that spiritual interpretations are linked to delayed psychiatric care. Many cases involve extended prayer sessions and deliverance practices while symptoms persist or worsen. This pattern increases the risk of mental deterioration and long term impairment. The study calls for improved mental health awareness and meaningful engagement with religious leaders.*

**Keywords:** Religious Beliefs, Duration of Untreated Psychosis (DUP), Young Adults, Psychiatric Care, Mental Health

## Introduction

Religion holds immense value, yet when taken to extremes, it can degenerate into grave superstition. Deeply religious individuals often attribute psychosis to evil forces and disregard medical explanations, seeking spiritual rather than clinical solutions. 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).

Psychosis is a severe disorder marked by a loss of contact with reality, hallucinations, delusions, disorganisation, and social dysfunction (Lindhardt et al., 2022). Prolonged duration of untreated psychosis (DUP) significantly affects prognosis and recovery (Zhang et al., 2021). This is particularly relevant among young adults in Igbo communities in Nigeria, where faith, culture, and medicine closely interact. In these communities, psychosis is often viewed as a spiritual affliction rather than a biological one (Ran et al., 2021). Families typically consult traditional healers or prophets before seeking psychiatric care, attributing symptoms to witchcraft or divine trial. These responses provide comfort but often prolong DUP and delay intervention (Uwayezu & Ntigura et al., 2022).

A critical problem persists. Although Pentecostal doctrine accepts medical care as a legitimate means of healing, many church leaders in Igbo communities nonetheless rely solely on prayer for psychosis, and this delay in seeking medical treatment increases the risk of long term impairment. Consequently, many affected young adults roam the streets without treatment as their conditions deteriorate (Igweze et al., 2017; Okeke et al., 2023; Eneh & Eneh, 2024). However, limited empirical research has examined how Pentecostal pastoral authority prolongs DUP among young adults in these communities, particularly why religious leaders discourage clinical treatment. Given the growing prevalence of psychosis in Igbo communities and the preventable harm from delayed care, empirical evidence is urgently needed. Guided by Kleinman's (1978) explanatory models of illness, this study therefore investigates how Pentecostal religious beliefs contribute to delayed psychiatric intervention for young adults aged 18 to 35 years with psychosis in Igbo communities in Nigeria. The objectives are to examine the role of Pentecostal teachings on spiritual warfare in discouraging clinical treatment and to assess how religious leaders influence public perceptions of psychiatric care.

### **Literature Review on Young Adult Psychosis in Igbo Communities in Nigeria**

Psychosis among young adults is prevalent in Igbo communities in Nigeria, particularly in Enugu, where schizophrenia spectrum disorders are the most frequent diagnoses (Ogbonna et al., 2020). Ughasoro and Onukwuli et al. (2022) reveal that adolescents in this region experience high levels of violence, mostly from relatives at home, and this violence strongly associates with mental illness. Girls from poor households not living with parents are most at risk.

Nwokocha and Chinawa et al. (2017) examined somatisation disorder among 485 adolescents aged 10 to 19 years in four secondary schools using the Enugu Somatization Scale. Results showed that 51.8 percent had head symptoms, 54.0 percent had body

symptoms, and 62.5 percent reported either, with 43.3 percent experiencing both. Males and females reported head symptoms at 51.3 percent and 52.2 percent respectively. Psychosomatic conditions are common and possibly increasing among young adults in the region.

Mbanuzuru and Oriji (2022) link methamphetamine use among young adults to rising violence and suspected psychosis. Easy access, supported by local production and global circulation, worsens the situation. Umezurike (2025) states that psychosis is increasingly associated with substances like "monkey tail," "gutter water," and "gegemu." The United Nations Office on Drugs and Crime reports over 14.3 million Nigerians aged 15 to 64 have used drugs, mainly cannabis. In urban and semi urban areas, about 20 percent of young adults have experimented with drugs, and over 10 percent are regular users. These substances link to drug induced psychosis, suicide, rape, assault, truancy, academic decline, and violence among school pupils and street young adults.

Eneh and Eneh (2024) analysed three years of mental health hospital records involving 380 index and 180 post index cases. Of these, 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 was 68.42 percent of diagnoses, with a relapse rate of 52.1 percent, mainly among males (61.62 percent) and the unemployed (61.62 percent). Relapse was more frequent in those with illness lasting five years or more (52.02 percent) and those with poor drug compliance (66.16 percent). Illness over three years increased relapse risk 1.17 times, and early onset increased it 2.479 times. Employment and family support reduced relapse risk by 1.110 times. The authors call for better mental health services, education, and jobs for single, unemployed, uneducated individuals below thirty-five years.

The reviewed studies provide evidence on the prevalence, causes, and clinical features of young adult psychosis in Igbo communities, but they do not address how Pentecostal beliefs shape responses to the condition. Most research focuses on epidemiology, drug abuse, violence, and relapse, ignoring the socio religious dynamics that prolong untreated psychosis. Limited inquiry exists on how Pentecostal teachings on spiritual warfare, demonology, and divine healing block timely psychiatric care. The gap is in understanding how religious interpretations replace medical reasoning, especially among families who choose prayer houses over hospitals. Using Arthur Kleinman's Explanatory Model of Illness, this study therefore examines how Pentecostal beliefs influence help seeking decisions and reinforce prolonged untreated psychosis among young adults in Igbo communities.

### **Theoretical Framework**

This study applies Arthur Kleinman's Explanatory Model of Illness (1978) to explain how religious beliefs shape the understanding of psychosis and care seeking among young adults in Igbo communities in Nigeria. The model shows that people interpret illness

through cultural, religious, and personal meanings, which may differ from medical views (Kleinman, 1978). Within many Pentecostal settings, psychosis is often seen as a spiritual attack or evidence of demonic activity. Such interpretations influence families and pastors to favour prayer and deliverance over clinical care. This pattern contributes to delayed psychiatric intervention among young adults, as reflected in the problem identified in this study. The model further explains how religious leaders shape illness perceptions. Pastors often guide decisions on treatment. In some cases, they discourage hospital care and promote spiritual solutions. This influence aligns with the study's focus on how religious beliefs affect help seeking behaviour and delay access to mental health services. Kleinman noted that understanding a patient's belief system helps clinicians ask clear questions, interpret meanings, and align care with patient expectations (Hallenbeck, 2024). This approach supports the study's objective of examining how belief systems affect treatment choices and outcomes.

Despite its relevance, the model has limitations. It tends to simplify complex health beliefs into fixed cultural categories. It may ignore power relations and social pressures that affect patient choices (Dein, 2003; Good, 2012). It also assumes equal dialogue between clinician and patient, which is not always realistic (Lynch & Medin, 2006; Hodson, 2025). Even with these limits, the model remains useful. It explains the gap between medical knowledge and local interpretations of psychosis. It shows why many families delay clinical care and rely on spiritual interventions. It also supports the need for culturally informed mental health strategies.

Engagement with religious leaders is important. Their influence can support early intervention when they recognise the value of medical care. Integration of spiritual support and psychiatric treatment may improve outcomes and reduce delays in care among young adults.

### **Methodology**

A qualitative design was employed to examine how Pentecostal religious beliefs influence delayed psychiatric intervention among young adults aged 18 to 35 years with psychosis in Igbo communities in Nigeria. Data were obtained through personal communication with affected individuals, family members, and persons familiar with Pentecostal practices, alongside a review of extant literature. Purposive sampling ensured inclusion of participants with relevant experience. Data were analysed using thematic analysis to identify patterns in illness interpretation, help seeking behaviour, and treatment choices. Emerging themes were aligned with the study objectives and Kleinman's framework. Ethical standards were observed. Informed consent was obtained. Confidentiality and anonymity were ensured. Participation was voluntary, and sensitivity was maintained throughout.

### **Understanding Duration of Untreated Psychosis (DUP)**

Morré and Hancq (2023) define Duration of Untreated Psychosis (DUP) as the period between first psychotic symptoms and the start of adequate treatment. In the United States, the median DUP is about 74 weeks. Longer DUP is linked to poorer social functioning, more severe symptoms, reduced insight, and higher substance use. It is also associated with lower treatment success. Zoghbi et al. (2022) report that prolonged DUP relates to reduced grey matter, altered brain structure, and chemical imbalance. Early care can limit such changes and improve recovery. Salazar de Pablo et al. (2022) find limited evidence for widespread brain damage, though some studies show changes in the temporal regions.

Marshall et al. (2005) show that delayed treatment after first symptoms leads to worse outcomes, even after accounting for early life adjustment. Clear differences appear at six and twelve months. Longer delays are linked to higher symptom levels, poor functioning, and low remission. Early detection and prompt care remain essential. In many Igbo communities in Nigeria, religious beliefs often delay hospital care. Families may seek spiritual intervention first. Among young adults, such delays increase illness severity and worsen outcomes (A. Aku, P. Ajah, J. Okafor & K. Ezu, personal communication, March 30, 2026).

### **Origins and Spiritual Emphasis of Nigerian Pentecostalism**

The Pentecostal movement in Nigeria began in the early twentieth century as believers sought deeper spiritual experiences outside mission churches. The call, “Come out from among them,” from 2 Corinthians 6:17 symbolised a deliberate break from established ecclesiastical structures (Afunugo, 2025). Joseph Ayo Babalola's leadership led to the formation of the Christ Apostolic Church in 1941, while the Cherubim and Seraphim movement gained influence around the same period (Afunugo, 2025). From the 1970s, Pentecostalism expanded across Nigeria, built large congregations, and contributed to education and social services. It became a major force within Nigeria's Christian space, shaping politics and development (Afunugo, 2025). Afunugo (2025) notes that Pentecostals emerged as a strong social and religious presence with clear influence.

Pentecostal spirituality in Nigeria centres on divine healing, deliverance, and miracles as expressions of authentic belief (Afunugo, 2025). Miracles serve as evidence of God's presence, while prayer, holiness, and religious beliefs act as channels for supernatural intervention. This worldview reflects belief in an unseen spiritual realm that shapes moral, cultural, and political life (Wariboko, 2014). Bachmann (2017) explains that Pentecostals view witchcraft as a real expression of evil linked to illness, misfortune, and family disorder. Testimonies and media narratives connect such forces to the devil and encourage responses through prayer and deliverance. This perception sustains fear and reinforces strong spiritual interpretations. Within this framework, mental illness is often seen as a spiritual condition that requires spiritual intervention. G. Anaso, C. Ike, O. Emele, and K. Obidiegwu (personal communication, 30 June 2025) confirm that spiritual authenticity

remains central under leaders such as Bishop David Oyedepo and Pastor Enoch Adeboye. I. Ofor, A. Anene, and I. Okafor (personal communication, 30 June 2025) state that in Igbo communities in Nigeria, this belief system leads many Pentecostal leaders to interpret psychosis among young adults as a demonic attack. Medical care is often rejected in favour of prayer and deliverance. Such delays in clinical response extend the Duration of Untreated Psychosis and worsen 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) revealed that several Pentecostal churches in Igbo communities in 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 argued that deliverance sessions in which young adults 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 young adults.

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 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.

Ikwuka et al. (2016) conducted a study among 602 Igbo respondents across Igbo communities in Nigeria and found that more than half displayed authoritarian views and preferred primary social restrictiveness, rejected community based care, and supported secondary social distance from people with mental illness. One third of the participants endorsed supernatural views, while those with higher education and members of mission churches were more likely to endorse psychosocial or biological causes. The 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. Negative attitudes were significantly predicted by older age, male gender, low education, Pentecostal affiliation, and lack of contact with persons with mental illness. The churches were more likely to endorse psychosocial or biological causes.

According to I. Edeh, A. Eze, O. Nwankwo and O. Obodoeze (personal communication, June 30, 2025), many people in Igbo communities depend on deliverance prayers, believing that religious beliefs rather than clinical care are sufficient 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. 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. This belief system sustains prolonged DUP and worsens suffering among affected young adults.

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. However, after prayer sessions, the psychosis worsened, and the boy later died. 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 young adult later died. A subsequent medical report confirmed advanced paranoid schizophrenia. These experiences reveal how early reliance on spiritual intervention rather than clinical care produces delayed treatment and chronic illness. Pentecostal practices and prayers are often preferred, reinforcing superstitious interpretations of young adult psychosis. The evidence across these studies and communications demonstrates that superstition surrounding young adult psychosis in Igbo communities remains entrenched. Pentecostal leaders often interpret the condition as demonic and prescribe prayer warfare as the only solution. This belief system, combined with stigma and cultural expectations, discourages help seeking and delays clinical intervention.

### **Significant Causes of Young Adults Psychosis in Igbo Communities in Nigeria**

The evidence based findings and literature review of this study reveal that young adult psychosis in Igbo communities in Nigeria results from a mix of biological, psychological

and social factors. Major causes include genetic weakness, substance use such as mkpulummiri, cannabis, methamphetamine and alcohol, childhood trauma and poor parental care (A. Okafor, O. Ezichi and H. Iloh, personal communication, June 28, 2025). Many young adults struggle with academic pressure, peer influence and social isolation, which undermine mental stability and may trigger early signs of psychosis if not addressed.

The ongoing economic hardship in Nigeria has increased family stress in Igbo communities. Many households face poverty, joblessness and rising living costs. Young adults 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 low awareness, makes the problem worse 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 Igbo communities teach that demonic powers and evil forces are responsible for young adult psychosis. This study, however, confirms 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 a full medical evaluation finds no biological cause.

### **Dispelling Superstition through Faith Inspired Mental Health Care**

This study does not deny the reality of miracles or the existence of evil, but it stresses that evidence shows many cases arise from stress, substance abuse, obsession and frustration. It is also deceptive to preach religious beliefs in public while privately taking one's family to the hospital for treatment. Many faith-based clerics and adherents have lost their lives, both in the past and in recent times, because of too much 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.

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 young adult 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. Medical and psychological care should not be treated with

suspicion, for such care is also a divine provision.

Pentecostal churches in Nigeria, particularly in Igbo communities, use social media and digital platforms to share messages, advertise programmes and communicate with followers. It is therefore hypocritical to claim that young adult psychosis is caused only by evil forces when individuals must know when to seek help through legitimate means. 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.

### Conclusion

This study examined how Pentecostal religious beliefs contribute to delayed psychiatric intervention among young adults aged 18 to 35 years with psychosis in Igbo communities in Nigeria. Findings confirm that spiritual interpretations of psychosis as demonic possession or divine trial remain widespread. These views directly prolong Duration of Untreated Psychosis (DUP). Many families prioritise deliverance sessions and prayer warfare over clinical assessment. Consequently, symptoms worsen, relapse rates increase, and avoidable deaths occur.

The application of Kleinman's explanatory model proved useful. It clarified how Pentecostal teachings shape illness perceptions and treatment decisions. Religious leaders exert strong authority. They often discourage hospital care. This pattern is not merely cultural. It reflects a structured belief system that replaces medical reasoning with spiritual causality. The study provides empirical evidence from personal communications and extant literature. It fills a gap left by prior epidemiological studies that overlooked socio-religious mechanisms delaying care.

However, this study has limitations. The qualitative design and purposive sampling limit generalisability. Findings derive largely from Igbo communities in Southeast, Nigeria. Experiences may differ in other regions or religious groups. Personal communications, though valuable, carry recall bias and lack clinical verification. The absence of quantitative data prevents statistical estimation of average DUP length or correlation strength between Pentecostal affiliation and treatment delay.

The significance of the study lies in its critical interrogation of superstition disguised as spiritual discernment. It challenges the hypocrisy of rejecting medical care while accepting modern technologies. It affirms that medicine and prayer are not oppositional but complementary. Faith-inspired mental health care is possible when religious leaders acquire formal education in theology, psychology, or counselling.

Further studies should adopt mixed methods. Quantitative surveys can measure DUP

differences across Pentecostal, mission church, and traditional religious groups. Longitudinal designs would clarify whether pastoral training interventions reduce treatment delay. Comparative research across Nigeria's six geopolitical zones is needed. Ethnographic work may explore how gender, education, and economic status moderate religious influence on help-seeking. Ultimately, reducing DUP among Igbo young adults requires meaningful engagement with Pentecostal leaders. Mental health awareness must integrate spiritual frameworks without compromising clinical standards. Delayed care is not inevitable. It persists because superstition has been normalised. Rejecting that normalisation is the first step toward recovery.

### Recommendations

1. Integrate mental health literacy into Pentecostal teaching and practice. Church leaders should present psychosis as a medical condition with known biological and psychosocial causes. Sermons and counselling sessions should discourage exclusive reliance on spiritual explanations. Clear guidance should emphasise early clinical assessment alongside prayer.
2. Establish structured collaboration between mental health professionals and Pentecostal leaders. Psychiatrists, psychologists, and trained counsellors should engage churches through seminars and joint outreach. Such collaboration should correct misconceptions and promote timely referral pathways for affected young adults.
3. Develop community-based early detection programmes within Igbo communities. Screening initiatives should target young adults aged 18 to 35 years in churches, schools, and local associations. Early identification of symptoms should lead to immediate referral to psychiatric services.
4. Strengthen regulation and monitoring of informal healing centres and prayer houses. Relevant authorities should set minimum standards for care. Harmful practices that delay treatment or endanger patients should attract sanctions. Compliance should be linked to basic mental health training.
5. Promote formal education and interdisciplinary training for Pentecostal clergy. Training should include basic psychiatry, counselling, and ethics. Exposure to evidence-based mental health knowledge should improve pastoral judgement and reduce harmful interpretations of psychosis.
6. Expand access to affordable and youth-friendly mental health services. Public health systems should prioritise early intervention units in South East Nigeria. Services should address stigma and ensure confidentiality to encourage help seeking among young adults.
7. Address substance abuse as a major driver of psychosis among young adults. Prevention programmes should focus on drugs such as methamphetamine, cannabis, and local mixtures. Community campaigns should link substance use to mental health risks and long-term impairment.

8. Incorporate culturally sensitive frameworks in psychiatric care. Clinicians should recognise the influence of religious beliefs on illness perception. Treatment plans should respect spiritual concerns while maintaining clinical standards. This approach may improve adherence and outcomes.
9. Support families through targeted education and counselling. Families should receive clear information on early symptoms, risks of delayed care, and benefits of treatment. Support groups within communities and churches should reinforce informed decision-making.
10. Encourage empirical research using mixed methods across Nigeria's geopolitical zones. Quantitative studies should measure DUP across religious groups. Longitudinal designs should assess the impact of pastoral training and community interventions on treatment delay.

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