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# Beyond '*Kerasukan*': Integrating Traditional Beliefs with Modern Psychiatric Frameworks in Indonesia's Mental Health Discourse

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## Abstract

In many Indonesian communities, mental health crises are frequently interpreted through the lens of spiritual possession (*kerasukan*) or supernatural intervention. This study explores the discursive gap between traditional healing practices and modern psychiatric frameworks. Through a qualitative multi-sited ethnography involving spiritual healers (*dukun*), psychiatrists, and families of patients in Java and South Sulawesi, the research investigates how pluralistic health-seeking behaviors are negotiated. The results reveal that while clinical psychiatry is increasingly accessible, patients often prefer a hybrid approach that addresses both biological symptoms and spiritual anxieties. The study identifies "cultural translation" as a critical missing link in Indonesia's public health policy, where psychiatric interventions often fail due to a lack of engagement with local ontological beliefs. By proposing a collaborative model of "culturally-informed psychiatry," this research contributes to the global

discourse on decolonizing mental health. It argues that recognizing the validity of cultural idioms of distress is essential for improving treatment adherence and reducing the stigma associated with mental illness in non-Western contexts.

**Keywords:** Mental Health, Traditional Healing, Psychiatry, Cultural Idioms of Distress, Indonesia

## Introduction

Over the past two decades, the Global Mental Health (GMH) movement has emerged as a transnational effort to reduce disparities in access to mental health care, particularly in low- and middle-income countries. Landmark initiatives such as the World Health Organization Mental Health Gap Action Programme (mhGAP) have promoted the scaling up of standardized, evidence-based interventions through task-shifting and primary care integration (Patel et al., 2018). While these efforts have increased visibility and funding for mental health, they have also intensified debates regarding the epistemological foundations of psychiatric knowledge. Critics argue that GMH initiatives often assume the universality of Western diagnostic categories and therapeutic models, thereby risking the marginalization of culturally embedded understandings of distress (Fernando, 2014). This tension situates global mental health within broader conversations about power, knowledge production, and the politics of expertise in international health governance.

Central to these critiques is the global dominance of DSM-based psychiatry, institutionalized through the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The DSM's symptom-based, categorical framework has become the lingua franca of psychiatric diagnosis, shaping research protocols, insurance systems, and clinical training worldwide. However, anthropologists and transcultural psychiatrists caution that such classificatory systems are not culturally neutral but are historically situated within Euro-American biomedical traditions (Kirmayer & Pedersen, 2014). The universal application of these categories may obscure local idioms of distress, moral worlds, and spiritual ontologies that structure experiences of suffering in non-Western societies. Consequently, the exportation of DSM frameworks can inadvertently produce

epistemic hierarchies in which indigenous interpretations are reframed as superstition or misrecognition.

In response, scholars have called for the decolonization of mental health, emphasizing epistemic pluralism and community-grounded models of care (Mills, 2014). Decolonizing approaches do not reject psychiatry *per se*; rather, they question its uncritical universalization and advocate for dialogical engagement between biomedical and local systems of meaning. This perspective foregrounds “cultural idioms of distress” as legitimate forms of expressing psychological suffering that must be interpreted within their sociocultural contexts (Kirmayer & Pedersen, 2014). In the Global South, where spiritual, relational, and cosmological dimensions of illness often coexist with biomedical explanations, mental health interventions that ignore these dimensions risk limited uptake and sustainability. Thus, the challenge is not merely to expand services but to reconceptualize care in ways that are culturally intelligible and ethically responsive.

Indonesia presents a compelling case for examining these tensions, given its rich tapestry of religious traditions, local cosmologies, and rapidly modernizing health infrastructure. Across regions such as Java and South Sulawesi, acute psychological disturbances are frequently interpreted through concepts of spirit possession (*kerasukan*), sorcery, or disruptions in spiritual balance. These interpretations are embedded within Islamic, animist, and syncretic belief systems that shape everyday moral life. Mental crises, therefore, are not solely viewed as individual pathologies but as disturbances within relational and spiritual networks. Such ontological orientations profoundly influence help-seeking behaviors and community responses to distress.

Within this landscape, spiritual healers—commonly referred to as *dukun*—play a pivotal role. They offer ritual healing, prayer, herbal remedies, and divination practices that address both metaphysical causation and psychosocial stressors. Their authority derives not only from perceived spiritual power but also from social embeddedness and cultural legitimacy. For many families, consulting a *dukun* constitutes a first-line response to unusual behavior, hallucinations, or emotional volatility. Importantly, these practices are not necessarily opposed to biomedical treatment; rather, they reflect a pluralistic health logic in which multiple explanatory models coexist and are sequentially or simultaneously mobilized.

Concurrently, Indonesia has expanded its formal mental health services under the coordination of the Kementerian Kesehatan Republik Indonesia. National reforms have promoted community-based mental health care, integration into

primary health centers (puskesmas), and the reduction of coercive practices such as pasung. Legislative frameworks, including the 2014 Mental Health Act, signal the state's commitment to rights-based psychiatric services. Nevertheless, infrastructural limitations, uneven specialist distribution, and persistent stigma continue to shape service utilization. As a result, many Indonesians navigate a hybrid therapeutic pathway that combines hospital psychiatry with traditional healing, reflecting both pragmatic considerations and deeply rooted ontological commitments.

Despite policy advancements, a significant discursive gap persists between spiritual ontologies and biomedical paradigms. Psychiatric professionals typically conceptualize severe disturbances—such as psychosis or major mood disorders—through neurobiological and psychosocial frameworks grounded in standardized diagnostic criteria. In contrast, patients and families may interpret identical symptoms as evidence of possession, divine testing, or spiritual imbalance. When clinicians dismiss these interpretations as irrational, they risk undermining trust and weakening therapeutic alliances. Conversely, exclusive reliance on spiritual healing may delay critical psychiatric intervention. The problem, therefore, is not simply one of access but of epistemological misalignment.

This study conceptualizes the gap as a failure of “cultural translation,” defined as the process of rendering meanings intelligible across distinct ontological systems. Without such translation, psychiatric encounters may reproduce asymmetrical power relations in which biomedical knowledge is privileged and local belief systems are delegitimized. Anthropological research suggests that recognition of patients' explanatory models enhances treatment adherence and reduces stigma (Kirmayer & Pedersen, 2014). In Indonesia, however, structured mechanisms for integrating spiritual perspectives into clinical settings remain limited. Addressing this lacuna requires moving beyond cultural competence as individual sensitivity toward institutionalized forms of collaboration and dialogue.

Guided by these concerns, this study addresses three primary research questions. First, how are mental health crises interpreted and narrated within Javanese and South Sulawesi communities, particularly in relation to spirit possession and moral disruption? Second, how do families, dukun, and psychiatrists negotiate authority, legitimacy, and therapeutic decision-making in contexts of pluralistic belief? Third, how does public health policy respond to—or fail to accommodate—this ontological pluralism? Through multi-sited ethnographic research, the study foregrounds lived negotiations rather than abstract dichotomies between “traditional” and “modern” medicine.

The study contributes to the broader discourse on decolonizing global mental health by proposing a model of “culturally-informed psychiatry” grounded in epistemological integration. Rather than subordinating traditional healing to biomedical authority, the model envisions structured collaboration, mutual referral pathways, and dialogical training frameworks. By situating Indonesian experiences within global critiques of psychiatric universalism (Fernando, 2014; Mills, 2014), the research offers comparative insight into how non-Western societies navigate psychiatric modernity. Ultimately, recognizing cultural idioms of distress as meaningful—not merely symbolic—constitutes both an ethical commitment and a pragmatic strategy for enhancing treatment adherence, reducing stigma, and strengthening public trust in mental health systems.

## Literature Review

### *A. Cultural Psychiatry and Idioms of Distress*

Cultural psychiatry has long challenged the assumption that mental disorders are universally experienced and expressed in identical forms across societies. Central to this field is the concept of “cultural idioms of distress,” which refers to socially and linguistically patterned ways of experiencing, expressing, and interpreting psychological suffering (Kirmayer & Pedersen, 2014). Idioms of distress function as communicative bridges between individual experience and collective meaning systems, embedding symptoms within moral, spiritual, and relational frameworks. Rather than viewing such idioms as distortions of “true” pathology, cultural psychiatry understands them as culturally legitimate articulations of suffering. This perspective underscores that diagnostic categories are always interpreted through local symbolic systems, thereby complicating claims of universality in psychiatric nosology.

A foundational contribution to this discussion is the work of Arthur Kleinman, particularly his formulation of “explanatory models.” Kleinman (1980) argued that patients, families, and clinicians each hold culturally shaped explanations regarding the cause, course, and appropriate treatment of illness. These explanatory models influence help-seeking behavior, therapeutic expectations, and clinical outcomes. When biomedical practitioners fail to elicit and engage with patients’ models, misunderstandings and non-adherence may follow. Kleinman’s framework thus shifted attention from symptom classification alone to the interpretive processes that

structure illness narratives. In pluralistic societies, multiple explanatory models may coexist and be strategically mobilized, further highlighting the necessity of dialogical engagement within psychiatric encounters.

Building on these insights, scholars have critiqued the global dominance of DSM-based psychiatry, institutionalized through the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Although the DSM includes a Cultural Formulation Interview, critics contend that its categorical structure remains grounded in Western epistemologies that privilege symptom clusters over contextual meaning (Mills, 2014). The risk lies not only in misdiagnosis but also in epistemic marginalization, whereby culturally embedded experiences are reframed as deviations from biomedical norms. Consequently, cultural psychiatry advocates for reflexive practice that situates diagnostic reasoning within broader sociohistorical and cosmological contexts.

### *B. Spirit Possession and Mental Health*

Spirit possession has been widely documented across cultures as a meaningful framework for interpreting altered states of consciousness, behavioral changes, and emotional disturbances. Anthropological research demonstrates that possession states may function as culturally sanctioned expressions of distress, moral protest, or social commentary rather than as unequivocal indicators of psychopathology (Boddy, 1994). In many contexts, possession provides a culturally intelligible narrative that situates suffering within spiritual or communal dynamics. This framing can reduce individual blame and redistribute responsibility to supernatural or relational forces, thereby shaping community responses and therapeutic strategies.

Comparative studies in Southeast Asia reveal diverse interpretations of possession, often embedded within Islamic, animist, or syncretic cosmologies. In Indonesia and Malaysia, for instance, possession (*kerasukan*) may be attributed to jinn, ancestral spirits, or sorcery, and treatment commonly involves ritual healing and Qur'anic recitation. Such practices are frequently pursued alongside biomedical care, reflecting pragmatic pluralism rather than categorical opposition. In contrast, research in parts of Africa—such as studies of zar cults in Sudan and Ethiopia—illustrates how possession rituals can serve as structured communal therapies that provide social recognition and emotional catharsis (Boddy, 1994). While biomedical psychiatry may interpret certain possession phenomena as dissociative or psychotic disorders, cross-cultural scholarship cautions against reductive pathologization.

These comparative insights suggest that possession cannot be uniformly equated with mental illness; instead, its meaning depends on local ontologies and social institutions. In some cases, possession states are transient and socially integrative; in others, they overlap with severe psychiatric conditions requiring clinical intervention. The challenge for mental health practitioners lies in discerning when possession narratives function as adaptive idioms of distress and when they mask conditions that benefit from biomedical treatment. This interpretive tension underscores the importance of culturally informed assessment frameworks capable of navigating spiritual epistemologies without either romanticizing or dismissing them.

### *C. Medical Pluralism and Hybrid Health-Seeking*

The concept of medical pluralism provides a theoretical lens for understanding the coexistence of multiple healing systems within a single sociocultural context. Medical pluralism recognizes that individuals often draw upon diverse therapeutic resources—including biomedicine, traditional healing, and religious practices—based on accessibility, perceived efficacy, and cultural legitimacy (Leslie, 1980). Rather than viewing these systems as mutually exclusive, anthropologists emphasize their dynamic interaction and negotiated boundaries. Patients and families may sequentially or simultaneously consult hospitals, spiritual healers, and herbalists, constructing hybrid pathways of care that reflect both pragmatic and symbolic considerations.

Negotiations between biomedicine and traditional healing are shaped by power relations, professional hierarchies, and state regulation. Biomedical institutions frequently claim scientific authority, while traditional healers derive legitimacy from spiritual charisma and community trust. In practice, however, boundaries are porous. Families may seek psychiatric diagnosis to obtain medication while continuing ritual treatments to address spiritual causation. Such hybrid strategies complicate linear models of modernization that presume the eventual replacement of traditional systems by biomedicine. Instead, pluralism persists as a structural feature of many societies, including Indonesia.

Importantly, medical pluralism also reveals the limitations of top-down health reforms that assume rational choice models of service utilization. Decisions are embedded in kinship networks, moral obligations, and economic constraints. Hybrid health-seeking can thus be understood as a rational response to ontological uncertainty, where multiple explanatory models are maintained to maximize

therapeutic possibility. Recognizing this logic is essential for designing mental health policies that engage, rather than dismiss, pluralistic practices.

#### *D. Decolonizing Global Mental Health*

The call to decolonize global mental health emerges from critiques of technocratic, top-down interventions that prioritize scalability over contextual depth (Mills, 2014). Programs spearheaded by institutions such as the World Health Organization have significantly advanced advocacy and resource mobilization, yet they have also been critiqued for insufficient engagement with local epistemologies. Decolonizing perspectives argue that exporting standardized psychiatric packages risks reproducing colonial hierarchies of knowledge, wherein Western diagnostic categories are treated as universally valid while indigenous frameworks are relegated to the realm of culture or belief.

Advocates of epistemological integration propose that mental health systems must incorporate local cosmologies, healing traditions, and community actors into formal service structures. This approach moves beyond superficial cultural competence toward structural transformation, including participatory policy design and collaborative training. Rather than positioning local healers as obstacles to modernization, decolonizing frameworks consider them potential partners in expanding access and enhancing legitimacy. Such integration, however, requires careful negotiation to ensure ethical standards, human rights protections, and evidence-informed practice are upheld.

Decolonization thus involves both epistemic humility and institutional innovation. It demands that mental health professionals critically examine the cultural assumptions embedded in diagnostic tools, therapeutic modalities, and research methodologies. At the same time, it calls for policies that facilitate dialogue between biomedical and traditional practitioners without collapsing important distinctions. This balance remains a central challenge for global mental health reform.

#### *E. Research Gap*

Despite extensive theoretical debates, empirical research on the interaction between psychiatry and spiritual healing in Indonesia remains limited. Existing studies often focus on single sites or specific disorders, providing valuable but fragmented insights.

Multi-sited ethnographic research that compares regions with distinct religious and cultural traditions—such as Java and South Sulawesi—is relatively scarce. As a result, broader patterns of negotiation, translation, and conflict between dukun and psychiatrists remain underexplored. The absence of comparative analysis constrains the development of contextually nuanced theoretical models.

Furthermore, there is a notable lack of integrative policy frameworks grounded in local practice. While national mental health reforms emphasize community-based care, few institutional mechanisms formally engage traditional healers in referral systems or collaborative dialogue. Without such models, cultural translation remains an informal and individualized process dependent on personal initiative rather than systemic design. Addressing this research gap requires empirically grounded frameworks capable of informing policy innovation.

By situating Indonesian case studies within global scholarship on cultural psychiatry, possession, medical pluralism, and decolonization, this study seeks to bridge theoretical and policy domains. It advances the argument that culturally-informed psychiatry must be institutionally embedded, empirically grounded, and epistemologically plural. Through multi-sited ethnography, the research responds to calls for deeper contextual engagement in global mental health while contributing regionally specific insights to an expanding international discourse.

## Theoretical Framework

### *A. Medical Pluralism*

This study is grounded in the theory of medical pluralism, which conceptualizes the coexistence of multiple healing systems within a single sociocultural field. Medical pluralism challenges linear modernization narratives that predict the eventual dominance of biomedicine, instead emphasizing the persistent and dynamic interaction between formal and informal health sectors (Leslie, 1980). In many postcolonial societies, including Indonesia, state-regulated psychiatric services operate alongside spiritual healing, herbal medicine, and religious counseling. These systems are not merely parallel; they overlap, compete, and at times collaborate, forming a complex therapeutic marketplace in which authority and legitimacy are continually negotiated.

Within this framework, biomedicine is typically associated with institutional legitimacy, scientific rationality, and regulatory oversight, whereas informal

systems—such as dukun-led spiritual healing—derive credibility from cultural embeddedness and moral authority. Patients and families navigate these systems pragmatically, often pursuing sequential or simultaneous consultations. Medical pluralism thus provides an analytical lens for understanding hybrid health-seeking behaviors not as confusion or irrationality but as contextually rational strategies in environments characterized by ontological multiplicity. By foregrounding coexistence rather than substitution, this framework enables a nuanced examination of how psychiatric and spiritual paradigms intersect in practice.

### *B. Explanatory Models of Illness*

To analyze how individuals interpret mental distress, this study draws on the concept of explanatory models developed by Arthur Kleinman. Explanatory models refer to the culturally shaped beliefs that patients, families, and clinicians hold regarding the causes, symptoms, trajectory, and appropriate treatment of illness (Kleinman, 1980). These models structure help-seeking decisions and shape expectations of recovery. In contexts where mental crises may be attributed to spirit possession, divine testing, or sorcery, explanatory models extend beyond neurobiological causation to encompass moral and cosmological dimensions.

Applying this framework involves examining how patients and their kin narrate the onset of symptoms, identify perceived etiologies, and evaluate therapeutic efficacy. Divergences between biomedical and spiritual explanatory models can produce tension within clinical encounters, particularly when psychiatric interpretations are perceived as dismissive of deeply held beliefs. Conversely, areas of convergence—such as shared concern for restoring social functioning—may provide entry points for collaboration. By systematically eliciting and comparing explanatory models, this study highlights the interpretive processes that mediate between symptom presentation and therapeutic choice, thereby illuminating the epistemological negotiations embedded in pluralistic care pathways.

### *C. Cultural Translation*

Building upon medical pluralism and explanatory models, the concept of cultural translation serves as a central analytical tool in this research. Cultural translation refers to the process of rendering meanings intelligible across distinct ontological and epistemological systems. In clinical practice, this involves translating spiritual

narratives of possession or metaphysical imbalance into psychiatric terminology without erasing their symbolic significance. Rather than reducing spiritual explanations to psychopathology, cultural translation seeks a dialogical bridge that preserves moral and cosmological meanings while facilitating biomedical intervention.

Ontological translation is particularly salient in cases where patients interpret hallucinations or behavioral disturbances as evidence of external spiritual agency. Psychiatric discourse, by contrast, may frame these phenomena as symptoms of psychosis or mood disorder. Effective translation requires clinicians to engage patients' spiritual language as meaningful rather than erroneous, reframing biomedical treatment as complementary rather than contradictory. Such bridging strategies may include collaborative consultations, culturally adapted psychoeducation, and negotiated treatment plans. By conceptualizing translation as an institutional practice rather than solely an interpersonal skill, this framework underscores the need for systemic mechanisms that support sustained dialogue between psychiatric professionals and culturally recognized healers.

#### *D. Stigma and the Social Meaning of Mental Illness*

Mental illness is not merely a clinical category but also a moral and social designation embedded in local value systems. Sociological theories of stigma emphasize how diagnostic labels can mark individuals as deviant, dangerous, or morally deficient, thereby affecting social status and life opportunities (Goffman, 1963). In many communities, psychiatric diagnoses may carry connotations of chronic incapacity or familial shame. Conversely, spiritual interpretations such as possession may, in certain contexts, redistribute responsibility to supernatural forces, thereby mitigating individual blame. The moral valence of these categories significantly influences help-seeking behavior and disclosure practices.

The relationship between stigma and spiritual legitimacy is complex. While possession narratives can reduce personal culpability, they may also expose individuals to alternative forms of marginalization if perceived as evidence of spiritual vulnerability or divine disfavor. The choice between psychiatric and spiritual frameworks thus entails negotiations of social identity and moral worth. By analyzing stigma as a socially constructed phenomenon intertwined with religious and cultural meanings, this study highlights how therapeutic decisions are shaped not only by symptom severity but also by concerns about honor, community perception, and

spiritual standing. Understanding these dynamics is essential for developing culturally-informed psychiatric practices that address both clinical efficacy and social consequences.

## Methodology

### *A. Research Design*

This study employs a qualitative multi-sited ethnographic design to explore the intersection of spiritual healing and psychiatric practice in Indonesia. Multi-sited ethnography enables the tracing of meanings, practices, and institutional interactions across distinct but interconnected locations, thereby capturing the relational dynamics of medical pluralism. Rather than confining analysis to a single community, this approach follows therapeutic trajectories across ritual spaces, households, clinics, and policy arenas. Such design is particularly appropriate for examining pluralistic health-seeking behaviors that unfold across social and institutional boundaries.

Epistemologically, the research is grounded in an interpretative and constructivist paradigm. It assumes that experiences of mental distress are not merely biomedical facts but socially constructed phenomena embedded in cultural narratives and moral worlds. Knowledge is therefore co-produced through dialogue between researcher and participants, with attention to context, symbolism, and power relations. This orientation prioritizes depth over generalizability, seeking to illuminate processes of meaning-making and negotiation rather than to quantify prevalence. By integrating ethnographic immersion with analytical reflexivity, the study aims to generate theoretically informed and contextually grounded insights.

### *B. Field Sites*

Fieldwork was conducted across multiple sites in Java and South Sulawesi to capture regional diversity in religious practice, social organization, and access to psychiatric services. In Java, research was undertaken in both rural villages and urban neighborhoods, reflecting contrasts in infrastructural development and exposure to biomedical institutions. Rural settings provided insight into community-based spiritual healing practices and kinship-mediated decision-making, while urban sites offered perspectives on psychiatric hospital services and private clinical practice.

In South Sulawesi, the study focused on local communities where Islamic traditions intersect with indigenous cosmologies. These settings allowed for comparative exploration of how possession narratives and spiritual authority are articulated outside the Javanese cultural sphere. The inclusion of geographically and culturally distinct regions strengthens the analytical capacity to identify both convergences and divergences in explanatory models, therapeutic negotiations, and institutional engagement. Multi-sited comparison thus enhances the robustness of findings by situating localized experiences within broader national patterns.

### *C. Participants*

Participants were purposively selected to reflect the plurality of actors involved in mental health care pathways. The first group comprised dukun and other recognized spiritual healers who regularly treat individuals experiencing possession states or severe psychological distress. Their inclusion provides insight into ritual diagnostic frameworks, therapeutic practices, and perceptions of psychiatric medicine. The second group consisted of psychiatrists, general practitioners, and mental health nurses working in public hospitals and primary health centers. These professionals offer perspectives on diagnostic reasoning, clinical constraints, and engagement with culturally embedded beliefs.

The third group included patients and their family members who had navigated both spiritual and biomedical treatment modalities. Families were considered essential participants, given their central role in decision-making, financial management, and caregiving. By incorporating diverse stakeholder perspectives, the study captures the dialogical processes through which authority, legitimacy, and treatment strategies are negotiated. Sampling continued until thematic saturation was achieved, ensuring depth and variation within each participant category.

### *D. Data Collection*

Data were collected through in-depth, semi-structured interviews, participant observation, and policy document analysis. Interviews explored participants' explanatory models of illness, therapeutic experiences, and perceptions of inter-system collaboration. Open-ended questioning enabled participants to narrate mental health crises in their own terms, facilitating the identification of culturally

embedded meanings. Interviews were conducted in Indonesian and relevant local languages, recorded with consent, and transcribed verbatim for analysis.

Participant observation was undertaken in ritual healing sessions, clinical consultations, and community interactions, where permissible. This immersive approach allowed the researcher to observe embodied practices, symbolic gestures, and interpersonal dynamics that may not be fully articulated in interviews. In addition, policy documents, legislative texts, and national mental health guidelines were analyzed to contextualize local practices within broader governance frameworks. The triangulation of interviews, observation, and documentary analysis enhances the credibility and richness of the dataset.

### *E. Data Analysis*

Data analysis followed an iterative and inductive-deductive process. Thematic coding was first employed to identify recurring patterns related to explanatory models, stigma, therapeutic negotiation, and perceptions of collaboration. Codes were developed both from theoretical constructs—such as medical pluralism and cultural translation—and from emergent themes within the data. This flexible coding strategy enabled the integration of existing theoretical insights with context-specific findings.

Subsequently, narrative analysis was conducted to examine how participants structured stories of illness onset, crisis, and recovery. Attention was paid to plotlines, moral positioning, and the attribution of causality. Discourse analysis further explored how language constructs authority, legitimacy, and ontological claims within clinical and ritual contexts. By combining thematic, narrative, and discourse analytic techniques, the study seeks to capture both the content and the performative dimensions of mental health discourse.

### *F. Ethical Considerations*

Ethical integrity was central to all stages of the research process. Informed consent was obtained from all participants prior to data collection, with clear explanations provided regarding the study's objectives, voluntary participation, and the right to withdraw at any time. Given the sensitivity of mental health and spiritual beliefs, particular care was taken to ensure that participants fully understood the scope of the research and the intended use of findings.

Cultural sensitivity guided field interactions, especially during ritual observations and discussions of possession experiences. The researcher adopted a stance of respect toward spiritual practices and avoided evaluative language that might delegitimize participants' beliefs. Confidentiality was strictly maintained through the use of pseudonyms and the removal of identifying details in transcripts and publications. Data were securely stored and accessible only to authorized researchers. These measures aim to protect participants' privacy, dignity, and social standing, while fostering trust and ethical accountability throughout the study.

## Findings

### A. "Kerasukan" as Cultural Ontology

The findings demonstrate that *kerasukan* (spirit possession) operates as a coherent cultural ontology through which psychological disturbance is interpreted and managed. Participants across both Java and South Sulawesi described possession not as metaphor but as a plausible and structured explanation grounded in Islamic theology, local cosmology, and inherited communal narratives. Experiences such as sudden behavioral change, dissociative episodes, auditory phenomena, or bodily convulsions were interpreted as manifestations of intrusion by jinn, ancestral spirits, or malevolent forces. In this framework, causality extends beyond neurobiology to encompass unseen agencies and moral imbalance. Such interpretations align with anthropological analyses of possession as a culturally meaningful system of knowledge rather than a misrecognition of pathology (Boddy, 1994).

Participants emphasized that possession constitutes an internally consistent diagnostic logic. Symptoms are evaluated in relation to spiritual vulnerability, recent life stressors, or perceived moral transgressions. For instance, several families linked the onset of symptoms to neglect of prayer, interpersonal conflict, or exposure to spiritually "unclean" environments. These explanations reflect what Arthur Kleinman conceptualized as explanatory models of illness, wherein causation, meaning, and treatment are embedded within cultural frameworks (Kleinman, 1980). Within this ontological structure, distress is not random but narratively integrated into a moral universe.

The moral dimension of possession was particularly salient. Unlike psychiatric labels, which some participants associated with inherent defectiveness, possession externalized causality. By attributing unusual behavior to spiritual intrusion, families

preserved the moral identity of the affected individual. This externalization reduced direct blame and protected social reputation, echoing sociological theories that diagnostic categories shape moral evaluation (Goffman, 1963). Possession, therefore, functioned as both explanation and social shield, mitigating stigma associated with “madness.”

However, possession was not devoid of moral implication. Participants described expectations that families must respond appropriately through ritual action, prayer, and moral rectification. Failure to address spiritual causes could be interpreted as negligence. Thus, the diagnosis carried prescriptive obligations, structuring caregiving practices and communal responsibility. Possession narratives reinforced relational ethics rather than individual pathology, situating healing within collective moral effort.

Ethnographic observation revealed that ritual healing sessions provided social validation and emotional catharsis. During ruqyah or dukun-led rituals, the afflicted individual’s suffering was publicly acknowledged, and spiritual causation was collectively affirmed. Such gatherings transformed private distress into shared concern, often alleviating feelings of isolation. These practices resemble cross-cultural findings in which possession rituals operate as communal therapeutic spaces (Boddy, 1994). Overall, *kerasukan* emerged as a culturally embedded ontology that integrates symptomatology, morality, and social relations into a coherent explanatory system. Rather than representing epistemic error, possession narratives constitute meaningful frameworks that organize care, distribute responsibility, and shape therapeutic expectations. Recognizing this ontological coherence is essential for understanding subsequent negotiations with biomedical psychiatry.

### *B. Psychiatry as Biomedical Authority*

Psychiatry, by contrast, was widely perceived as representing biomedical authority grounded in scientific rationality and pharmacological expertise. Clinical practitioners typically framed reported symptoms within diagnostic categories aligned with the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (American Psychiatric Association, 2013). Hallucinations, mood instability, or behavioral disorganization were interpreted as indicators of psychotic or affective disorders requiring medication and structured follow-up. This classificatory approach provided clarity for clinicians but often recontextualized spiritual experiences into biomedical language.

Participants frequently described psychiatric consultation as efficient but emotionally distant. Symptom checklists and diagnostic labeling were perceived as prioritizing categorization over narrative meaning. This dynamic reflects critiques of psychiatric universalism, which argue that standardized nosology may marginalize culturally embedded idioms of distress (Mills, 2014). For families accustomed to spiritual explanations, the clinical reframing of possession as psychosis represented not merely diagnostic translation but ontological displacement.

Medicalization of symptoms also influenced perceptions of identity. Psychiatric labels such as schizophrenia were associated with chronicity and social marginalization. In line with stigma theory (Goffman, 1963), participants expressed concern that biomedical diagnoses might permanently mark individuals as incapable or dangerous. Unlike possession, which could be ritually resolved, psychiatric illness was perceived as enduring and biologically fixed. This perception generated ambivalence toward formal diagnosis.

Nevertheless, many families acknowledged the symptomatic relief provided by medication. Antipsychotics and mood stabilizers were described as effective in reducing aggression, insomnia, or severe agitation. Biomedical authority thus derived practical legitimacy from observable improvement. The tension, therefore, was not between efficacy and belief, but between competing ontologies of causation.

Clinicians interviewed in this study expressed awareness of spiritual interpretations but reported limited institutional support for integrating them into consultation. Time constraints, administrative requirements, and standardized documentation procedures restricted opportunities for extended dialogue. As a result, biomedical authority was structurally reinforced, even when individual practitioners sought culturally sensitive engagement. Ultimately, psychiatry emerged as both indispensable and contested. It provided tools for crisis stabilization but operated within epistemic boundaries that sometimes limited dialogical exchange. The coexistence of respect for pharmacological efficacy and resistance to psychiatric labeling highlights the complexity of biomedical authority in pluralistic contexts.

### *C. Hybrid Health-Seeking Practices*

A central finding of this research is the prevalence of hybrid health-seeking strategies that combine spiritual and biomedical interventions. Families frequently described consulting dukun or religious leaders for ruqyah while simultaneously maintaining psychiatric appointments and medication regimens. This pattern exemplifies medical

pluralism, wherein multiple healing systems coexist and are pragmatically mobilized (Leslie, 1980). Rather than perceiving contradiction, participants framed these approaches as complementary responses to multidimensional illness.

Hybrid strategies were often sequential. In some cases, families initially pursued spiritual treatment; when symptoms persisted, they sought psychiatric care. In others, hospital intervention preceded ritual therapy intended to address residual spiritual concerns. These sequences were shaped by symptom severity, financial considerations, and community advice. The fluidity of movement between systems reflects strategic adaptation rather than indecision.

Ritual and pharmacological interventions were conceptualized as targeting distinct domains. Ruqyah addressed spiritual causation and moral imbalance, while medication regulated bodily or neurological instability. This dual framework aligns with Kleinman's (1980) observation that multiple explanatory models may coexist within a single illness narrative. Families did not necessarily seek epistemological coherence; instead, they sought maximal therapeutic coverage.

Family negotiation played a decisive role in shaping treatment pathways. Decisions were rarely individual but emerged through consultation with elders, religious authorities, and extended kin. Such collective deliberation underscores the relational nature of health decision-making in Indonesian contexts.

Hybrid care also functioned as risk management. By engaging both systems, families minimized the possibility of neglecting either spiritual or biomedical dimensions. This strategy reflects what Kirmayer and Pedersen (2014) describe as epistemological pluralism in global mental health contexts. Overall, hybrid health-seeking practices demonstrate that pluralism is not transitional but structural. Families actively construct therapeutic assemblages that respond to layered ontologies of distress, challenging binary representations of "traditional" versus "modern" medicine.

#### *D. Cultural Translation Gap*

Despite widespread hybrid practice at the community level, a significant cultural translation gap persists within formal clinical encounters. Many participants reported that spiritual explanations were acknowledged politely but rarely substantively engaged. Consultation often redirected narratives toward symptom duration, medication adherence, and risk assessment. This pattern reflects broader

critiques that global psychiatry insufficiently integrates cultural meaning into standardized practice (Mills, 2014).

The absence of ontological translation generated feelings of partial recognition. Patients described experiences of being heard but not fully understood. When spiritual narratives were reframed solely as delusion or superstition, therapeutic rapport weakened. Kleinman (1980) emphasizes that failure to engage explanatory models undermines treatment adherence; this dynamic was evident in cases where families discontinued medication after perceiving epistemic dismissal.

Clinicians who demonstrated openness to discussing spiritual beliefs reported improved cooperation. Even without endorsing literal spiritual causation, acknowledgment of patients' cosmologies fostered trust. Such dialogical gestures represent practical forms of cultural translation, bridging symbolic language with psychiatric terminology. Institutionally, however, translation remained informal and dependent on individual initiative. There were few structured referral pathways between psychiatric services and recognized spiritual healers. The lack of systemic collaboration limited sustained integration.

The treatment adherence consequences were tangible. Inconsistent follow-up, abrupt medication cessation, and return to exclusive ritual therapy often followed experiences of misrecognition. Conversely, collaborative framing enhanced continuity of care. These findings underscore that the challenge is not epistemological incompatibility per se but institutional inertia. Developing structured mechanisms for cultural translation may reduce stigma, strengthen therapeutic alliance, and improve long-term outcomes in pluralistic mental health settings.

## Discussion

### *A. Rethinking Universality in Psychiatry*

The findings challenge the assumption that psychiatric categories, particularly those codified in the DSM-5, possess universal applicability across diverse cultural contexts. The prevalence of *kerasukan* as a coherent explanatory model illustrates that local idioms of distress carry analytic validity and must be considered more than symbolic or erroneous interpretations (Kirmayer & Pedersen, 2014). These findings echo critiques that DSM-centric approaches, while useful for standardization, risk marginalizing culturally embedded expressions of suffering (Mills, 2014).

By privileging symptom clusters over moral, relational, or spiritual dimensions, the DSM framework can inadvertently obscure the lived experience of patients, particularly in contexts where distress is inseparable from social and cosmological order. Families' reliance on hybrid therapeutic pathways demonstrates that psychiatric treatment alone may inadequately address the ontological and moral frameworks that structure health-seeking behavior. This observation aligns with Kleinman's (1980) assertion that explanatory models—rather than isolated symptoms—determine patient engagement and adherence.

Recognizing the analytic validity of local idioms does not require abandoning biomedical diagnosis but instead reframes universality as conditional and context-sensitive. Psychiatric categories must be interpreted relationally, in dialogue with culturally grounded understandings. Doing so encourages epistemic humility and mitigates the risk of imposing external frameworks that may inadvertently delegitimize patient experience.

The study also underscores the importance of ontological pluralism in understanding mental health. Local explanations such as *kerasukan* are neither peripheral nor optional; they serve practical, moral, and social functions that inform therapeutic choice. Acknowledging these frameworks challenges psychiatry to reconceptualize symptom assessment, clinical communication, and treatment planning beyond purely biological parameters.

Finally, the findings suggest that claims of psychiatric universality must be tempered by empirical observation of local practice. The interplay between spiritual, moral, and biomedical dimensions demonstrates that meaningful mental health intervention requires attentiveness to context-specific ontologies. This perspective extends critiques of global mental health that advocate for decolonizing frameworks sensitive to cultural difference. In sum, rethinking universality entails moving from rigid symptom-based frameworks toward relational, culturally attuned diagnostic processes. Such a shift does not undermine psychiatry but strengthens its relevance and effectiveness in diverse cultural settings.

### *B. Toward Culturally-Informed Psychiatry*

Building on the recognition of local idioms, this study advocates for a model of culturally-informed psychiatry that actively bridges biomedical and spiritual frameworks. Hybrid care trajectories observed in Java and South Sulawesi illustrate the feasibility of collaborative arrangements between psychiatrists and dukun, where

complementary expertise addresses both biological and spiritual dimensions of distress (Leslie, 1980). A culturally-informed model would formalize such collaboration through referral systems, joint case discussions, and coordinated treatment plans.

Training is central to this approach. Psychiatric education should include cultural competency modules that go beyond superficial awareness to develop deep understanding of local explanatory models, ritual practices, and moral frameworks. Clinicians trained in interpretive engagement are better equipped to elicit and negotiate explanatory models, enhancing therapeutic alliance and treatment adherence (Kirmayer & Pedersen, 2014). Such training could incorporate field immersion, simulated interactions with spiritual healers, and structured reflective exercises that cultivate epistemic humility.

Collaborative frameworks also require institutional support. Health systems must recognize dukun as legitimate actors within mental health ecosystems, with clear guidelines for engagement that respect both cultural authority and clinical standards. This includes clarifying ethical boundaries, documenting treatment plans, and ensuring human rights compliance. Such structured integration mitigates ad hoc negotiation and supports sustainability of hybrid care pathways.

Culturally-informed psychiatry should also incorporate mechanisms for feedback and iterative learning. Case reviews, interdisciplinary workshops, and participatory evaluation can identify challenges in aligning therapeutic strategies and promote mutual understanding. This adaptive approach positions psychiatry as responsive rather than prescriptive, reinforcing its role as a facilitator of dialogue.

Importantly, culturally-informed models recognize that spiritual explanations are not obstacles but analytic and therapeutic resources. Validating these frameworks does not compromise biomedical rigor; instead, it enriches clinical reasoning by situating symptoms within moral, relational, and symbolic networks. In essence, culturally-informed psychiatry redefines success not merely as symptom reduction but as meaningful engagement with the patient's lived experience, moral world, and community context. This approach has potential to reduce stigma, improve adherence, and strengthen legitimacy of mental health services in culturally diverse settings.

### *C. Policy Implications*

The findings carry significant implications for mental health policy and professional education in Indonesia. First, psychiatry curricula should integrate cultural competency training as a core component. This includes both theoretical knowledge of local cosmologies and practical exposure to ritual practices and spiritual healers. Such reforms can equip new clinicians with skills to navigate hybrid care pathways effectively and reduce epistemic conflict between biomedical and spiritual systems.

Second, national implementation of programs such as the World Health Organization Mental Health Gap Action Programme (mhGAP) should embed culturally-sensitive strategies. While mhGAP emphasizes task-shifting and evidence-based interventions, it currently lacks structured mechanisms for integrating traditional healing. Policy guidelines could formalize collaboration with dukun, provide training for culturally-informed assessment, and create channels for community feedback.

Third, regulatory frameworks must balance recognition of spiritual practices with protection of human rights and clinical standards. Formalizing referral pathways, setting minimum ethical requirements, and documenting hybrid interventions can prevent misuse while sustaining legitimacy. Policies that fail to address these intersections risk undermining both biomedical efficacy and cultural relevance.

Community engagement is also crucial. Policymakers should involve local stakeholders, including spiritual healers, patients, and families, in the design and evaluation of programs. Participatory approaches ensure that policy reflects lived experience and cultural priorities rather than top-down assumptions.

Furthermore, integration of cultural frameworks into monitoring and evaluation metrics can improve program effectiveness. Beyond symptom reduction, metrics might include patient satisfaction, treatment adherence, and perceived respect for moral and spiritual frameworks. Finally, sustained dialogue between policymakers, clinicians, and community actors is necessary to institutionalize culturally-informed practice. Policy must support adaptive, context-sensitive interventions that bridge global standards and local realities, strengthening mental health systems across Indonesia.

#### *D. Contribution to Decolonizing Mental Health*

This study contributes to decolonizing global mental health by shifting the paradigm from correction to dialogue. Traditional top-down approaches often prioritize the imposition of standardized psychiatric models, implicitly delegitimizing local knowledge. The Indonesian case demonstrates that respectful engagement with spiritual frameworks enhances therapeutic outcomes and restores epistemic equity. Such a dialogical approach aligns with calls to recognize non-Western knowledge systems as valid contributors to mental health discourse (Mills, 2014).

By foregrounding the legitimacy of *kerasukan* and hybrid care practices, the study challenges dominant narratives that position Western biomedical psychiatry as universally superior. It highlights the productive possibilities of integrating diverse ontologies within formal mental health systems, demonstrating that pluralism is a resource rather than an obstacle.

Indonesia provides a valuable case for the Global South, where colonial histories, religious syncretism, and pluralistic health landscapes intersect. Insights from Java and South Sulawesi illustrate how culturally-informed frameworks can be operationalized at both clinical and policy levels, offering models adaptable to other postcolonial contexts.

The study also underscores the importance of epistemic humility in global mental health. Recognizing that psychiatric categories are socially and historically situated encourages reflexive practice, mitigates stigma, and strengthens trust between practitioners and communities. Finally, by integrating hybrid therapeutic practices, culturally-informed psychiatry reconceptualizes the goal of intervention from symptom correction to relational and moral restoration. This approach not only improves treatment adherence but also addresses broader social and spiritual well-being, aligning mental health practice with community priorities. In sum, the study advances the decolonization agenda by demonstrating that culturally-grounded, dialogical approaches are both ethically imperative and pragmatically effective in enhancing mental health care across pluralistic societies.

## Conclusion

### *A. Summary of Key Findings*

This study highlights pluralistic ontologies as a pervasive social reality in Indonesian mental health. The research demonstrates that *kerasukan* (spirit possession) operates as a coherent explanatory model, deeply embedded in moral, relational, and cosmological frameworks. Families and patients navigate hybrid pathways that integrate spiritual rituals, biomedical interventions, and communal negotiation, reflecting pragmatic and adaptive responses to mental distress. These findings underscore the insufficiency of singular, biomedical frameworks to address the multidimensionality of local experiences (Kirmayer & Pedersen, 2014).

A central insight is the critical need for epistemological bridging between local spiritual interpretations and psychiatric practice. The observed cultural translation gap limits treatment adherence and undermines therapeutic engagement, whereas acknowledgment of spiritual ontologies facilitates cooperation and strengthens clinical relationships. Effective mental health intervention in pluralistic settings, therefore, requires mechanisms to translate between culturally grounded explanatory models and biomedical diagnostic frameworks (Kleinman, 1980).

The study also illuminates the moral and social dimensions of mental illness. Spiritual frameworks redistribute responsibility, mitigate stigma, and structure care obligations, highlighting the interdependence of cultural meaning and clinical outcomes. By recognizing these dimensions, mental health practitioners can design interventions that resonate with patients' lived realities rather than imposing externally derived norms. Overall, the research demonstrates that pluralism is not a transitional anomaly but a structural feature of Indonesian mental health practice. Hybrid practices and negotiated pathways represent rational strategies that integrate competing epistemologies, emphasizing the relational and adaptive character of care in culturally diverse contexts.

### *B. Theoretical Contributions*

The study makes several important theoretical contributions. First, it strengthens the concept of cultural translation as an analytical and practical framework for bridging ontological differences. By framing translation as a dialogical process rather than a one-way conversion, the study operationalizes cultural translation as both

interpretive and institutional practice, linking patient explanatory models with biomedical assessment.

Second, the research advances the model of culturally-informed psychiatry, integrating medical pluralism, explanatory models, and translation strategies into a cohesive framework. This model conceptualizes collaboration between psychiatrists and spiritual healers as both feasible and beneficial, emphasizing relational negotiation, cultural competence, and ethical alignment. It extends the literature on decolonizing global mental health by providing a concrete operationalization of culturally grounded interventions in postcolonial contexts (Mills, 2014).

Third, the findings contribute to epistemic critique within psychiatry. By foregrounding local idioms as analytically valid, the study challenges assumptions of universal symptomatology and encourages epistemic humility. This approach reorients clinical reasoning to accommodate layered ontologies, highlighting how culture shapes both perception and engagement with mental health. Finally, the integration of moral, social, and spiritual dimensions into analytic frameworks underscores the value of interdisciplinary perspectives. Combining anthropology, psychiatry, and policy analysis, the study demonstrates the importance of situating clinical practice within broader socio-cultural ecosystems.

### *C. Practical Implications*

Practically, the findings suggest several avenues for improving mental health care. By incorporating culturally-informed approaches, practitioners can enhance adherence to biomedical interventions while reducing stigma associated with psychiatric labeling. Families who perceive their spiritual frameworks as acknowledged are more likely to engage consistently with treatment, creating conditions for improved outcomes.

Policy design should also reflect pluralism, integrating traditional healing practices and culturally grounded explanatory models into programmatic frameworks. For example, structured collaboration with dukun, culturally-informed training modules for clinicians, and community-based education initiatives can institutionalize hybrid care pathways. Programs such as the World Health Organization's mhGAP could be adapted to include mechanisms for cultural dialogue, enhancing relevance and effectiveness in Indonesian contexts.

Furthermore, health education and public outreach should emphasize the complementarity of spiritual and biomedical care. Such messaging can reduce

stigma, promote mutual legitimacy, and empower families to navigate hybrid pathways responsibly.

In clinical settings, culturally-informed protocols can guide assessment, triage, and treatment planning, ensuring that biomedical intervention does not inadvertently negate cultural meaning. These practical measures reinforce the notion that effective mental health care requires epistemic as well as clinical responsiveness.

#### *D. Limitations and Future Research*

Despite its contributions, the study has several limitations. Fieldwork was conducted in selected communities in Java and South Sulawesi, limiting the generalizability of findings across Indonesia's highly diverse socio-cultural landscape. Variations in religious affiliation, ethnic composition, and health infrastructure may yield differing experiences of possession and hybrid care.

Future research should pursue comparative studies across provinces and religious contexts to examine how hybrid health-seeking practices and cultural translation vary regionally. Cross-faith comparisons may reveal how Islamic, Christian, Hindu, or indigenous cosmologies shape explanatory models and engagement with psychiatry.

Additionally, longitudinal research could investigate how hybrid pathways influence treatment adherence, clinical outcomes, and community perceptions over time. Experimental or participatory designs could also evaluate the effectiveness of structured cultural translation interventions in psychiatric practice. Finally, expanding multi-sited ethnography to include policymakers, training institutions, and national mental health programs could inform systemic strategies for integrating cultural frameworks into governance. These extensions would strengthen the applicability of culturally-informed psychiatry across the Indonesian archipelago and contribute to broader decolonizing agendas in global mental health.

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