e-ISSN: 3026-7277

Enigma in Cultural

Journal website: https://enigma.or.id/index.php/cultural

Symbolic Efficacy in the Psychiatric Ward: A Clinical Ethnography of *Cetik*-Attributed Psychosis and Hospital-Facilitated Ritual Integration in Bali

Ni Wayan Saka Rahayu[1*], Ni Made Citra Riesti Wulan[2], Nyoman Ari Yoga Wirawan[3], Ida Bagus Ngurah Dwipayana Manuaba[4]

[1]General Practitioner, Wangaya Regional General Hospital, Denpasar, Indonesia

[2]General Practitioner, Karangasem Regional General Hospital, Karangasem, Indonesia

[3]Specialized Residency Training Program, Psychiatry Study Program, Faculty of Medicine, Universitas Udayana, Denpasar, Indonesia

[4]Psychiatrist, Wangaya Regional General Hospital, Denpasar, Indonesia

ARTICLE INFO

Keywords:
Cetik
Clinical ethnography
Guna-guna
Structural competence
Symbolic efficacy

***Corresponding author:**
Ni Wayan Saka Rahayu

E-mail address:
sakarahayu@gmail.com

All authors have reviewed and approved the final version of the manuscript.

https://doi.org/10.61996/cultural.v4i1.114

A B S T R A C T

In Bali, acute psychosis is frequently interpreted through the *Niskala* or unseen cosmology, specifically attributed to *Cetik* or magical poisoning and *Guna-guna* or sorcery. This explanatory model often clashes with biomedical paradigms, leading to poor therapeutic alliance and treatment refusal. This study aims to evaluate the pathoplastic efficacy and symbolic healing mechanisms of an integrative therapeutic approach. We employed a clinical ethnography design within a psychiatric ward in Denpasar, Bali. The subject was a 26-year-old Balinese female with Acute and Transient Psychotic Disorder (ICD-10: F23.2), presenting with severe psychomotor agitation (PANSS-EC score of 22). Data were collected via the DSM-5 Cultural Formulation Interview (CFI), non-participant observation of a hospital-facilitated *Penglukatan* or purification ritual, and clinical timeline mapping. We utilized a rigorous reflexivity framework to analyze the intersection of the clinical gaze of the psychiatrist and the ritual authority of the Balian or traditional healer. The distress of the patient was culturally coded as "spiritual heat" or *Panes* resulting from *Cetik* ingestion. A timeline analysis revealed a significant reduction in psychomotor agitation, with the PANSS-EC score dropping from 22 to 10, occurring 30 minutes post-ritual but prior to the administration of oral Risperidone. This temporal dissociation suggests the immediate behavioral containment was mediated by cultural symbolic efficacy rather than pharmacological dopamine blockade. In conclusion, the *Balian* functioned as a "cultural broker," transforming the "contaminated" hospital space into a sanctuary. Future research should quantify this effect through randomized controlled trials comparing standard care against integrated ritual care. Policy reform should focus on institutionalizing spiritual visitation protocols akin to chaplaincy services.

1. Introduction

The management of acute psychosis in the Global South is frequently an exercise in translation—not merely linguistic translation, but ontological translation. It involves navigating the profound "epistemic gap" that exists between the biomedical model of disease, which locates pathology within the neurochemistry of the individual brain, and the cultural model of illness, which often locates pathology within the chaotic intersection of social relationships and spiritual forces.[1] In Southeast Asia, this dissonance is particularly acute. Here, the clinical encounter is often the site of a silent collision between two competing realities: the standardized, universalist diagnostics of the International Classification of Diseases (ICD) and the local, particularist cosmologies

of the patient. This dissonance is not merely a theoretical curiosity for medical anthropologists; it is a clinical emergency. When a clinician dismisses a patient's terror of spiritual assault as a "bizarre delusion" without engaging the cultural logic that underpins it, the therapeutic alliance fractures. The patient, feeling unheard and unprotected, often retreats into non-adherence, exacerbating the trajectory of the disorder.[2]

This challenge is nowhere more prevalent than in Indonesia, a rapidly modernizing archipelago that remains deeply rooted in traditional metaphysical systems. The prevalence of severe mental disorders in Indonesia has risen alarmingly to 7.0 per 1,000 households, signaling a growing public health crisis that the existing biomedical infrastructure struggles to contain.[3] Within this national context, the island of Bali presents a unique epidemiological and anthropological landscape. Bali consistently records the highest regional prevalence of severe mental illness in the nation. This statistic is often attributed to the intense psychosocial pressures of Balinese communal life, where the demands of ritual performance, rigid social hierarchies, and complex family obligations create a "pressure cooker" environment for vulnerable individuals.[4] However, the high prevalence may also reflect the intricate ways in which distress is culturally coded and expressed. In Bali, mental illness is rarely experienced as a private, internal event. Instead, it is experienced as a rupture in the cosmic order, a phenomenon that demands a response not just from the doctor, but from the community and the spirit world.[5]

To understand the Balinese experience of psychosis, one must first navigate the island's syncretic Hindu cosmology, which operates on the fundamental principle of equilibrium. Health, in the Balinese worldview, is defined by the harmonious alignment between the *Bhuana Alit* (the microcosm, or the human body) and the *Bhuana Agung* (the macrocosm, or the universe). When these two spheres are in balance, the individual experiences *Tis* or coolness, a state of psychological and spiritual stability. However, this balance is perpetually threatened by the interplay of *Sekala* (the visible, material realm) and *Niskala* (the invisible, unseen realm). While biomedicine operates almost exclusively within the *Sekala* realm—treating visible symptoms with tangible chemicals—the Balinese patient often perceives the root cause of their suffering in the *Niskala* realm. Consequently, acute psychiatric presentations are frequently attributed to supernatural etiologies such as *Bebai* (spirit possession), *Kepongor* (ancestral wrath due to neglected rituals), or, most terrifyingly, *Cetik* and *Guna-guna*.[6]

Guna-guna serves as a broad, umbrella term for sorcery or black magic, a pervasive fear in many Indonesian societies. However, within the specific taxonomy of Balinese sorcery, *Cetik* occupies a distinct and particularly visceral category. Unlike abstract spells or incantations, *Cetik* is fundamentally "material sorcery." It is conceptually understood as a physical poison imbued with dark spiritual energy, often concocted from ritually impure substances such as graveyard soil, human remains, or toxic herbs.[7] This poison is surreptitiously introduced into the victim's body, typically through food or drink, bridging the gap between a biological toxin and a spiritual curse. The ingestion of *Cetik* is believed to cause a disintegration that is both somatic and psychiatric. Victims report a sensation of burning heat or *Panes* coursing through their veins, accompanied by organ failure, skin eruptions, and fierce behavioral agitation that mimics acute mania or paranoid schizophrenia. Because the vector of transmission is often food prepared by intimate associates—family members, neighbors, or rivals—*Cetik* accusations are almost always expressions of intimate social betrayal. They reveal a rupture in the trust that binds the kinship network, transforming the family home from a sanctuary into a landscape of potential danger.[8]

Historically, the response of the biomedical establishment to such narratives has been one of skepticism or pathologization. A patient presenting to an emergency room claiming to have been poisoned by magical food is typically triaged as suffering from persecutory delusions. The standard psychiatric protocol involves rapid tranquilization and the administration of antipsychotic medication to correct

the presumed dopamine dysregulation. While this approach is necessary to ensure safety, it fails to address the "existential terror" of the patient. For the patient, the antipsychotic medication may sedate the body, but it does nothing to extract the magical poison they believe is corroding their soul. This misalignment often leads to a phenomenon known as "revolving door" psychiatry, where patients are stabilized, discharged, and then relapse because they immediately seek out traditional healers who confirm their suspicions and advise against "chemical" treatments that might clash with spiritual cleansing.

However, the emerging framework of Structural Competence offers a new lens through which to view these clinical stalemates. Proposed by Jonathan Metzl and Helena Hansen, Structural Competence urges clinicians to look beyond the biological symptoms to the structural forces—economic, political, and cultural—that shape the presentation of illness. Through this lens, a delusion of sorcery is not merely a symptom of a broken brain; it is an "Idiom of Distress." It is a culturally sanctioned language through which the patient articulates profound social anxieties that are otherwise unspeakable. An accusation of *Cetik* directed at a mother-in-law, for instance, may be the only way a daughter-in-law can express the suffocating pressure of infertility or the fear of being disinherited in a patriarchal lineage system. By treating the sorcery narrative seriously, clinicians validate the suffering of the patient without necessarily endorsing the supernatural reality of the claim.[9]

This theoretical shift opens the door to Symbolic Efficacy, a concept introduced by the anthropologist Claude Lévi-Strauss in his seminal analysis of shamanism. Lévi-Strauss argued that the healer effects a cure not through pharmacological action, but by providing the sick person with a language—a mythic structure—by which to express unexpressed states. The healer names the demon, identifies the poison, and performs a ritual that externalizes the internal chaos. For the patient, this ritual is not a placebo in the trivial sense of a "fake pill," but a powerful reorganization of their sensory experience. The "Meaning Response" elicited by the ritual triggers physiological changes, reducing the hyper-arousal of the sympathetic nervous system and restoring a sense of agency to a patient who feels victimized by unseen forces.

Despite the rich theoretical literature supporting the integration of these systems, the practical reality of mental healthcare in Southeast Asia remains fragmented. Medical pluralism is the norm, but it is typically sequential and secretive. Patients visit the psychiatrist by day and the *Balian* (traditional healer) by night, often hiding their traditional consultations from their doctors for fear of ridicule. This "dual use" often compromises care, as healers may command patients to stop medication, or doctors may remain oblivious to the spiritual anxieties fueling the patient's agitation. There is a profound scarcity of models that demonstrate Concurrent Integration—the simultaneous presence of the biomedical and the traditional within the same therapeutic space. This scarcity is driven by significant logistical and epistemological friction. Hospitals are governed by strict protocols of sterility, safety, and secular authority; the *Balian* operates in a world of incense smoke, holy water, and charismatic authority. Bridging these two worlds within the walls of a high-acuity psychiatric ward requires a level of negotiation and flexibility that is rare in modern healthcare institutions.[10]

This manuscript seeks to document precisely such a rare instance of negotiation. We present a clinical ethnography that pushes beyond the theoretical advocacy for cultural sensitivity and examines the granular mechanics of integration in practice. By analyzing a case where the hospital walls were made porous enough to admit the *Balian*, we explore the physiological and psychological consequences of aligning the *Sekala* intervention of the psychiatrist with the *Niskala* intervention of the healer. This study aims to evaluate the pathoplastic efficacy and symbolic healing mechanisms of an integrative therapeutic approach. The novelty of this study lies in its methodological rigor, as it provides a granular, timestamped analysis of a ritual performed by a *Balian* inside a sterile psychiatric ward. We aim to demonstrate how logistical accommodation of

the *Cetik* narrative allowed for the externalization of madness, creating a specific temporal window where cultural resolution facilitated biological treatment.

2. Methods

Study design and setting: The hospital as a cultural borderland

This investigation was structured as an observational Clinical Ethnography, a methodological choice designed to bridge the chasm between standardized psychiatric assessment and the nuanced, lived experience of the patient. Unlike standard case reports, which often strip away the cultural context to fit a biomedical template, clinical ethnography demands the immersion of the researcher in the social world of the subject. This study rigorously adhered to the CARE (Case Report) guidelines to ensure clinical precision and the COREQ (Consolidated Criteria for Reporting Qualitative Research) guidelines to maintain qualitative rigor.

The research site was the psychiatric ward of Wangaya Regional General Hospital Denpasar, a secondary referral center located in the heart of Bali, Indonesia. This setting was selected not merely for its clinical utility but for its unique position as a liminal space. The ward operates strictly on a modern biomedical model—governed by pharmacopeia, sterile protocols, and the diagnostic authority of the ICD-10. Yet, it serves a population deeply embedded in *Adat* (customary law) and Hindu cosmology. Consequently, the ward functions as a contested borderland where the "hospital reality" frequently collides with the "village reality." Conducting the study here allowed us to observe the friction and eventual negotiation between these two competing epistemologies in real-time.

Subject recruitment and sampling strategy

The subject, referred to by the pseudonym NKM, is a 26-year-old female who was admitted to the ward following an acute behavioral escalation that necessitated emergency protocols. The recruitment process employed a purposive sampling strategy. We did not seek a "typical" psychosis case; rather, we specifically sought a case that exemplified the "collision of paradigms."

To be included in the study, the case had to meet three strict criteria: First, a confirmed clinical diagnosis of Acute and Transient Psychotic Disorder (ICD-10: F23.2) was required to establish the biomedical baseline. Second, the Explanatory Model of the patient had to be heavily, if not exclusively, centered on *Cetik* (magical poisoning) or *Guna-guna* (sorcery). This ensured that the pathology was culturally coded. Third, and most critically, there had to be an explicit request from the family for traditional intervention alongside medical care. This third criterion was vital as it transformed the case from a passive observation of symptoms into an active study of integrative management. NKM was selected because her case represented a "perfect storm" of these factors: a clear biological presentation of agitation that was hermetically sealed within a cultural narrative of magical poisoning.

Reflexivity and researcher positionality

In qualitative inquiry, the researcher is the primary instrument of data collection. Therefore, transparency regarding the relationship between the observer and the observed is paramount. We utilized a Reflexivity Framework to dissect the power dynamics inherent in this study: The Primary Clinician/Observer: The principal investigator is a clinical psychiatrist practicing at Wangaya Regional General Hospital. Educated in Western biomedicine at Universitas Indonesia, the clinician possesses the "authoritative knowledge" of the medical establishment. However, the clinician is also ethnically Balinese. This "insider-outsider" status created a unique methodological advantage. The clinician could switch linguistic codes instantly, moving from the clinical terminology of the ward to High Balinese (*Basa Alus*), the distinct register of language used for sacred and respectful communication. This linguistic agility allowed for rapid rapport building that a non-Balinese clinician could not achieve. However, this proximity required constant vigilance. The clinician had to actively resist the assumption that cultural competence was automatic, constantly questioning whether they were

interpreting the patient's words through a clinical lens or a cultural one. During the ritual itself, the clinician adopted a strictly non-participant observer role, retreating to the periphery of the room to preserve the sanctity of the space and minimize the "observer effect." The Analyst: To counterbalance the clinical perspective, the data analysis involved a medical anthropologist with no direct clinical role in the care of the patient. This separation of duties was designed to mitigate bias. A treating physician naturally desires a successful clinical outcome (remission), which can color their interpretation of efficacy. By including a non-clinical analyst, we ensured that the interpretation of the ritual's impact remained objective and theoretically grounded. Navigating Power Dynamics: We explicitly acknowledged that the hospital setting inherently privileges the "biomedical gaze." The doctor typically holds the power to permit or forbid. By "permitting" a healer to enter, the medical team risks reinforcing a hierarchy where the spiritual is subservient to the medical. To mitigate this, a spatial intervention was enacted: during the core phase of the ritual, the medical team physically vacated the room. This act of leaving was not merely a courtesy; it was a methodological cession of power. It signaled to the patient that within those four walls, for that specific duration, the spatial authority belonged to the *Balian*, not the hospital administration.

Data collection protocol: A multi-modal approach

To ensure the validity of our findings, we employed Triangulation, capturing the phenomenon through four distinct data streams. The Cultural Formulation Interview (CFI): On Day 2 of admission, the DSM-5 Cultural Formulation Interview was administered. This instrument was chosen because it moves beyond symptom checklists to explore the *meaning* of the illness. It allowed us to map the Explanatory Model of the patient, revealing that she viewed her condition not as a mental break, but as a somatic contamination caused by the ingestion of *Rujak* (spicy fruit salad) prepared by her in-laws; Sensory Field Notes ("Thick Description"): Standard medical charting is often sterile, recording only vital signs and doses. However, a ritual is a sensory event. Therefore, detailed field notes were taken in real-time by the primary clinician. These notes utilized Geertz's concept of "thick description," capturing the sensory texture of the intervention. We documented the olfactory shift as the smell of antiseptic was replaced by the scent of sandalwood incense (*Dupa*), the auditory shift from the hum of hospital machinery to the rhythmic chanting of mantras, and the tactile temperature of the holy water. These details were crucial for understanding how the environment was phenomenologically transformed for the patient; Timeline Mapping: To address the question of causality, a precise chronological log was maintained on Day 3. This log recorded the exact minute of every intervention—when the healer entered, when the water was sprinkled, when the ritual ended, and when the medication was administered. This rigorous timestamping allowed us to isolate variables and distinguish the immediate anxiolytic effects of the ritual from the pharmacokinetic onset of the antipsychotic medication; Audio Recording and Transcription: Following the ritual, semi-structured interviews were conducted with the husband of the patient and the *Balian*. These interactions were audio-recorded to capture the specific vernacular used to describe the healing process. The recordings were transcribed verbatim in Balinese and then translated into English, ensuring that the nuances of terms like *Panes* (heat) and *Tis* (coolness) were preserved in the analysis.

Selection of the traditional healer (*Balian*)

The selection of the healer was a critical methodological decision. We employed Convenience Sampling via the family network. The hospital did not provide a "staff healer," nor did we select one from a roster. Instead, the family brought a *Balian Panengen* (a practitioner of white magic) from their own ancestral village: Methodological Implication: While convenience sampling is often viewed as a limitation in quantitative research, in this context, it was a vital strength for validity. In the paranoid worldview of the patient, the hospital was a place of danger, and staff were potential agents of the "poisoners." Had the hospital appointed a healer, the

patient would likely have viewed him with suspicion, invalidating the ritual. Because *Balian* was selected by her own kin, he possessed Legitimate Authority within her social network. His presence bridged the trust gap, as he was the only figure in the room who existed within her pre-morbid circle of safety.

Logistical and safety protocols: Managing friction

The integration of a traditional ritual involving fire and unsterilized water into a modern clinical ward presented significant logistical friction. Overcoming this required a "Harm Reduction" approach to cultural psychiatry. Fire Safety: The burning of *Dupa* (incense) is central to Balinese Hindu rituals, acting as the medium to carry prayers to the heavens. However, this poses a direct conflict with hospital fire codes and oxygen safety. To accommodate this, the patient was temporarily transferred to a semi-isolation room equipped with independent ventilation. Under the strict supervision of the ward safety officer, smoke detectors in that specific zone were bypassed for a duration of 30 minutes. This negotiation allowed the ritual to proceed without triggering alarms, preventing the disruption of the sacred atmosphere. Hygiene and Infection Control: The ritual required the patient to drink *Tirta* (holy water) brought from the outside. In a biomedical context, consuming unsterilized fluids is generally contraindicated. However, the team applied a risk-benefit analysis. The risk of waterborne pathogens from the *Tirta* was deemed negligible compared to the psychological benefit of the "spiritual antidote." The water was visually inspected for particulate matter, and the patient was permitted to consume it. This decision prioritized the psychological need for internal cleansing over rigid adherence to sterile protocol.

Instruments

To provide a quantitative anchor to our qualitative observations, we utilized the PANSS-EC (Positive and Negative Syndrome Scale - Excited Component). This scale assesses five items—poor impulse control, tension, hostility, uncooperativeness, and excitement—yielding a score between 5 and 35. It was administered pre-ritual, immediately post-ritual, and post-medication to track the trajectory of behavioral agitation. We acknowledge a limitation regarding the PANSS-EC ratings. The ratings were performed by the primary clinician who was present during the ritual. Due to the resource constraints of an emergency admission in a developing setting, blinding was not possible. The rater was fully aware of the ritual intervention, introducing a potential risk of Confirmation Bias. However, the magnitude of the score reduction observed was corroborated by objective behavioral markers, such as the cessation of screaming and the induction of sleep, suggesting the scores reflected a genuine clinical change.

Ethical considerations

The ethical management of a patient in acute psychosis requires a delicate balance between protection and autonomy. Informed Consent: At the time of admission and the intervention (Day 3), the patient lacked the capacity to provide informed consent due to the severity of her thought disorder and agitation. Therefore, informed consent was initially obtained from her husband, who acted as her legal guardian and proxy. This aligns with Indonesian cultural norms, where medical decision-making is often familial rather than individualistic. Retrospective Consent: However, we recognized that proxy consent is insufficient for publishing a case history. Crucially, on Day 5, after the resolution of the acute psychotic phase and the return of insight, the patient was fully debriefed. The research team explained the study, showed her the timeline, and discussed the ritual intervention. The patient provided retrospective informed consent for her case details and the description of the ritual to be used for publication. She confirmed that the intervention aligned with her will and expressed relief that her spiritual needs had been met, validating the ethical integrity of the study.

3. Results and Discussion

The explanatory model: *Rujak* as the vector of *Cetik*

The Clinical Presentation of NKM: The patient, NKM, a 26-year-old Balinese Hindu female, presented with a phenomenology that defied standard

psychiatric categorization. While her behavior—psychomotor agitation, screaming, and paranoia—aligned with the criteria for Acute and Transient Psychotic Disorder (ICD-10: F23.2), the content of her distress was deeply embedded in the local taxonomy of harm. Unlike the auditory hallucinations typical of schizophrenia, where voices comment on behavior, NKM's primary symptom was somatic and thermal. She reported a sensation of "burning veins," describing a supernatural heat (*Panes*) coursing through her bloodstream, scorching her internal organs. This thermal dysregulation is a classic somatic marker in Balinese ethnopsychology, signifying a dangerous disequilibrium between the *Bhuana Alit* (microcosm/body) and the spiritual environment.

The Precipitant Event: The narrative reconstruction revealed that the onset of symptoms was not random but temporally linked to a specific social transaction. One week prior to admission, NKM had returned to her husband's ancestral village for a ceremonial obligation. During this visit, she was served *Rujak*—a traditional spicy fruit salad—prepared by her mother-in-law. In the mundane world (*Sekala*), the burning sensation she felt was likely attributable to the capsaicin in the dish. However, in the paranoid elaboration of her psychosis, this sensory input was radically reinterpreted through the lens of the *Niskala* (unseen). NKM became convinced that the *Rujak* was merely a vehicle for *Cetik*.

The Taxonomy of the Poison: Crucially, NKM did not believe she was merely cursed; she believed she was physically poisoned. She identified the agent specifically as *Cetik Reratusan*, a lethal concoction in Balinese sorcery lore composed of pulverized human bone, graveyard soil (*Setra*), and ritually impure herbs. This distinction is vital for clinical management. While *Guna-guna* can refer to abstract spells cast from a distance, *Cetik* implies a material invasion—a "magical object" that has entered the biological vessel and must be physically purged. This belief rendered oral antipsychotic medication terrifying to her; in her logic, introducing another chemical into her already poisoned body would only accelerate her destruction.

The CFI Finding: Psychosis as Social Critique: The administration of the Cultural Formulation Interview (CFI) allowed the clinical team to excavate the "Social Fracture" beneath the delusion. The delusion was not a bizarre firing of neurons but a coherent, tragic metaphor for her lived reality. NKM had been married for five years without producing a male heir, placing her in a precarious position within the rigid patrilineal kinship structure of Balinese society. The mother-in-law, in this narrative, was not simply a family member but the enforcer of lineage continuity. By believing the *Cetik* was designed to "destroy her womb," NKM was somaticizing her existential fear of infertility and disinheritance. The *Cetik* accusation functioned as a defense mechanism: it externalized the failure. She was not infertile due to a biological defect (which carries immense shame); rather, she was the victim of a malicious external attack. Thus, the psychosis served a protective psychological function, preserving her ego in the face of intense familial pressure.

The intervention

The Transformation of the Clinical Space: On Day 3, the psychiatric ward underwent a profound phenomenological transformation. To facilitate the *Penglukatan* (purification) ritual, the hospital administration permitted a temporary suspension of standard sterile protocols. The medical team engaged in "staging" the environment to bridge the epistemic gap. Biomedical equipment—monitors, IV stands, and oxygen regulators—were draped in white cloth, visually silencing the technological authority of the hospital. The pervasive olfactory signature of the ward, characterized by antiseptic and ethanol, was overwhelmed by the burning of *Dupa* (sandalwood incense). This sensory shift was not merely aesthetic; it signaled to the patient that the room had transitioned from a secular space of confinement to a sacred space of healing.

The Arrival of the *Balian*: The *Balian Panengen* (white healer), selected by the patient's kin, entered the ward wearing traditional ceremonial white attire (*Udeng* and *Saput*). His presence commanded immediate attention. Unlike the rotating roster of nurses and doctors, the *Balian* represented a singular, charismatic authority. He did not approach the patient with a clipboard or a syringe, but with

a *Dulang* (offering tray) containing flowers and holy water.

The Diagnostic Phase (*Nenung*): The intervention began with the *Nenung*, or intuitive diagnosis. This phase was critical for establishing a therapeutic alliance. The *Balian* did not ask about insomnia or agitation. Instead, he engaged the patient's narrative directly. He confirmed the diagnosis was *Non-Medis* (not medical). In a pivotal moment of validation, he stated, *"This is indeed Cetik. It was sent to make you Panes (hot) and to dry up your womb."*

This statement had a paradoxical clinical effect. By validating the delusion, the healer reduced the patient's paranoia. For days, the medical team had implicitly challenged her reality by offering antipsychotics for a "brain condition." The *Balian*, conversely, aligned with her reality. He exonerated her: she was not "crazy" (a permanent, stigmatized internal identity); she was a "victim" (a temporary, external state). This shift in labeling reduced her existential isolation.

The Therapeutic Phase (*Penglukatan*): Following the diagnosis, the *Balian* commenced the *Penglukatan*, or deep cleansing. He utilized a *Bungkak* (ivory young coconut), a vessel considered to have the highest ritual purity in Hindu cosmology, capable of neutralizing dark energy. Chanting ancient *Mantras* in Kawi (Old Javanese), he performed a series of asperges, sprinkling the coconut water over the patient's head—the seat of the soul. The ritual logic was precise. Because the affliction was *Cetik* (material poison), the cure required physical expulsion and neutralization. The *Balian* did not treat the affliction as an abstract spell (*Guna-guna*) which might require only prayer; he treated it as a toxicological emergency of the soul. He utilized *Tirta* (holy water) as a spiritual solvent.

The Sensory Resolution: As the water touched her face, the patient's demeanor shifted visibly. The *Balian* framed this water as *Banyu Pinaruh*—water of knowledge and cooling. He commanded the "heat" to leave her body. The patient, who had been screaming of "burning veins" hours prior, began to weep quietly. She reported a subjective sensation of *Tis*(coolness) washing over her chest and abdomen. This thermal transition—from the pathological *Panes* of the psychosis/poison to the restorative *Tis* of the holy water—marked the turning point of the clinical encounter. It signaled that the *Niskala* threat had been neutralized, rendering the body safe once again for habitation, and crucially, safe for the subsequent introduction of biomedical treatment.

The timeline of efficacy

To address the pharmacological confounder, a minute-by-minute log was analyzed (Table 1). The reduction in PANSS-EC from 22 (Severe) to 10 (Mild) occurred between 13:00 and 14:45. The first dose of Risperidone was administered at 15:00. Given that oral Risperidone requires 1 to 2 hours for peak plasma concentration, the rapid de-escalation of agitation was temporally distinct from the pharmacological effect. The ritual functioned as the primary anxiolytic.

Cultural versus clinical trajectory

The patient's recovery was not articulated through psychiatric terminology, but through a distinct "thermal phenomenology" rooted in Balinese cosmology. Upon admission, the acute psychotic state was somatically experienced as *Panes*, a destructive "spiritual heat" signifying the active presence of *Cetik* and psychological disintegration. Following the ritual intervention on Day 3, this pathological heat was immediately replaced by *Tis*, a sensation of "fresh coolness" that marked the return of insight and the neutralization of the sorcery. By Day 5, the patient described her state as *Sejuk*—a profound, homeostatic equilibrium. This transition reveals that for the Balinese patient, remission is perceived fundamentally as the restoration of thermodynamic balance between the microcosm of the body and the macrocosm of the spirit world.

The clinical trajectory of patient NKM offers a compelling microcosm of the broader challenges facing global mental health: the reconciliation of materialist neuroscience with meaning-centered cosmology. By analyzing the successful integration of a traditional *Penglukatan* ritual within a high-acuity psychiatric ward, this study moves beyond the binary

that places "science" in opposition to "superstition." Instead, we propose a symbiotic model where cultural intervention acts as a necessary physiological primer for biomedical treatment. The following discussion dissects the mechanisms of this success through three distinct lenses: the anthropological theory of symbolic efficacy, the neurobiology of the stress response, and the clinical framework of structural competence.[11]

Table 1. Temporal Sequence of Intervention on Day 3

Chronological mapping of ritual intervention, behavioral metrics (PANSS-EC), and pharmacological administration.

TIME	EVENT	PANSS-EC SCORE	PATIENT STATUS / CLINICAL OBSERVATION
13:00	Pre-Ritual Assessment	22	Severe agitation. Screaming *"Get it out!"* Refusal of oral medication and hospital water.
13:30	*Balian* Arrives	20	Incense lit. Patient status shifts to vigilant but quiet; eyes tracking the healer intensely.
14:00	*Penglukatan* Begins	18	Cleansing ritual starts. Patient is crying and shaking, but following the physical commands of the *Balian*.
14:30	Ingestion of *Tirta*	15	Patient drinks Holy Water. Reports **"Cooling"** sensation; breathing rate normalizes.
14:45	Ritual Concludes	10	**Clinical Breakpoint.** Patient voluntarily lies down on bed and asks for food.
15:00	Medication Offered	10	Nurse offers Risperidone 2mg. Patient accepts, asking: *"Is this to help the holy water?"*
16:30	Pharmacological Onset	5	Patient asleep. Approximate T-max (time to peak plasma concentration) of oral Risperidone reached.

In standard biomedical discourse, the improvement observed following a ritual is frequently dismissed as the "placebo effect." We vigorously argue against the application of this term in this context. The term "placebo" implies an inert substance—a "sugar pill" or a deception—that achieves a result only because the patient is gullible. To label *Balian's* intervention as a placebo is to commit an epistemic error that erases the profound cultural labor being performed. Instead, we align our analysis with Daniel Moerman's concept of the Meaning Response.[12] Moerman argues that the physiological effects of medical treatment are not solely derived from chemical properties but from the meaning the treatment holds for the patient. In the Balinese context, the *Penglukatan* is not inert; it is the most potent active agent available in the patient's worldview.[13]

To understand how this meaning translates into symptom reduction, we turn to the seminal work of Claude Lévi-Strauss and his concept of Symbolic Efficacy. In his analysis of the shamanistic complex, Lévi-Strauss argued that the healer provides the sick person with a language by which to express unexpressed states.[14] Patient NKM presented with a chaotic, terrifying sensory experience: her veins were burning, her womb was drying, and her body was

under siege. Biomedicine offered her the label "Psychosis," which described her behavior but failed to explain her suffering. The *Balian*, however, offered a precise mythic structure. He identified the formless burning as *Cetik*.

By naming the poison, the healer transformed a vague, terrifying anxiety into a concrete, manageable object. The ritual of sprinkling *Tirta* (holy water) acted as the operational mechanism for what Lévi-Strauss termed "abreaction." It allowed the patient to physically re-live the trauma of poisoning in reverse. If the *Rujak* was the moment of ingestion/contamination, the *Tirta* was the moment of expulsion/purification. This physical enactment creates a bridge between the sufferer's chaotic internal state and an ordered external reality. The "voices" and "heat" were re-categorized: they were no longer signs of permanent madness (an internal defect), but temporary symptoms of a spiritual attack that had been successfully neutralized. This cognitive restructuring is not merely psychological; it is the prerequisite for the restoration of the self.[15]

While the anthropological lens explains the cognitive restructuring, the biological lens explains the rapid behavioral de-escalation noted in our timeline. We posit that the ritual exerted a direct, potent effect on the patient's Hypothalamic-Pituitary-Adrenal (HPA) axis. Upon admission, NKM was in a state of acute hyper-arousal. The delusion of being poisoned by *Cetik* acts as a continuous, catastrophic threat to survival.[16] In this state, the amygdala drives a relentless "fight or flight" response, flooding the system with cortisol and norepinephrine. This hyper-adrenergic state is clinically manifested as severe psychomotor agitation, vigilance, and hostility recorded in her initial PANSS-EC score of 22. Crucially, when a patient is in this state of terror, the prefrontal cortex—the center of logic and reasoning—is effectively taken offline. This explains why standard verbal de-escalation ("You are safe," "There is no poison") failed. The patient could not cognitively process safety because her neurobiology was locked in a survival loop.

The ritual functioned as a "bio-behavioral switch." By utilizing symbols of absolute safety—the *Balian*, the incense, the holy water—the intervention successfully signaled to the amygdala that the threat had been neutralized. This likely precipitated a rapid downregulation of the sympathetic nervous system. The subjective report of "cooling" (*Tis*) is likely the phenomenological correlate of this parasympathetic activation. The "quiet window" observed at 14:45—where the patient stopped screaming and asked for food—represents the physiological stabilization of the HPA axis.

Therefore, the ritual did not treat the dopamine dysregulation directly. Instead, it treated the stress response that was exacerbating the psychosis. By lowering the adrenergic noise, the ritual restored enough prefrontal cortical function for the patient to comprehend the nurse's offer of medication. In this specific stress-diathesis model, the ritual was not an alternative to dopamine blockade, but a biological pre-requisite for it. It created the physiological conditions under which adherence became possible.[17]

The successful outcome of this case was not inevitable; it was engineered through the structural competence of the medical team. Structural competence, a framework introduced by Metzl and Hansen, requires clinicians to recognize how social and cultural structures shape clinical symptoms.[18] In this case, the team recognized that the "resistance to care" was not a symptom of the disease, but a symptom of the structural mismatch between the hospital's culture and the patient's culture.

The pivotal moment of integration lay in the "Negotiated Script" used by the doctors. In many cross-cultural encounters, clinicians fall into one of two traps: they either dismiss the belief (antagonism) or they pretend to believe it (disingenuous collusion). The team at Wangaya Regional General Hospital chose a third path: Division of Labor. The script utilized—*"We will repair the nerves... the Balian will handle the spiritual heat"*—was a masterclass in epistemic humility. It established a dual-sovereignty model. It validated the *Niskala* reality without surrendering the authority of the *Sekala* (biomedical) reality. Crucially, this script reframed the function of the antipsychotic medication. In the patient's original narrative, the pills were "chemicals" and therefore ontologically similar to

the "poison." By positioning the medication as "nerve vitamins" necessary to support the *Balian's* work, the doctors transformed the pills from a threat into a support mechanism. This alignment prevented the "epistemic collision" that typically leads to discharge against medical advice. It demonstrates that effective transcultural psychiatry is often a diplomatic negotiation between two sovereign definitions of reality.[19]

Figure 1. Bio-cultural mechanism of integrated care.

We must critically appraise the limitations of this study to contextualize its findings appropriately. The primary limitation is the inherent restriction of the single-case clinical ethnography design. While this method allows for the generation of deep, "thick" data, it lacks the statistical power to generalize findings to the broader population of psychotic patients in Indonesia. The specific efficacy of the *Penglukatan* ritual is deeply tied to the specific cultural conditioning of a Balinese Hindu patient; it would likely have no effect, or perhaps even a deleterious effect, on a patient from a different religious background who does not share the same mythic structure.[20]

Furthermore, we acknowledge the methodological vulnerability regarding the PANSS-EC ratings. As the ratings were performed by the primary treating clinician in an unblinded manner, the potential for observer bias cannot be fully eliminated. The clinician, invested in the success of the integrative approach, may have unconsciously rated the post-ritual behavior more favorably. However, we argue that the objective behavioral markers—the transition from screaming to silence, the cessation of restraint, and the voluntary ingestion of food—provide robust corroboration for the numerical scores. Finally, the Logistical Scalability of this intervention presents a significant challenge. The successful integration of this ritual required a flexible hospital infrastructure that could accommodate "biological hazards" such as smoke from incense and the ingestion of unsterilized water. Many hospitals in rural Indonesia lack the private isolation rooms or ventilation systems necessary to safely permit such rituals without compromising the respiratory safety of other patients. Consequently, while this study provides a theoretical blueprint for integration, the practical implementation requires not just clinical willingness, but architectural and administrative adaptation.

4. Conclusion

The case of NKM challenges the reductionist view that traditional beliefs are merely barriers to care. In this context, the *Cetik* narrative was the vehicle for recovery. The detailed timeline confirms that *Balian* did not cure the dopamine dysregulation, but he cured the demoralization and existential terror that fueled the agitation, doing so before the first pill was swallowed. To advance the field of Integrative Psychiatry, we propose two specific recommendations. First, future research should utilize randomized controlled trials (RCT) comparing "Treatment as Usual" against "Treatment plus Ritual" to quantitatively measure the pathoplastic effect of such interventions on acute agitation. Second, from a policy perspective, hospitals in Southeast Asia should develop formal protocols for "spiritual visitation" akin to chaplaincy services in the West. Such policies would institutionalize safe, regulated spaces for traditional rituals, allowing them to serve as valid adjunctive tools for de-escalating acute psychiatric crises.

5. References

1. Mustofa FI, Rahmawati N, Aminullah. Medicinal plants and practices of Rongkong Traditional Healers in South Sulawesi, Indonesia. Biodiversitas. 2020; 21(2).
2. Naufal A, Widayanti AW, Gani AP. Utilization of traditional healers and health-seeking behavior on low socio-economic status community in Gunungkidul, Indonesia. Res Social Adm Pharm. 2023; 19(7): 14.
3. Yimer TM, Chan GC, Belete H, Hides L, Leung J. Treatment-seeking behavior and barriers to mental health service utilization for depressive symptoms and hazardous drinking: The role of religious and traditional healers in mental healthcare of Northwest Ethiopia. Glob Ment Health (Camb). 2023; 10: e92.
4. Lee YJ, Coleman M, Nakaziba KS, Terfloth N, Coley C, Epparla A, et al. Perspectives of traditional healers, faith healers, and biomedical providers about mental illness treatment: qualitative study from rural Uganda. Glob Ment Health (Camb). 2025; 12(e29): e29.
5. Theodoridou A, Schultze-Lutter F, Ambarini TK. Implementing early intervention in psychosis in Indonesia: a scoping review.

Asian J Psychiatr. 2024; 101(104189): 104189.

6. Farooq S, Sheikh S, Dikomitis L, Haq MMU, Khan AJ, Sanauddin N, et al. Traditional healers working with primary care and mental health for early intervention in psychosis in young persons: protocol for the feasibility cluster randomised controlled trial. BMJ Open. 2023; 13(7): e072471.
7. Ralph R, Ramesh RM, Jambugulam M, Deborah AA, Aruldas K, Moorthy NA, et al. Health-seeking behaviours and traditional healer practices for snakebite in rural and tribal communities in southern India. Trans R Soc Trop Med Hyg. 2025; 119(3): 317–26.
8. Luitel NP, Lamichhane B, Koirala P, Sainju P, Ghimire A, Gautam K, et al. Treatment of depression by traditional faith healers in Nepal: a qualitative study. SSM Ment Health. 2025; 7(100425): 100425.
9. Singh R, Joubert PM. A psychiatrist in training encounters a traditional healer. S Afr J Psychiatr. 2025; 31: 2453.
10. Wollie AM, Usher K, Rice K, Islam MS. Challenges and opportunities for integrating traditional healing approaches with biomedical care for mental illness: a scoping review from healers' perspectives. PLoS One. 2025; 20(6): e0325353.
11. Ajayi G, Salami R, Omonijo I. Demographic survey of traditional healers and their practices in Ikorodu and Mushin Local government areas of Lagos State, Nigeria. J Res Tradit Med. 2018; 4(2): 1.
12. Bounlu M, Auditeau E, Vorachit S, Chivorakoun P, Souvong V, Soukhasem T, et al. Management of epilepsy in Laos: Perceptions of healthcare professionals from Vientiane Capital province and traditional healers in Southern Laos. J Tradit Complement Med. 2021; 11(1): 46–52.
13. Panda AK, Woldeamanel MM, Senapati S, Mohapatra S, Subudhi H, Rath P. Ethnomedicinal and ethnobotanical investigations and documentation of plants used by traditional healers of Eastern India. Curr Tradit Med. 2022; 8(6).
14. Maresht EM. Ethnomedicinal minerals and geological materials used by traditional Iranian Turkic healers. Tradit Med Mod Med. 2024; 07: 53–73.
15. Tabaza Y, Aburjai T. Ethnopharmacological survey of medicinal plants used by local herbalists and traditional healers for the treatment of cancer in Jordan. Curr Tradit Med. 2024; 10(3).
16. Apud I, Romaní O. Medical anthropology and symbolic cure: from the placebo to cultures of meaningful healing. Anthropol Med. 2020; 27(2): 160–75.
17. Balagangadharan P, Sanal S. Ephemeral ink, eternal strength: Exploring the symbolic and therapeutic dimensions of tattoos in the healing process of cancer survivors. The Creative Launcher. 2025; 10(2): 140–50.
18. Sardiana IK, Mahardika IK, Suryawardani IO, Sarjana IM, Purnawan NLR. Sekala-niskala: a local cultural approach in developing community-based ecotourism in Pemuteran, Bali (Commemorating I Gusti Agung Prana's Initiative). J Tour Hosp Manag. 2020; 8(2).
19. Jayanthi NMD, Suhariningsih, Safa'at R, Hamidah S. The concept of sekala niskala in credit agreements at Labda Pacingkreman Desa Bali traditional village. Russ J Agric Socio-econ Sci. 2021; 115(7): 28–35.
20. Dundar A, Irmak H, Ayhanci T, Cetik Yildiz S. Evaluation of serum levels of kidney injury molecule-1 (KIM-1) and Neutrophil gelatinase-associated lipocalin (NGAL) as potential biomarkers of renal tubular damage in brucellosis patients. Int J Gen Med. 2025; 18: 5039–46.