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The Power of Faith: Health Belief Model in Spiritual Water-Based Healing Practices

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Abstract. *This qualitative case study explores the application of the Health Belief Model (HBM) in understanding the decision-making processes of individuals in Sleman, Yogyakarta Special Region, who utilize prayer-based water spiritual alternative treatments for healing. Using purposive sampling, three primary subjects and their significant others were selected based on their exclusive use of prayer water, Islamic faith, and local upbringing. Data were collected through in-depth interviews and analyzed to identify HBM dimensions: perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy. Findings reveal that unexplained symptoms heightened perceived susceptibility, while severe physical and psychological impacts underscored perceived severity. Perceived benefits, including inner peace and spiritual enhancement, were the primary motivators, supported by low barriers due to cultural acceptance. Cues to action, such as family and religious leader support, and high self-efficacy further drove treatment adoption. These results highlight the interplay of personal health perceptions, spiritual beliefs, and socio-cultural influences in shaping health behaviors. The study underscores the HBM's relevance in explaining spiritual health practices and offers insights for culturally sensitive health education to balance traditional beliefs with evidence-based medical care.*

Keywords: *health belief model, prayer-based water, qualitative study, Sleman, spiritual alternative treatment*

Introduction

The equitable distribution of healthcare facilities and personnel aims to ensure communities receive scientifically validated medical treatment. However, some individuals experience despair when conventional treatments fail to cure their ailments, prompting them to seek alternative approaches, such as prayer-based water spiritual healing (Astin, 1998). Triratnawati (2010) notes that alternative treatments are often perceived as more affordable, accessible, and effective compared to conventional medicine. A survey by Yanti et al. (2021) highlights economic and cultural factors as

primary reasons for choosing alternative treatments, alongside a desire to avoid the side effects of medical interventions (Kamaluddin, 2010). Additionally, physical and mental exhaustion from unsatisfactory medical procedures further drives individuals toward alternative options (Bishop et al., 2007).

This phenomenon is particularly striking in regions with abundant access to biomedical care. Misnaniarti et al. (2018) reported that Java and Bali have the highest density of healthcare providers in Indonesia, meaning that residents of Sleman, Yogyakarta Special Region, face no geographic or structural barrier to evidence-based medical treatment. Yet, despite this access, a considerable portion of the population continues to rely on spiritual alternative treatments — most notably, prayer-infused water (air doa) — as their primary healing modality (Yanti et al., 2021). This paradox raises a critical question: what psychological and socio-cultural factors drive individuals with ready access to scientific medicine to choose spiritual healing instead? Answering this question requires a framework that goes beyond structural determinants and examines subjective health perceptions.

One form of spiritual alternative treatment imbued with religious elements is prayer-based healing using water as a medium (Wardiani & Gunawan, 2017). Septia et al. (2023) suggest that certain religious teachings possess psychotherapeutic elements that foster a belief in recovery, positively impacting health. This aligns with Kellner's (1994) assertion that psychological processes significantly influence biological processes, including health outcomes, often referred to as psychosomatic effects.

The Health Belief Model (HBM) provides a relevant theoretical framework for examining this phenomenon. The HBM identifies how perceptions of susceptibility, severity, benefits, barriers, cues to action, and self-efficacy influence decisions to adopt specific treatments (Champion & Skinner, 2008). According to Janz and Becker (1984), the HBM can explain a range of health behaviors, from the use of healthcare services to preventive actions and the pursuit of alternative treatments. The model's relevance to spiritual health behaviors is supported by prior studies. Fanani and Dewi (2014) found that the use of supernatural alternative treatments, such as those involving traditional

healers, is influenced by perceived susceptibility to unusual illnesses, symptom severity, perceived benefits of simpler and faster remedies, and family influence as a cue to action. Similarly, Nurjannah and Laksmiwati (2023) revealed that, despite criticisms and risks associated with spiritual treatments, individuals choose them due to perceived benefits, external support, and high self-efficacy for recovery. These findings affirm that spiritual practices are shaped not only by cultural or religious factors but also by health perceptions. However, both prior studies examined shamanic or traditional healer (dukun)-based practices — forms of alternative treatment that carry strong stigma and are typically sought covertly. The present study addresses a distinct gap: it examines prayer-infused water (air doa) obtained through mainstream Islamic religious channels, such as mosque congregations and ustadz residences, a practice that is openly accepted and normatively embedded in Sleman's community life. This distinction allows the HBM to be applied in a context where cultural and religious support is high, rather than stigmatised, enabling a richer understanding of how spiritual beliefs function as perceived benefits and self-efficacy enhancers.

A preliminary interview conducted with one of the research participants, confirmed the prevalence of this practice in Sleman. In that region, individuals commonly bring containers of water to mosque gatherings to be blessed (didoakan) by religious leaders, and then consume or apply the water with the intention of fulfilling prayers for health, prosperity, or ease of life. Prayer water is also obtained by visiting ustadz residences specifically for healing purposes. Crucially, these subjects had first sought conventional medical care — including clinical examinations, blood tests, and imaging — which returned normal results, leaving their complaints unexplained by biomedical science. This sequence, in which modern medicine fails to provide relief and spiritual treatment is subsequently adopted, sits at the heart of the HBM's explanatory power: perceived susceptibility and severity escalate precisely when medical answers are absent.

This study aims to describe the perceptions of individuals in Sleman who have used prayer-based water spiritual alternative treatments, guided by the HBM. The

research seeks to address the gap between the availability of conventional medical care and the preference for spiritual alternatives, offering insights for culturally sensitive health education that respects spiritual practices while emphasizing evidence-based medical treatments.

Methodology

This study employs a qualitative approach using a multiple case study design (Yin, 2018), in which each of the three participants constitutes an individual case and the unit of analysis is the health belief system of each person who has used prayer-based water (air doa) spiritual alternative treatment for healing. A case study design was selected over a phenomenological approach because the research objective is not to capture the essence of a shared lived experience, but to examine how a specific theoretical model — the Health Belief Model — operates within and across distinct individual contexts embedded in a particular cultural and geographic setting. The multiple case design allows for cross-case comparison of HBM dimensions, strengthening the transferability of findings.

The study was conducted in Sleman, Yogyakarta Special Region, selected due to preliminary interview data indicating the prevalence of spiritual alternative treatments, such as prayer water, in this region. The Health Belief Model serves as the primary theoretical framework, encompassing six dimensions: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Rosenstock, 1988).

The study involved three primary subjects, each supplemented by one significant other to validate and enrich the data. Participants were selected using purposive sampling, targeting individuals who had used prayer-based spiritual alternative treatments for healing. The inclusion criteria were:

The First, Grew up and raised in Sleman, Yogyakarta Special Region, to ensure perceptions reflect the local cultural and environmental context (Hakim et al., 2021). Second, Engaged in prayer-based water spiritual alternative treatment more than once during illness, to provide richer data for HBM analysis. Third, used spiritual alternative

treatment without concurrent conventional medical treatment (e.g., prescription drugs, surgery, or medical therapies) to avoid perceptual bias, though general health check-ups were permitted (Kherad et al., 2023). Fourth, muslim as the treatment incorporates Islamic practices, aligning with subjects' religious beliefs.

Data were collected through two rounds of semi-structured in-depth interviews with each primary participant, supplemented by interviews with one significant other per subject to validate and triangulate the data. Data analysis followed a deductive thematic analysis approach guided by the six dimensions of the HBM (Rosenstock, 1988), in accordance with the six-phase framework proposed by Braun and Clarke (2006): (1) familiarisation with data through repeated reading of transcripts, (2) generating initial codes, (3) searching for themes, (4) reviewing themes against HBM categories, (5) defining and naming themes, and (6) producing the report. While the primary coding framework was deductive — mapping data onto the six predefined HBM dimensions — an inductive sub-coding layer was retained to allow culturally specific themes (such as the role of Islamic belief and Javanese cosmology) to emerge where they fell outside the standard HBM categories. This hybrid approach ensures both theoretical coherence and cultural sensitivity.

Ethical considerations were observed throughout the research process. Prior to each interview, participants were provided with a written informed consent form explaining the study's purpose, their right to withdraw at any time without consequence, and the voluntary nature of their participation. All participants provided written consent before data collection commenced, as documented in the research appendices. To protect confidentiality, participants are identified in this article using initials only, and all data are stored securely with access restricted to the research team. Given that the research participants are individuals who sought alternative healing — a potentially sensitive subject involving personal health struggles and beliefs — particular care was taken to ensure a non-judgmental interview approach.

Findings and Discussion

The findings indicate that all subjects applied the Health Belief Model dimensions

in their decision-making process regarding the use of prayer-based water spiritual alternative treatments. The findings indicate that all subjects demonstrated clear application of the Health Belief Model dimensions in their decision to use prayer-based water spiritual alternative treatments. Perceived susceptibility in all three cases emerged not from a general fear of illness, but specifically after experiencing symptoms that resisted biomedical explanation. All subjects had first sought conventional medical treatment — including blood tests, rontgen (X-ray), and in one case a CT scan — before turning to prayer water. When medical results returned normal, the perceived threat was not reduced but rather amplified, because the source of suffering remained unknown. Subject RA described this turning point: *"Because when we checked, the results were all normal — there was nothing wrong. So they couldn't give us any treatment, because they didn't know what procedure to follow"* (RA, Interview 1). Similarly, Subject SR articulated a sense of anxious vigilance: *"I only knew about it superficially — I wasn't really a believer"* (SR, Interview 1), until the illness struck his own family and could no longer be dismissed. The significant others of each participant corroborated this narrative, reporting that their family members had visibly sought medical help first, and that the turn to spiritual treatment came only after conventional medicine provided no answers.

Regarding perceived severity, all subjects reported that their conditions produced significant physical, psychological, and social burdens. Physically, symptoms ranged from limb pain, gastric disturbances, and extreme fatigue to recurring headaches and bodily heaviness that defied biomedical diagnosis. Psychologically, subjects experienced anxiety, social withdrawal, and emotional instability. Subject RA noted: *"It made me uncomfortable physically and mentally… the mind was tested again"* (RA, Interview 1). Subject SR described his father's condition as life-threatening: *"He was almost gone — his whole body turned yellow, like someone about to die"* (SR, Interview 1). Subject NLS reported debilitating daily headaches: *"I was dizzy every single day — there were specific hours when the dizziness hit, from midday to late afternoon"* (NLS, Interview 1). Notably, perceived severity was experienced differently by subjects and their significant others.

While subjects themselves described their conditions in measured terms, significant others perceived the situation as more threatening, which in several cases increased pressure on the subject to seek alternative treatment. This divergence in severity perception within the family unit served as an important catalyst for treatment adoption.

Perceived benefits emerged as the most dominant motivating factor across all three cases. Benefits were not limited to physical recovery but encompassed inner peace, enhanced spirituality, and renewed hope. Subject RA framed prayer water as a form of intercession within an Islamic worldview: *"There are many ways to pray — maybe when we pray directly it's not enough, so we can also ask others to convey [our prayer] to God"* (RA, Interview 1). Subject SR described an immediate sense of relief after consumption: *"I just didn't feel at peace — there was something disturbing me. But after drinking it, it started to calm down"* (SR, Interview 1). Subject NLS felt reassured because the prayer water originated from a trusted religious scholar: *"It was prayed over by a kyai — so there's already a prayer embedded in it before you even drink it"* (NLS, Interview 1). Significant others reinforced these perceived benefits by sharing their own positive observations of the subjects' recovery trajectory, strengthening each subject's conviction that the treatment was effective. This finding aligns with Nurjannah and Laksmiwati (2023), but the present study adds that in mainstream mosque-based contexts, perceived benefits are amplified by collective religious identity rather than private or stigmatised belief.

Perceived barriers to adopting prayer water treatment were generally low across all subjects, which is a distinctive finding of this study relative to prior work on alternative treatments in less culturally supportive contexts (Ernst, 2002). The primary barriers reported were initial personal scepticism and transient concerns about social perception. Subject SR recalled: *"Before it happened to me, I thought 'how could people still do things like that in this day and age?' — I was aware, but not really a believer"* (SR, Interview 1). However, this initial doubt was rapidly overcome when symptoms did not improve through medical channels and family encouragement was provided.

Significant others played a key role in lowering barriers: in all three cases, a family member or close community figure had prior experience with prayer water and actively endorsed its use, normalising the treatment within the subject's immediate social environment. The broad cultural acceptance of Islamic healing practices in Sleman's predominantly Muslim community further reduced the perceived social cost of choosing spiritual treatment, making barriers negligible in practice.

Cues to action were multifaceted and operated through both interpersonal and institutional channels. Family members were the most consistent cue: in all three cases, a parent, sibling, or close relative had either experienced the treatment themselves or actively introduced the subject to it. Subject RA reported that her father, after exhausting medical options, sought out a religious leader on behalf of the whole family: *"Because nothing improved with the rituals, my father decided to stop and move to an ustadz. There we were given prayer water — we were told to drink it and apply it to our bodies"* (RA, Interview 1). For Subject NLS, the cue came through her family's procurement of prayer water from a kyai in Kudus for her grandfather, and she began using it herself when her own symptoms emerged. Religious leader endorsement functioned as an authoritative cue, lending the treatment legitimacy within an Islamic framework. The failure of conventional medicine — receiving normal test results while still suffering — was itself a powerful institutional cue that redirected subjects toward spiritual alternatives. Significant others confirmed that they had actively encouraged or facilitated the subjects' use of prayer water, in some cases by procuring or preparing it.

Self-efficacy was evident in all three subjects, manifested as a growing confidence in their ability to manage symptoms through prayer water, reinforced over time by positive personal experience. Subject RA observed a marked increase in her sense of control as treatment continued: *"Compared to the first year, my confidence is much higher now. In the early years I was still somewhat in denial because it was all so new"* (RA, Interview 1). Subject SR grounded her self-efficacy in Islamic faith and filial responsibility: *"As the eldest child, I had to reassure my mother — I kept telling her, God willing, we will recover, no matter how. As long as we keep praying and doing good, we will"*

(SR, Interview 1). For Subject NLS, self-efficacy was mediated by the perceived spiritual authority of the source: *"Before you drink it, there's already a prayer in it — you just have to be sincere and believe"* (NLS, Interview 1). Significant others reinforced this self-efficacy by expressing their own confidence in the treatment's outcome, thereby creating a social ecosystem of mutual reassurance. High self-efficacy in this context was thus not merely an individual cognitive state but a co-constructed belief maintained through ongoing social and spiritual support.

The findings align with the Health Belief Model (Rosenstock, 1988) and corroborate prior studies by Fanani and Dewi (2014) and Nurjannah and Laksmiwati (2023), emphasizing the pivotal role of spiritual values in health decision-making. The study demonstrates that the use of prayer water is not solely a rational health decision but also an expression of religious and cultural traditions. Perceived susceptibility and severity underscore the psychological and physical burdens of illness, driving individuals toward alternatives when conventional treatments fail. The prominence of perceived benefits, particularly spiritual and emotional gains, highlights the unique contribution of prayer water as a culturally embedded practice.

Low perceived barriers reflect Sleman's cultural acceptance of spiritual treatments, supported by community and religious networks, which contrasts with findings on alternative treatments in less culturally supportive contexts (Ernst, 2002). Cues to action, such as family and religious leader endorsements, align with the collectivist nature of Indonesian society, reinforcing treatment adoption. High self-efficacy, bolstered by social and spiritual support, further distinguishes this study, as it underscores the interplay of individual agency and communal influence.

This study contributes to the literature by illustrating how spiritual health practices are shaped by a complex interplay of personal perceptions, cultural norms, and religious beliefs, offering a novel perspective on the HBM's application in spiritual contexts.

Conclusion and Recommendations

This study set out to understand a genuine paradox: why do individuals in Sleman — a region with some of the highest healthcare provider density in Indonesia — choose prayer-based water (air doa) over evidence-based medical care? The Health Belief Model provides a compelling answer, but only when its dimensions are read as an integrated system rather than isolated factors. The core finding is that modern medicine, rather than displacing spiritual treatment, inadvertently enabled it. When biomedical examinations returned normal results for all three participants despite persistent and debilitating symptoms, perceived susceptibility and severity did not diminish — they intensified. The absence of a medical explanation created a perceptual vacuum that spiritual framing filled: the illness was re-attributed to non-biomedical causes, and prayer water was adopted as the most culturally coherent response available. The primacy of perceived benefits — particularly inner peace, spiritual closeness to God, and renewed hope — reveals that subjects were not rejecting medicine so much as seeking a dimension of healing that medicine could not provide. Low perceived barriers and strong cues to action (from family, religious leaders, and community norms) lowered the threshold for adoption, while high self-efficacy, co-constructed through collective Islamic faith and social support, sustained commitment to treatment. Together, these findings demonstrate that in a collectivist, devoutly Muslim society such as Sleman, the HBM dimensions do not operate independently: spiritual belief functions simultaneously as a perceived benefit, a self-efficacy resource, and a cue to action, creating a mutually reinforcing system that conventional medical outreach — however geographically accessible — is unlikely to displace without culturally sensitive engagement.

These findings carry practical implications for healthcare communication in Muslim-majority communities. Health educators and practitioners should recognise that for many patients, spiritual healing and biomedical treatment are not mutually exclusive choices but parallel pathways to wholeness. Programmes that acknowledge the legitimacy of Islamic healing practices while transparently communicating the risks

of delayed biomedical diagnosis — such as missed pathologies during the period of exclusive spiritual treatment — are more likely to build trust than those that dismiss traditional beliefs. This study also contributes methodologically by demonstrating that a multiple case study design, guided by deductive HBM thematic analysis, is well-suited to capturing both the commonalities and contextual variations in spiritual health decision-making. Future research should extend this framework to larger, more diverse samples, explore the role of digital platforms (such as WhatsApp prayer water communities) in reshaping cues to action, and examine whether the HBM's explanatory power holds across different religious traditions and cultural settings beyond the Javanese-Islamic context studied here.

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