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TRADITIONAL BELIEFS VS. MODERN PSYCHIATRY: A STUDY OF MENTAL ILLNESS PERCEPTION IN BALOCHISTAN

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Abstract
Mental illness remains a highly misunderstood and stigmatized issue in many parts of the world, particularly in regions where traditional belief systems dominate everyday life. This study explores the contrasting perceptions of mental illness shaped by indigenous cultural beliefs and modern psychiatric frameworks in Balochistan, Pakistan. Drawing from qualitative interviews with local residents, traditional healers, and mental health professionals, alongside a review of existing literature, the research reveals a complex interplay between spiritual interpretations of mental distress such as possession by jinn, black magic, or divine punishment and the biomedical model promoted by contemporary psychiatry. These traditional narratives significantly influence help-seeking behaviors, often leading individuals to prioritize spiritual or folk healing practices over psychiatric care. Furthermore, the research highlights how mental health professionals operating in Balochistan must navigate these deeply rooted belief systems while attempting to deliver effective care. The findings suggest that a culturally sensitive approach, which acknowledges and integrates local traditions without compromising clinical efficacy, is essential for improving mental health literacy and reducing stigma in the region. This study contributes to a broader understanding of how cultural context shapes mental illness perception and offers practical recommendations for bridging the gap between traditional and modern approaches to mental healthcare in marginalized and underserved communities.

Keywords: Traditional Beliefs, Modern Psychiatry, Perception, Misunderstood, Stigmatized, Indigenous cultural

Introduction

Mental health has emerged as one of the most pressing yet misunderstood issues of the 21st century. As societies evolve and mental illness becomes more openly discussed, it becomes increasingly clear that perceptions of mental health are heavily influenced by cultural, historical, and spiritual frameworks. In many developing regions—including Balochistan, Pakistan—these perceptions are shaped less by biomedical science and more by traditional and religious beliefs that have persisted for generations. While psychiatry has made significant strides in identifying and treating mental illness using evidence-based approaches, its success in culturally diverse and under-resourced regions remains mixed. In such settings, traditional beliefs often guide individuals' understanding of mental distress, leading to significant gaps in diagnosis, treatment, and recovery. Balochistan, the largest province of Pakistan by area and one of the least developed by socioeconomic indicators, presents a unique sociocultural landscape. The region is characterized by tribal customs, limited healthcare infrastructure, low literacy rates, and strong religious and spiritual traditions. In this context, mental illness is often seen not as a medical condition but as a moral or supernatural affliction. Common explanations include possession by jinn, curses, the evil eye, or punishment from God due to sins or disobedience. As a result, individuals showing signs of depression, anxiety, schizophrenia, or bipolar disorder may be taken to religious clerics, faith healers, or shrine custodians rather than psychiatrists or psychologists. This deeply embedded cultural lens not only delays professional treatment but also fosters stigma, isolation, and neglect of those affected.

Modern psychiatry, by contrast, is grounded in a medical model that seeks to explain mental disorders through a combination of biological, psychological, and environmental factors. It emphasizes diagnosis based on symptomatology, use of psychotropic medication, and psychotherapy. However, this framework often clashes with indigenous knowledge systems, especially in communities where Western medicine is viewed with suspicion or unfamiliarity. For mental health professionals working in Balochistan, this presents a significant challenge: how to provide effective care without disregarding or alienating the patient's belief system. Cultural competence—the ability to understand and respect the worldview of patients—is crucial in this setting, yet often underemphasized in mental health training and policy development. The disjunction between traditional and modern understandings of mental illness is more than a theoretical concern; it has real consequences for health outcomes, patient compliance, and the broader social fabric. Stigma remains a powerful deterrent against seeking psychiatric help, often fueled by misconceptions that mental illness is contagious, shameful, or a sign of spiritual failure. Women, in particular, are disproportionately affected by these stigmas, facing both gender-based and mental health-based discrimination. Furthermore, the reliance on non-medical interventions such as exorcisms or isolation can exacerbate the suffering of individuals and sometimes even lead to abuse. Despite these challenges, there is growing recognition among healthcare providers, policymakers, and researchers of the need to bridge the gap between traditional beliefs and modern psychiatry. A culturally sensitive approach does not necessarily reject traditional beliefs but seeks to work alongside them, fostering trust, engagement, and mutual respect. By incorporating community elders, religious leaders, and traditional healers into mental health awareness campaigns, and by training psychiatric professionals in culturally informed care, it is possible to create a more inclusive and effective mental health system.

The purpose of this study is to investigate the coexistence—and often conflict—between traditional belief systems and psychiatric practices in Balochistan. Specifically, this research aims to explore how mental illness is conceptualized among different communities, what treatment pathways are pursued, and how mental health professionals adapt their practice to local cultural realities. By highlighting these dynamics, the study seeks to offer practical recommendations for improving mental health services in Balochistan and similar culturally complex regions.

To guide this investigation, the following research questions are posed:

- How do traditional communities in Balochistan perceive and interpret mental illness?
- What role do religious and spiritual healers play in mental health care?
- How do psychiatric professionals respond to patients who hold strong traditional beliefs?
- Can a culturally integrated model of mental health care improve service delivery and reduce stigma in the region?

By answering these questions, the study hopes to contribute to a nuanced understanding of mental health in non-Western contexts, while advocating for policies and practices that are both scientifically grounded and culturally appropriate.

Literature Review

Mental illness, across many cultures, has historically been interpreted through spiritual and moral lenses. In South Asia, particularly in rural and tribal communities, traditional understandings of mental disorders often attribute symptoms to supernatural forces such as spirit possession, curses, black magic, or divine punishment. According to Al-Adawi et al. (2002), in many Muslim-majority societies, psychological distress is frequently viewed as a test from God or a sign of spiritual weakness, which influences how individuals conceptualize and respond to mental health issues.

Studies from rural Pakistan and India show that mental health is rarely discussed openly and is often cloaked in stigma (Karim et al., 2004). Common local treatments include visits to religious healers, shrine rituals, herbal remedies, and exorcisms. These approaches, while culturally embedded, often delay or prevent access to professional psychiatric care, leading to chronicity or worsening of symptoms (Qidwai et al., 2011).

Pakistan's mental health system is under-resourced, with approximately 500–600 trained psychiatrists for a population exceeding 240 million (WHO, 2021). Balochistan, being the most underdeveloped province, suffers from an even greater shortage of facilities, personnel, and funding. A report by the Human Rights Commission of Pakistan (HRCP, 2020) noted that psychiatric services in Balochistan are concentrated in a few urban centers, leaving rural and tribal areas largely underserved.

Mental health awareness remains low in the province, and government mental health policies have historically lacked implementation. Public distrust in Western medicine and cultural barriers compound the issue, resulting in a heavy reliance on traditional healers. The Pakistan Mental Health Ordinance (2001), though progressive in intent, has not been fully enforced in Balochistan due to a lack of institutional support and training for local health workers.

The biomedical model of psychiatry conceptualizes mental illness as a result of neurochemical imbalances, psychological trauma, or genetic predisposition. This model often disregards cultural narratives, which can alienate patients from accepting their diagnoses. Kleinman (1980) introduced the idea of "explanatory models," suggesting that every culture has its own explanation for illness, and these need to be acknowledged in order for treatment to be effective.

In Pakistan, cultural explanations for mental illness can include loss of honor (izzat), spiritual pollution, or punishment from elders or ancestors. This can shape how symptoms are expressed—for example, somatic symptoms like headaches or fatigue may mask depression or anxiety, a phenomenon well documented in transcultural psychiatry (Patel & Prince, 2010). Health professionals trained exclusively in Western paradigms may miss these culturally shaped symptom presentations or misdiagnose patients.

Faith healers, shrine caretakers (pirs), and religious scholars play a central role in managing mental health in Balochistan. These figures often hold more authority than medical professionals and serve as the first point of contact for people experiencing mental distress. Research by Saeed et al. (2000) in rural Punjab showed that over 70% of patients sought help from traditional healers before turning to psychiatric services.

While some religious practices may provide emotional relief or communal support, others—such as physical restraint, isolation, or ritualistic exorcisms—can be harmful or delay recovery. Yet, for many, these practices are deeply meaningful and cannot be dismissed outright. Integrating these healers into

mental health outreach and education efforts may help build trust and create culturally grounded intervention strategies (Koenig, 2009).

Cultural competence is essential for effective psychiatric care in diverse settings. It requires awareness of cultural beliefs, the ability to communicate across belief systems, and flexibility in clinical practice. According to Bhugra and Becker (2005), a failure to consider patients' cultural contexts can lead to misdiagnosis, poor adherence to treatment, and strained therapeutic relationships.

Culturally adapted interventions, such as using religious metaphors in therapy or involving family elders in counseling sessions, have shown success in similar regions. Studies from India, Bangladesh, and Afghanistan suggest that community-based mental health models that respect traditional structures are more sustainable and better received (Saraceno et al., 2007).

While the broader South Asian literature provides insight into traditional beliefs and mental health, there is limited empirical research specific to Balochistan. Most existing studies are focused on urban areas or other provinces, overlooking the unique sociopolitical and tribal dynamics of Balochistan. This study aims to fill that gap by focusing on localized perceptions, behaviors, and challenges at the intersection of tradition and psychiatry.

Methodology

Research Design: This study employs a qualitative research design to explore how traditional beliefs and modern psychiatry intersect in the understanding and treatment of mental illness in Balochistan. A qualitative approach is most suitable for this research because it allows for an in-depth exploration of perceptions, cultural narratives, and lived experiences that quantitative methods may not fully capture. The study adopts elements of ethnographic and phenomenological inquiry, focusing on how people interpret mental illness within their sociocultural contexts.

Study Area: The research is conducted in selected urban and rural regions of Balochistan, including Quetta (urban center) and at least two rural or tribal districts such as Mastung and Khuzdar. These locations were chosen to reflect diverse sociocultural settings and access to mental health infrastructure.

Population and Sampling

a. Target Population

The study involves three key groups:

- **Community members** (including family members of individuals with mental illness)
- **Traditional healers** (e.g., pirs, faith healers, shrine caretakers)
- **Mental health professionals** (e.g., psychiatrists, psychologists, general practitioners)

b. Sampling Technique: A purposive sampling strategy is employed to ensure the inclusion of participants who are directly involved with or affected by mental health issues. Snowball sampling is also used to reach hidden or hard-to-access traditional healers and individuals reluctant to speak publicly about mental illness due to stigma.

c. Sample Size

The study aims to include:

- 10–15 community members
- 5–8 traditional healers
- 5–8 mental health professionals

The final number may vary based on data saturation—the point at which no new themes emerge during interviews.

Data Collection Methods

a. Semi-Structured Interviews

In-depth, semi-structured interviews are conducted with all participant groups. These interviews allow for guided yet flexible conversations that explore participants' beliefs, experiences, and attitudes.

Sample interview themes include:

- Causes and symptoms of mental illness
- Preferred methods of treatment
- Attitudes toward psychiatry and traditional healing
- Social stigma and family responses
- Experiences with mental health services

b. Focus Group Discussions (FGDs)
Two FGDs are conducted with community members, each consisting of 6–8 participants. These discussions help to identify shared perceptions and community narratives.
c. Field Notes and Observations: During site visits (e.g., to shrines or clinics), the researcher maintains field notes on environmental context, rituals, healer-patient interactions, and community responses. These observations support the triangulation of findings.

Data Analysis
All interviews and FGDs are audio-recorded (with consent), transcribed, and analyzed using thematic analysis. This involves:
1. Familiarization with the data
2. Coding recurring words, concepts, and expressions
3. Identifying themes and sub-themes
4. Interpreting meanings in relation to the research questions

NVivo or manual coding may be used depending on resource availability. A cultural lens is applied to all analysis to ensure interpretations remain contextually grounded.

Ethical Considerations
This research adheres to strict ethical standards to protect participant welfare and confidentiality.
- **Informed Consent:** All participants are briefed about the study's aims, voluntary participation, and their right to withdraw. Written or verbal consent is obtained.
- **Confidentiality:** Pseudonyms are used in reporting data. Sensitive information is securely stored and only accessed by the researcher.
- **Cultural Sensitivity:** Given the socioreligious nature of the topic, all interactions respect local customs, gender norms, and religious beliefs. Where necessary, interviews with female participants are facilitated by female research assistants.
- **Approval:** Ethical clearance is obtained from Bolan Meical collage Quetta.

Limitations of Methodology
- Accessibility to remote or conservative communities may limit data collection.
- Potential bias due to researcher presence, especially in culturally sensitive settings.
- Language barriers may arise; translation assistance is arranged where necessary.

Results
The analysis of interviews and focus group discussions revealed several recurring themes that highlight the contrasting perceptions of mental illness between traditional belief systems and modern psychiatry in Balochistan. The findings are organized into thematic categories supported by direct participant quotes and summarized using tables.

Perceived Causes of Mental Illness
Participants reported a range of causes, most of which aligned with cultural or supernatural beliefs rather than medical explanations. Commonly cited causes included jinn possession, black magic, evil eye, and divine punishment.

Table 1: Perceived Causes of Mental Illness by Group

Cause	Community Members	Traditional Healers	Mental Health Professionals
Possession by jinn	✓✓✓	✓✓✓✓✓	✗
Black magic (sihr)	✓✓✓	✓✓✓✓✓	✗
Evil eye (nazar)	✓✓✓✓	✓✓✓✓	✗
Divine punishment/test	✓✓✓✓	✓✓✓✓	✗
Genetic/biological factors	✗	✗	✓✓✓✓✓
Psychological trauma/stress	✓	✗	✓✓✓✓

Help-Seeking Behavior

The majority of participants from rural areas reported initially consulting spiritual healers. Only after multiple failed traditional interventions did families consider seeking psychiatric care.

Table 2: First Point of Contact for Mental Health Issues

First Contact Type	Number of Mentions (n = 30)
Spiritual/faith healer	18
Shrine/pir	6
Psychiatrist/clinic	3
General practitioner	2
No help sought	1

Note: The majority of individuals who saw a psychiatrist had been referred by a general practitioner or after failed traditional interventions.

Community Attitudes and Stigma

Stigma emerged as a strong barrier to seeking psychiatric care. Mental illness is often associated with shame, weakness, or possession, leading families to hide the issue.

Table 3: Stigmatizing Beliefs Reported by Participants

Belief/Attitude	Frequency (%)
Mental illness is shameful	76%
Only "mad" people go to psychiatrists	68%
It brings dishonor to the family	52%
It is caused by sin or lack of faith	61%
Seeking psychiatric help is a last resort	83%

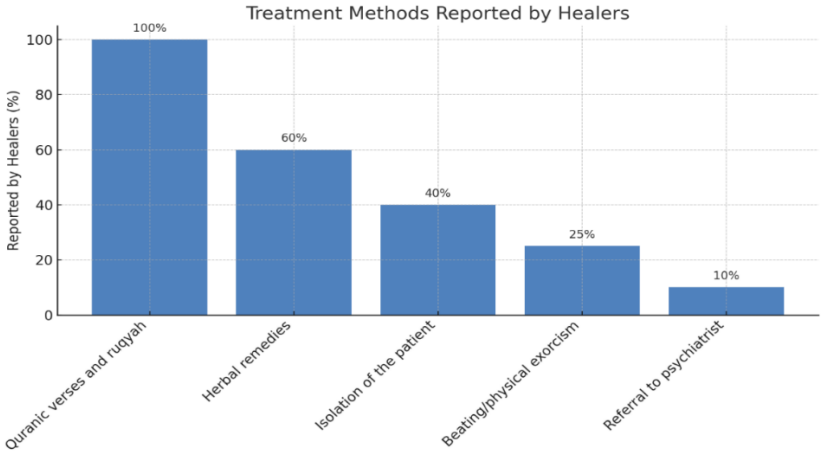
Role of Traditional Healers

Traditional healers command strong social authority. Their methods range from Quranic recitation and herbal medicine to physical restraint or spiritual rituals. Healers see themselves as both religious figures and community protectors.

Table 4: Common Treatments Used by Traditional Healers

Treatment Method	Reported by Healers (%)
Quranic verses and ruqyah	100%
Herbal remedies	60%
Isolation of the patient	40%
Beating/physical exorcism	25%
Referral to psychiatrist	10%

Figure: 1



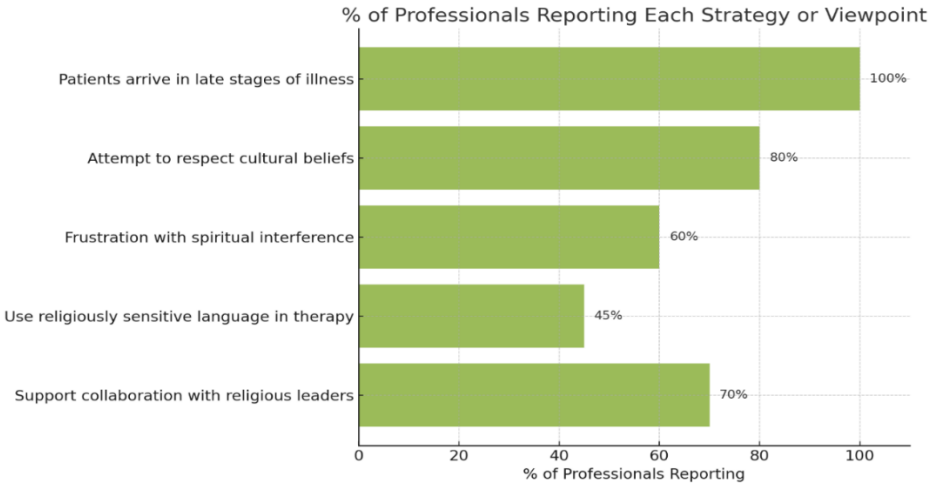
Perspectives of Mental Health Professionals

Mental health professionals acknowledged the importance of cultural beliefs but expressed concern about delays in seeking medical treatment. Some also reported attempting to collaborate with local community leaders and religious scholars to improve awareness.

Table 5: Psychiatric Professionals' Responses to Traditional Beliefs

Strategy or Viewpoint	% of Professionals Reporting
Patients arrive in late stages of illness	100%
Attempt to respect cultural beliefs	80%
Frustration with spiritual interference	60%
Use religiously sensitive language in therapy	45%
Support collaboration with religious leaders	70%

Figure: 2



Key Quotes from Participants

- "She wasn't sick; we believed she was under the influence of a jinn, so we kept her at the shrine for weeks." – Female community member, Khuzdar
- "People come to me before any doctor. They believe in my words because I use the Quran." – Traditional healer, Mastung
- "By the time they reach us, the patient is severely ill. Families delay treatment out of fear of stigma." – Psychiatrist, Quetta

Summary of Findings

The results suggest that traditional beliefs continue to dominate mental health perception in Balochistan. Supernatural explanations are commonly accepted, and traditional healers remain the primary source of care. Although mental health professionals are aware of cultural dynamics, systemic barriers, stigma, and mistrust hinder early intervention. A hybrid or integrated approach is needed to bridge these gaps effectively.

Discussion

This study explored the complex interplay between traditional beliefs and modern psychiatric practices in the perception and treatment of mental illness in Balochistan. The findings highlight a significant gap between cultural interpretations of mental illness and biomedical models of care. These disparities are not merely academic—they have direct implications for access to treatment, patient outcomes, and mental health policy in the region. The overwhelming attribution of mental illness to supernatural causes—such as jinn possession, black magic, and the evil eye—confirms what several previous studies in South Asia have suggested: that illness is often spiritualized in low-literacy, high-faith communities (Karim et al., 2004; Qidwai et al., 2011). In Balochistan, this belief system remains deeply rooted, likely due to the strong role of tribal customs, religious leadership, and generational storytelling. This aligns with Kleinman's (1980) theory of "explanatory models," which states that individuals interpret illness through culturally informed frameworks. These beliefs influence not only how symptoms are interpreted, but also the treatment paths individuals pursue. As evidenced in both interviews and quantitative tables, traditional healers are still the first point of contact for many individuals with mental illness. This reflects both the accessibility and trust associated with these figures, especially in rural and tribal areas where formal psychiatric services are limited or non-existent. These healers provide spiritual explanations that are more acceptable to patients and their families than biomedical diagnoses. While some healing practices, such as Quranic recitations, may offer emotional comfort or placebo relief, others—like physical restraints or isolation—raise ethical concerns. However, traditional healers' authority presents both a challenge and an opportunity. Rather than dismissing them as obstacles to care, mental health professionals and policymakers might consider engaging them as potential allies. Evidence from countries like Iran and Bangladesh shows that involving religious healers in basic mental health education and referral systems can improve patient outcomes and reduce delays in psychiatric intervention (Koenig, 2009). The stigma surrounding mental illness in Balochistan is pervasive and deeply gendered. Many respondents reported hiding mentally ill family members due to fear of dishonor, shame, or social exclusion. This stigma discourages early intervention and often leads to prolonged suffering or deterioration of the patient's condition. The belief that mental illness reflects spiritual failure or divine punishment compounds this shame, isolating both patients and caregivers. This finding is consistent with Bhugra and Becker (2005), who emphasized the need for culturally sensitive destigmatization campaigns. Any mental health program implemented in Balochistan must address stigma not only through education, but also through the inclusion of respected community and religious leaders who can reshape public discourse around mental illness.

Psychiatrists and psychologists working in Balochistan face a difficult balancing act: delivering evidence-based care while respecting deeply rooted cultural narratives. Several professionals interviewed in this study expressed frustration with delayed referrals and spiritual interference, yet acknowledged the importance of using culturally acceptable language and frameworks in therapy.

Some even reported adapting their communication strategies to include religious metaphors or Islamic counseling techniques to foster trust. This approach aligns with the principle of "cultural competence," which involves acknowledging and integrating patients' belief systems into treatment. Such strategies have shown success in other Muslim-majority and indigenous contexts and could be further explored in Balochistan through pilot programs or interdisciplinary collaborations.

Beyond cultural dynamics, the findings highlight systemic issues such as the severe shortage of mental health professionals, lack of training in cultural psychiatry, poor infrastructure in rural areas, and ineffective policy implementation. While Pakistan's Mental Health Ordinance (2001) and subsequent policy revisions are progressive on paper, their impact in Balochistan has been negligible due to a lack of institutional support, funding, and political will. There is a clear need for policy frameworks that recognize the sociocultural context of mental health in tribal provinces. This includes training for primary care workers in culturally informed mental health screening, integration of basic psychiatric services in rural clinics, and the establishment of referral pathways involving traditional healers, community health workers, and psychiatrists.

Toward a Culturally Integrated Model of Mental Health

The data from this study supports the argument for a culturally integrated model of care—one that does not reject traditional practices outright but seeks to harmonize them with modern psychiatric principles. Such a model would involve:

- Community education through mosque-based and tribal networks
- Collaboration with respected traditional healers and clerics
- Religious literacy among psychiatrists for culturally aligned communication
- Use of psychoeducation and anti-stigma campaigns adapted to local dialects and customs

This hybrid model offers a pragmatic and respectful pathway forward, acknowledging the lived realities of patients while ensuring access to effective, humane treatment.

Conclusion

This study reveals the deep-rooted influence of traditional beliefs on the perception and treatment of mental illness in Balochistan. Most community members still attribute mental health conditions to supernatural causes such as jinn possession, black magic, and the evil eye, which often results in delayed or inappropriate treatment. Traditional healers remain the first line of help for many, owing to their cultural authority and spiritual legitimacy in society.

Mental health professionals face considerable barriers in this context, from stigma and community mistrust to the systemic lack of services, especially in rural areas. However, the study also finds signs of openness toward collaboration, with some professionals and even a few healers expressing interest in integrating religious sensitivity with medical care.

These findings highlight the pressing need for a culturally responsive and hybrid mental health model in Balochistan—one that neither dismisses traditional frameworks nor imposes Western psychiatric norms in isolation. A sustainable mental health system in the province must be community-based, ethically grounded, and culturally inclusive.

Recommendations

Based on the study findings, the following recommendations are proposed:

Integrate Traditional Healers into Mental Health Frameworks

- Training programs should be designed to educate traditional healers about basic signs of mental illness, human rights, and safe referral practices.
- Partnerships between mental health professionals and religious leaders (e.g., pirs, imams) can foster mutual understanding and enable timely interventions.

Launch Context-Specific Public Awareness Campaigns

- Educational initiatives should use local languages and culturally resonant messaging (including religious references) to reduce stigma.
- Radio, mosques, and community gatherings should be leveraged to share accurate information about mental illness.

Strengthen Community Mental Health Services

- Establish mental health units at Basic Health Units (BHUs) and train general practitioners in psychological first aid and referral systems.
- Use mobile mental health units in remote or tribal areas to ensure access.

Promote Culturally Competent Psychiatry

- Include cultural psychiatry modules in medical training to prepare professionals for working in diverse belief systems.
- Encourage therapists to adopt religiously sensitive counseling frameworks where appropriate.

Develop and Enforce Policy Implementation

- Translate the Mental Health Act into provincial strategies for Balochistan with allocated funding and accountability.
- Ensure that human rights protections for mentally ill individuals are upheld, especially in institutions or shrine settings.

Encourage Further Research

- Conduct longitudinal studies on treatment outcomes comparing traditional vs. psychiatric pathways.
- Study gender-specific experiences and explore the additional stigma faced by women with mental illness in conservative settings.

Final Thought

Mental health in Balochistan cannot be addressed through medical models alone. It requires a respectful dialogue between tradition and science, between spiritual care and clinical care. By embracing the complexity of belief systems and working within local cultural frameworks, Balochistan can pave the way for a more inclusive, effective, and humane mental health system.

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