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Navigating Dual Realities: Cultural Dissonance in Mental Health Help-Seeking in Rural Malaysia

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Abstract

Conventional approaches often frame low mental health help-seeking as a literacy deficit, viewing traditional beliefs merely as barriers. This overlooks the profound cultural and spiritual significance of local healing practices. Moving beyond the deficit model, this study explores the lived experience of cultural dissonance -the tension arising from navigating competing biomedical and traditional frameworks- and the resulting adaptive strategies. A 12-month integrated qualitative study, combining Critical Ethnography and Interpretative Phenomenological Analysis. Participants (N= 42) included patients, family caregivers, traditional healers (*bomoh*), and healthcare providers. Data were gathered through 1,200 hours of immersive observation, semi-structured interviews, and visual narrative elicitation. Findings reveal three dimensions of cultural dissonance: Compartmentalized Compliance, where patients lead a double life by presenting a clinical self in biomedical settings and a spiritual village self at home; Semantic Dissonance, the reframing of diagnoses into culturally meaningful terms to preserve identity; and Silent Betrayal, where accepting biomedical treatment is perceived as a transgression of faith or filial loyalty. Resolution occurs primarily through cultural authorization, where trusted authorities (*ustaz*, *bomoh, elders*) legitimize medical care within a spiritual framework. Consequently, stigma and non-compliance are often expressions of unresolved dissonance. To be effective, mental health systems must shift from purely educational campaigns toward culturally embedded collaboration, partnering with traditional and religious authorities to create hybrid, acceptable pathways to care.

Key words: mental health stigma, cultural dissonance, ethnography, phenomenological analysis, traditional healing, rural Malaysia.

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Novelty and Significance

What is already known about the topic?

- Mental health help-seeking in Malaysia and similar Southeast Asian contexts is frequently framed through a deficit model, attributing low service utilization to biomedical literacy gaps and mistaken cultural beliefs, despite growing evidence that traditional healing carries profound cultural and spiritual significance.
- Studies in collectivist societies consistently show that help-seeking decisions are fundamentally collective and relational, shaped by family consensus and cultural authorization, rather than by individual rational choice alone.
- Cognitive dissonance theory, primarily developed in Western individualist contexts, has limited application to understanding how individuals in collectivist societies navigate competing epistemological frameworks simultaneously.

What this paper adds?

- This study reconceptualizes mental health stigma and apparent non-compliance as cultural dissonance rather than as a literacy or attitudinal deficit.
- Three novel dimensions of dissonance was documented: Compartmentalized Compliance, Semantic Dissonance, and Silent Betrayal.
- Cultural authorization was identified as the critical relational mechanism that resolves dissonance and enables biomedical help-seeking.

The global mental health agenda has expanded considerably in recent decades, and Malaysia exemplifies this trajectory through its substantial investments in psychiatric infrastructure: government mental health units, community health clinics, and nationwide public campaigns that encourage citizens to recognise mental illness as a treatable medical condition (Raaj, Navanathan, Tharmaselan, & Lally, 2021; Ibrahim, Mohd Safien, Siau, & Shahar, 2020). Yet significant treatment gaps persist. Help seeking is

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delayed, diagnostic disclosure carries profound shame, and many patients continue to pursue traditional healing alongside or instead of psychiatric care. These patterns reflect deeper cultural and epistemological tensions that infrastructure alone cannot resolve (Raaj *et alii*, 2021).

Within the mental health literature, this persistence is typically explained through a deficit lens: communities are said to hold mistaken cultural beliefs that obstruct access to scientific treatment (Andary *et alii*, 2023; Muda & Ahmad, 2025). The conventional response is fundamentally educational, implemented through psychoeducation programmes, mental health literacy initiatives, and community awareness campaigns, all of which position biomedicine as objective truth while framing traditional beliefs as obstacles to be overcome. This model rests on a critical assumption that may not hold in practice (Mathias *et alii*, 2024; Wardani, Jannah, & Tunggal, 2025). The notion that comprehending psychiatric science will lead individuals to abandon traditional interpretations underestimates the deep cultural, spiritual, and relational meanings embedded within traditional healing systems, which are not merely informational in nature but integral to personal and communal identity.

The lived experience of patients and families in rural Kelantan and Terengganu tells a considerably more complex story. Stigma in these communities is not primarily rooted in ignorance but in what this study terms cultural dissonance: a profound and often unarticulated tension between competing ways of knowing, interpreting suffering, and being in the world (Arif & Olagoke, 2024; Thong, Ting, Takeuchi, Jobson, & Phipps, 2025). To illustrate this tension, consider a mother whose son receives a psychiatric diagnosis of schizophrenia. She does not necessarily lack awareness that the condition involves brain chemistry; instead, she confronts an existential choice between a biomedical explanation that defines her son as neurologically impaired and a spiritual framework within which healing, moral meaning, and social reintegration remain possible. This study moves beyond the deficit model to ask not why people fail to understand psychiatric concepts, but how they actively reconcile incommensurable ways of understanding suffering while managing the psychological and social costs of living within that duality.

Scholarship in non-Western contexts has long recognized that individuals hold multiple, sometimes contradictory beliefs about mental illness (Wollie *et alii*, 2025), and some studies interpret this plurality as confusion or cognitive inconsistency (Lee *et alii*, 2025; Subu et *et alii*, 2022). More sophisticated anthropological and psychological research, however, offers a different reading: holding multiple belief systems is a rational and adaptive response to living across social domains governed by distinct and sometimes conflicting rules (Alabi, 2025). Cultural psychology describes this as domain specific reasoning, where biomedical frameworks are applied in clinical encounters while spiritual frameworks guide family and community life, without contradiction, because each serves a different purpose in a different context (Ayinde *et alii*, 2023). This is contextual appropriateness, not inconsistency.

Dissonance emerges, however, when these distinct domains collide. When a clinical diagnosis arrives home and family members interpret it through a spiritual lens, the comfortable coexistence of domain specific reasoning gives way to genuine tension (Lee *et alii*, 2025; Wollie *et alii*, 2025). When a doctor advises medication and a family elder urges a blessing for the same condition, this is no longer a matter of applying different frameworks to different purposes; it becomes a confrontation between competing truth claims about the same phenomenon, generating psychological tension precisely because both systems carry weight and validity within the patient's social world.

Research on cognitive dissonance in cross cultural contexts increasingly recognises its resolution as a social and relational process rather than a purely individual cognitive

event (Gawronski, Peters, & Strack, 2008; Reis & Judd, 2000). This understanding departs from Festinger's (1957) original theory, which emphasised individual psychological mechanisms; subsequent studies in collectivist societies demonstrate that dissonance is more commonly resolved by seeking permission from respected others, aligning with valued social groups, or accepting the guidance of cultural authorities (Hillman, Fowlie, & MacDonald, 2023; Gobel & Miyamoto, 2024). These patterns are strikingly evident in Malaysia, where Phang, Midin, and Aziz (2010) report that fifty four percent of first episode psychosis inpatients had consulted at least one *bomoh* before seeking psychiatric services, driven largely by family and community recommendation, and where Rajagopal, Stephenson, and Ousey (2023) confirm that mental health decisions remain fundamentally collective rather than individual. What outsiders frequently perceive as resistance to treatment often reflects not an unwillingness to recover but an absence of cultural permission. When an *Ustaz* affirms that medication is consistent with Islamic principles of preserving health, or when a respected *bomoh* refers a patient to hospital while promising complementary spiritual care, dissonance dissolves and help seeking follows naturally.

Ethnographic methods are uniquely suited to revealing these dynamics, accessing what surveys and brief interviews cannot (Bhui, Dein, & Pope, 2021; Heller, 2008). Geertz (1973) articulated ethnographic inquiry as uncovering the webs of meaning in which actions are suspended, going beyond surface observation to examine the stratified cultural contexts that give actions their significance (Susen, 2024). When a patient takes psychiatric medication in the morning yet wears a protective amulet, consults a *bomoh* privately, or performs Islamic supplications for healing, these are not contradictions to be explained away but meaningful acts whose significance can only be understood within their full cultural and relational context. Recent psychiatric ethnography in non-Western settings consistently finds that what clinicians interpret as non-compliance or poor insight reflects sophisticated cultural reasoning and relational navigation (Bhui *et alii*, 2021; Dikomitis & Shergill, 2025).

The present study is grounded in two complementary methodological traditions that together address both the macro structural and micro experiential dimensions of cultural dissonance. Critical Ethnography, informed by postcolonial theory and power conscious scholarship, extends classical ethnographic observation to explicitly examine how dominant systems, in this case biomedical psychiatry, interact with and potentially marginalize alternative knowledge systems such as traditional healing (Eatough & Smith, 2017; Alemu, Osborn, & Wasanga, 2023). This approach asks not only what is happening, but what power dynamics shape what is happening, whose voices are privileged, and what perspectives are rendered marginal. Interpretative Phenomenological Analysis, developed by Jonathan Smith and colleagues, provides a structured psychological framework for analysing how individual participants make sense of their experiences (Smith & Osborn, 2015). By integrating these two approaches, the study operates simultaneously at the macro level, examining how psychiatric and traditional healing systems interact as social institutions and structures of power, and at the micro level, exploring how individual patients experience and navigate the collision of these systems. This integration is theoretically grounded in what anthropologists call the practice theory perspective: the recognition that macro level social structures are reproduced, resisted, and transformed through the everyday practices and interpretations of individuals (Frost *et alii*, 2020; Gómez Carrillo & Kirmayer, 2023). The aim of the present study was to explore the lived experience of cultural dissonance and the adaptive strategies employed by patients, families, and community members in rural Malaysia to navigate competing biomedical and traditional frameworks of mental health.

METHOD

The study was conducted over a 12-month period from November 2024 to October 2025 across three rural districts in Kelantan and Terengganu, states located in the northeast of Peninsular Malaysia. These locations were strategically selected because prior epidemiological research demonstrates that rates of consultation with traditional *bomohs* remain elevated in these areas, particularly in rural communities (Merriam & Muhamad, 2013; Salleh, 1989). Both states are culturally and religiously conservative, with strong adherence to Islamic traditions and Malay customs. The communities maintain active networks of traditional healers, affording an opportunity to observe the interface between traditional and biomedical systems in everyday life. The lead researcher established residence in one community for the full 12 period, a commitment regarded as essential for genuine ethnographic immersion. Rather than conducting periodic visits, the researcher lived within the community, attended local gatherings, and maintained a presence across seasons and contexts, building the depth of trust necessary for participants to speak openly about sensitive matters.

Participants

The total sample of Participants (N= 42) were recruited through purposive and snowball sampling strategies appropriate for ethnographic research (Creswell & Poth, 2016; Ting, Memon, Thurasamy, & Cheah, 2025). The sample comprised four groups: patients with lived experience of mental illness (n=20), individuals aged eighteen to sixty five who had received a psychiatric diagnosis of schizophrenia, major depressive disorder, or anxiety disorder, and who had utilized both psychiatric services and traditional healing within the preceding twelve months; family caregivers (n=12), typically spouses, parents, or adult children responsible for treatment decisions and day to day care; traditional healers (n=5), including *bomohs* practicing within Malay animistic and Islamic healing traditions as well as Islamic medical practitioners; and healthcare providers (n=5), including psychiatric nurses and medical officers employed at government health clinics.

Table 1 presents the demographic profile of all participants across the four groups, including age range, gender, primary language, mental health condition, and prior consultation with a *bomoh*, providing the reader with the sampling context necessary to evaluate the breadth and representativeness of the data.

Table 1. Demographic data and characteristics of the participants.

Participant Group	*N*	Age Range	Gender	Primary Language	Mental Health Condition	Prior *Bomoh* Consultation
Patients with diagnosed mental illness	20	18-65 (*M*= 42.3)	12F, 8M	Malay/Kelantanese	Schizophrenia (8), MDD (7), Anxiety (5)	18/20 (90%)
Family caregivers	12	35-78 (*M*=54.6)	9F, 3M	Malay/Kelantanese	N/A	11/12 (92%)
Traditional healers (*Bomohs*)	5	48-72 (*M*=61.2)	2F, 3M	Malay	N/A	Self-identified practitioners
Healthcare providers	5	32-58 (*M*=44.8)	3F, 2M	Malay/English	N/A	N/A
TOTAL	42	18-78	24F, 18M	Multilingual	Diverse	29/32 (91%)

Notes: F= Female; M= Male; *M*= Mean; N/A= Not Applicable (in the Mental Health Condition column, N/A indicates that family caregivers, traditional healers, and healthcare providers were recruited on the basis of their professional or caregiving role and were not required to hold a psychiatric diagnosis, and this category therefore does not apply to these participant groups / in the Prior *Bomoh* Consultation column, N/A indicates that this measure pertains to patient and caregiver help-seeking behavior and is not applicable to healthcare providers recruited in a professional capacity); MDD= Major Depressive Disorder.

Design

This study employs an integrated qualitative design that brings together Critical Ethnography and Interpretive Phenomenological Analysis. This integration allows the phenomenon to be approached from two complementary perspectives: the sociopolitical structures that shape participants' reality, and the profound subjective meaning they attribute to their personal experiences. Critical ethnography situates participants within their systemic contexts, identifying the power relations, inequalities, and cultural norms that shape their circumstances. Interpretive phenomenological analysis focuses on the detailed exploration of lived experience, providing an idiographic lens through which individual voices are preserved rather than absorbed into structural analysis. The integration of these two approaches allows the present study to hold the social and the personal in productive dialogue throughout the analytical process.

Data Collection

Participant observation. Participant observation formed the primary data collection strategy. The researcher conducted systematic observation across multiple community settings: government health clinic waiting rooms and clinical encounters, traditional healing spaces including the clinics and homes of *bomohs*, family households, community gatherings, and religious settings. Over the twelve-month period, the researcher logged approximately 1,200 hours of field observation. Field notes served as the primary data source, documenting actions, statements, physical environments, and the researcher's own interpretive responses. Ethnographic field notes seek to capture what anthropologists' term thick description: not merely what happened, but the contextual layers that give actions their meaning. Notes also recorded the researcher's emotional responses and reflexive thoughts about how their positionality might be shaping observations. Rigorous reflexivity was maintained throughout the fieldwork period through regular debriefing discussions that explicitly examined potential biases and assumptions.

Semi-Structured Interviews. Semi structured interviews were conducted with all 42 participants. For core participants, meaning patients and close family members, multiple interviews were typically conducted, ranging from two to four interviews per person, to permit relationship building, reflection, and iterative exploration of emerging themes. Interview guides were designed to elicit phenomenological accounts rather than to test preexisting hypotheses. Questions were crafted to move beyond surface level inquiry toward deeper phenomenological engagement. All interviews were conducted in Malay, audio recorded with participant consent, and transcribed *verbatim*, preserving paralinguistic features including pauses, emphases, code switches between Malay and English, and instances of faltering speech that signaled emotional discomfort (Smith & Osborn, 2015).

Visual Narrative Elicitation. Recognizing that language alone cannot capture all dimensions of experience, particularly around topics associated with shame and stigma, the research also incorporated visual methods. Participants were invited to create visual representations of their healing journey. Instructions were deliberately open: "Draw or diagram how you got from feeling unwell to feeling better. Include places, people, and moments that mattered. There's no right or wrong way to do this." These drawings frequently revealed conflicts and relationships that verbal language had not surfaced, and they provided data that complemented the interviews in particularly valuable ways, capturing experiences that language might censor out of fear of clinical judgement or community disapproval (Labbouz *et alii*, 2025).

Procedure

This study received full ethical approval from the Institutional Review Board and adhered to international ethical standards, including the Declaration of Helsinki, as well as Malaysian regulatory requirements (Ref: AABB8854(M06Y23). A rigorous,

culturally adapted informed consent process was implemented. Participants were fully informed of the study's aims, procedures, potential emotional risks, and their right to withdraw. All narratives were anonymized and stored securely to protect confidentiality. Prospective participants received comprehensive verbal and written information about the study's purpose, procedures, potential risks and benefits, and confidentiality protections. Recognizing the diversity of literacy levels and communication norms within the participating communities, consent was frequently obtained verbally in the presence of a witness and documented through audio recording and field notes. Consent was treated as an ongoing process, reaffirmed throughout the twelve-month study period, with participants' rights to refuse questions or withdraw at any time without penalty explicitly communicated at each encounter.

Enhanced protections were employed given the vulnerability of the participant population. Individuals experiencing acute psychiatric crisis were excluded from participation. Additional safeguards included trauma informed interviewer training, the selection of safe and private interview locations, psychological debriefing following interviews, and established crisis referral pathways. The research was preceded by six months of community engagement with local leaders, religious figures, and traditional healers, undertaken to build trust and ensure cultural appropriateness throughout the fieldwork. The researcher maintained ongoing reflexivity through personal journaling and sustained collaboration with cultural advisors. Findings were shared with the community at the conclusion of the study to ensure mutual benefit and reciprocity. Strict confidentiality protocols were observed: all data were anonymized using pseudonyms, audio files were destroyed following transcription, and data were stored on encrypted, password protected systems with access limited to the core research team.

Data Analysis

Data analysis followed the Interpretative Phenomenological Analysis approach outlined by Smith and Osborn (2015), adapted and enriched by ethnographic sensibilities. The process unfolded through six iterative and mutually informing stages.

Stage 1. In the first stage, each interview transcript was read carefully and repeatedly alongside relevant field notes and visual materials. The research team annotated the left margin with descriptive, linguistic, and conceptual observations.

Stage 2. In the second stage, researchers proceeded to identify emergent themes, drawing out the meaningful content of participants' accounts, including rejection of biomedical diagnoses, persistence of supernatural causal models, and the experienced tension between clinical and lived experience explanations.

Stage 3. In the third stage, codes derived from one transcript were iteratively compared with those from subsequent transcripts, revealing both convergences and divergences (Miller, Chan, & Farmer, 2018). This analytical stage was enriched by the ethnographic field data: observation notes documenting the cultural context allowed researchers to distinguish between accounts reflecting genuine cognitive dissonance and those that were a form of situational performance or social politeness.

Stage 4. In the fourth stage, researchers clustered the identified codes and themes to arrive at broader superordinate themes that captured the essential structure of participants' experience.

Stage 5. The fifth stage involved interpretative synthesis, engaging what Interpretative Phenomenological Analysis scholars call the double hermeneutic: the participant interprets their own experience, and the researcher in turn interprets that interpretation. At this stage, researchers moved beyond description to engage in theory informed interpretation (Eatough & Smith, 2017; Miller *et alii*, 2018).

Stage 6. The final stage employed multiple strategies to ensure rigor and validity: investigator triangulation involving two independent researchers who coded a random selection of

ten transcripts, member checking through five sessions with community members and patient advisory groups, and peer debriefing in which interpretations were stress tested with clinicians, traditional healers, and other researchers.

Results

Analysis revealed that cultural dissonance in Malaysian mental health help-seeking is not a static state of confusion or rejection but rather an active, dynamic process (Raaj *et alii*, 2021). Individuals and families continuously work to navigate epistemological divides, employ sophisticated meaning-making strategies, and manage the relational consequences of their choices. Three superordinate themes captured the phenomenological structure of this experience: Compartmentalized Compliance, Semantic Dissonance, and Silent Betrayal.

Figure 1 presents a hierarchical conceptual model that illustrates the three-dimensional architecture of cultural dissonance as experienced by patients, family caregivers, and community members in rural Malaysia. This diagram synthesizes twelve months of ethnographic data and forty-two semi-structured interviews into a coherent theoretical structure. It reveals that cultural dissonance is not a monolithic phenomenon, but rather a complex and multifaceted process involving distinct yet interconnected mechanisms of negotiation, meaning making, and adaptation.

At the center of the diagram is the core concept under investigation: cultural dissonance in mental health help-seeking. This refers to the psychological and social tension individuals experience when navigating between fundamentally different systems for understanding mental illness. Unlike simple cognitive dissonance, which involves conflicting beliefs within a single framework, cultural dissonance arises from the collision of entire worldviews (Razak, 2017; Cucchi & Qoronfleh, 2025). This includes a biomedical or materialist framework on one side, and a spiritual, relational, and communal framework on the other. The research reveals that this dissonance is not merely a failure of understanding or a barrier but rather constitutes a sophisticated response to the genuine incommensurability between these systems.

The three superordinate themes in the diagram represent distinct but interconnected mechanisms through which this dissonance emerges and is negotiated. Rather than being separate phenomena, they represent three dimensions of a unified adaptive process. This theme captures the phenomenological reality that patients and families do not experience dissonance as a state of paralysis or refusal. Instead, ethnographic analysis reveals that they engage in a sophisticated strategy of compartmentalization. This involves maintaining parallel yet distinct senses of self that operate strategically across different social and institutional contexts.

The *Clinical Self*: Inside the government clinic or private psychiatry office, patients adopted psychiatric language, described symptoms in standardized terms ("I cannot sleep," "I have no energy"), acknowledged the clinician's explanation of chemical imbalance, and appeared to accept the treatment plan. Clinical documentation typically noted "good insight" and apparent compliance with treatment.

The *Village Self*: Once the patient crossed the clinic threshold back into the community, the narrative shifted. Mental distress was described through different categories: *semangat lemah* (weak spirit/lost of soul), *keresahan hati* (heart uneasiness/anxiety), *gangguan arwah* (disturbance from spirits). Treatment centered on ritual, including Quranic recitation, blessed water (*air tawar*), visits to ancestor graves, consultation with Islamic teachers.

Table 2 maps this parallel existence across six analytical dimensions, contrasting the clinical self and the village self in terms of diagnostic label, cause attribution, treatment

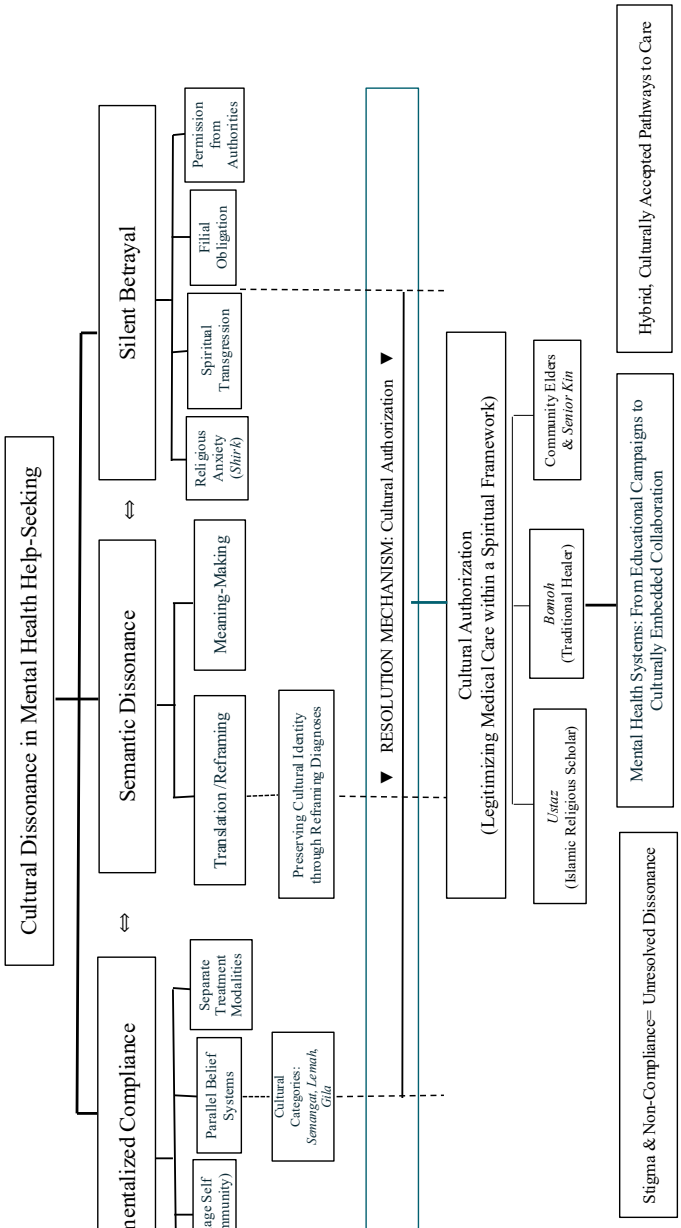

Figure 1. Thematic Architecture of Cultural Dissonance. How Patients and Families Negotiate the Collision Between Biomedical and Traditional Healing Systems.

Table 2. Compartmentalized Compliance-Clinical vs. Village Narrative.

Dimension	Clinical Self (Hospital/Clinic)	Village Self (Home/Community)
Diagnostic Label	Major Depressive Disorder	*Semangat Lemah* (weak spirit)
Cause Attribution	Chemical imbalance	"Spiritual disturbance"/"Test from Allah"
Treatment Modality	Psychiatric medications, therapy	Quranic recitation, blessed water, prayer
Location of Materials	Kitchen cupboard	Bedroom/prayer space
Recovery Narrative	Medication will stabilize symptoms	"Community support will restore my *semangat*." (spirit)
Social Identity	Individual medical condition	Integrated cultural/relational identity

modality, location of materials, recovery narrative, and social identity. Together, these dimensions reveal the systematic and deliberate nature of the compartmentalization strategy that patients employ to navigate both worlds simultaneously.

One patient, a 48-year-old woman diagnosed with major depressive disorder, articulated this splitting with clarity:

> "I take the white pill for my body because the doctor says the nerves are weak. But I drink the recited water for my spirit because the pill cannot touch the spirit. They are different things. They are like different lanes on the same highway. One does not interfere with the other."

Ethnographic observation revealed that this compartmentalization was physically manifest. Psychiatric medications were stored in the kitchen, associated with bodily nourishment. Amulets, holy water, and Quranic talismans were kept in prayer areas, associated with spiritual protection. By maintaining physical separation, families affirmed the parallel legitimacy of both systems.

A statement from a 32-year-old male participant:

> "At the hospital, I tell them about the sadness and the weight. I say 'depression' because that is the word they understand. But at home, with my mother, we talk about *hantu* [spirits/ghosts] and the prayers we must do. It is not lying; it is speaking the right language in the right place."

This statement clearly illustrates the compartmentalization of Diagnostic Label and Cause Attribution. In the clinical context, he adopts the biomedical label ("depression"). In the village context, he shifts to a spiritual causal model (hantu). He frames this not as dishonesty but as a strategic use of different cultural "languages," demonstrating how the Social Identity of a patient changes based on setting.

Statement from a 55-year-old female patient:

> "The doctor gives me pills for my brain. The *ustaz* gives me verses for my heart. My brain is cloudy, my heart is heavy. Why should I only choose one? I walk with two feet, not one."

Here, the participant maps different Treatment Modalities onto different aspects of her being medication for the brain (biomedical) and religious verses for the heart (spiritual). This reflects a distinct Cause Attribution, where distress has simultaneous physical and spiritual locations. Her rhetorical question challenges the notion of having to choose one system, embodying the parallel operation of both frameworks.

Statement from a 40-year-old male participant describing his father's care:

> "When we go to the clinic, we talk about symptoms and dosage. When we sit with the village elders, we talk about peace and broken taboos. My father listens

to both. In the clinic, he is a patient. In the village, he is *Pak Mat* who is being tested by God. He is both."

This narrative captures the shift in Social Identity and the content of help-seeking talk. In the clinic, the focus is on symptoms (biomedical). In the village, the focus is on social harmony and spiritual tests (communal/religious). The speaker explicitly names his father's dual identities: the individual patient and the socially integrated *Pak Mat*, demonstrating a fluid movement between these selves.

This strategy, while reducing the existential burden of choosing between systems, creates what from a biomedical perspective appears as non-compliance. Yet ninety percent of patient participants (18/20) explicitly described maintaining separate frameworks. Ninety-two percent of family caregivers (11/12) reported organizing treatment around both systems. Eighty percent of patients reported being able to take psychiatric medication while simultaneously maintaining traditional healing practices, not as contradiction but as complementary approaches.

Whereas Compartmentalized Compliance operates at the level of behavioral and relational management, Semantic Dissonance operates at the level of language and meaning. This theme captures the profound linguistic gap between psychiatric diagnostic categories and the culturally embedded vocabularies through which patients and communities understand mental distress.

Table 3 documents the semantic gap at the heart of this theme, presenting four key psychiatric diagnostic terms alongside their intended clinical meaning, the family or cultural interpretation applied in this rural Malaysian context, and the specific form of dissonance that each gap generates for patients and their families.

Table 3. Semantic Dissonance. Gap Between Psychiatric and Cultural Categories.

Psychiatric Term	Intended Meaning	Family/Cultural Interpretation	Resulting Dissonance
Depression	Treatable neurochemical disorder	*Lemah semangat* (weak spirit/motivation), lack of faith, moral failing	Patient feels labeled as spiritually deficient
Anxiety	Physiological arousal response	*Angin* (Vibe/Vibrancy), spiritual unease	Symptom re-framed as physical sensation not psychological disorder.
Schizophrenia	Brain disease with treatment	*Gila* (madness), possession, incurable	Profound shame, family withdrawal.
Hearing Voices	Neurobiological symptom	Ancestral communication, spiritual messages	Symptoms become spiritual gift requiring listening.

When a psychiatrist diagnosed a 34-year-old man with Generalized Anxiety Disorder, the diagnosis was received by his family as *gila*, a Malay term encompassing severe mental derangement. The gap between the clinician's intended meaning and the family's understanding is vast. *Gila* implies fundamental alteration of personhood, possible possession, dangerousness, and uncertain prognosis. The psychiatric diagnosis, carefully defined as a treatable brain condition, becomes experienced as a catastrophic label. Families withdraw not because they lack medical knowledge but because the cultural meaning of the category triggers appropriate protective responses. A 52-year-old woman exemplified this when she explained:

"The doctor says I have Major Depressive Disorder. But when I tell my family, I say my *semangat* is weak. When I say it this way, my husband understands. He knows I am tired and weak, not crazy. He knows I can recover."

Patients and families engaged in active semantic re-framing, a process of translating psychiatric categories back into culturally meaningful terms. This translation did not constitute a denial of illness but was instead a form of meaning-making that allowed

suffering to be integrated into a coherent narrative in which recovery was possible.

Statement from a mother, aged 58, regarding her son's diagnosis:

> "At the hospital, they wrote 'schizophrenia' in his book. In our village, that word is the same as *gila*. It means no future, no marriage, just shame. So at home, we say he has a 'sensitive spirit' (*semangat sensitif*). It means he needs more prayer and protection, not that he is lost. This way, we can still hope."

This statement directly corresponds to the term Schizophrenia (see Table 4). The mother acknowledges the clinical label but actively re-frames it from the catastrophic cultural interpretation of *gila* (madness/incurable) to *semangat sensitif*. This re-framing transforms the resulting Dissonance, from shame and withdrawal to a narrative where the condition requires spiritual care and retains hope for recovery.

Statement from a 29-year-old man diagnosed with anxiety:

> "The doctor told me I have 'Generalized Anxiety Disorder.' I feel that this constant worry. But I explain it to my friends as having too much *angin* in my body -it's restless and hot. They understand that. They suggest herbs to cool it down. If I said, 'anxiety disorder,' they would just think I'm weak-minded."

This illustrates the re-framing of the term Anxiety. The participant translates the psychological concept into a culturally recognized somatic idiom of imbalance (*angin* or *vibe*). This shift from a intended meaning of a physiological arousal response to a family interpretation of a physical/spiritual unease makes the experience legible and actionable within his social network, mitigating isolation.

Statement from a 45-year-old woman who hears voices:

> "My report says, 'auditory hallucinations.' To me, they are not hallucinations. They are the voices of my ancestors, especially my grandmother, trying to guide me because I am lost. The medicine makes them quieter, but I must also listen to what they might need. It is a message, not just a symptom."

This exemplifies the re-framing of the term Depression. The clinical diagnosis is translated into the culturally resonant concept of *lemah semangat* (weakened spirit). This moves the family interpretation away from potentially implying a moral or spiritual failing, and instead towards a framework of communal care and strengthening. The resulting Dissonance of being labeled spiritually deficient is replaced with an actionable recovery narrative involving family support. Ninety-five percent of patient participants (19/20) engaged in semantic re-framing. One hundred percent of family caregivers (12/12) translated psychiatric diagnoses into cultural terminology. Yet zero healthcare providers (0/5) recognized or worked with this translation process, interpreting it instead as denial or lack of insight.

While Compartmentalized Compliance addresses behavioral management and Semantic Dissonance addresses linguistic translation, The Silent Betrayal addresses the existential and relational dimensions of cultural dissonance. It captures the felt sense of transgression that arises when accepting biomedical diagnosis and treatment appears to require abandoning one's cultural and spiritual identity.

For religiously observant patients, there was particular anxiety about the relationship between medication and faith. A 41-year-old man explained:

> "The imam at the mosque says we must trust in Allah, and that our problems are tests from Allah. If I take medicine, am I saying that Allah's test is too hard for me? Am I showing lack of faith?"

This was not rhetorical anxiety; it was an existential concern grounded in his religious worldview.

For patients whose illness was understood by family as ancestral communication, accepting medication felt like a betrayal. One woman described:

> "My mother says the medicine will make me deaf to my grandmother's voice. If I take it, I'm rejecting my grandmother. That feels deeply wrong."

The 35-year-old female participant's fear that medication would make her "deaf" to her grandmother's voice illustrates how clinical recovery can be experienced as relational loss. In this context, "non-compliance" is not a refusal of health, but an act of loyalty to one's kin.

Table 4 maps the three dimensions of Silent Betrayal identified in the analysis, presenting for each dimension the core existential conflict at stake and the participant testimony that most directly illuminates the felt experience of transgression. The three dimensions, Religious Anxiety, Spiritual Transgression and Filial Obligation, and Communal Filial Obligation, together capture the full existential burden that biomedical help-seeking can impose when it is perceived as violating deeply held faith, relational, or communal commitments.

Table 4. The Anatomy of Silent Betrayal. Dimensions of Existential Transgression.

Dimension of Betrayal	Core Existential Conflict	Participant Oral Testament
Religious Anxiety	The Conflict: The fear that relying on Western medication implies a weakness of faith (iman) or a refusal to accept a test from God. The pill is seen as a competitor to prayer. The Transgression: "I am trusting the creation (medicine) more than the Creator."	"The imam at the mosque says we must trust in Allah, and that our problems are tests from Allah. If I take medicine, am I saying that Allah's test is too hard for me? Am I showing lack of faith?"
Spritual Transgression/ Fillial Obligation	The Conflict: The fear that biomedical treatment (which "silences" symptoms) will sever the spiritual link to ancestors, turning a gifted medium into a "deaf" descendent. The Transgression: "I am silencing the voice of my kin to fit into the doctor's world."	"My mother says the medicine will make me deaf to my grandmother's voice. If I take it, I'm rejecting my grandmother. That feels deeply wrong."
Communal Filial Obligation	The Conflict: The fear that accepting a clinical label (e.g., Schizophrenia) is to accept a permanent "spoiled identity" (*gila*) that removes one from the community's moral order. The Transgression: "I am agreeing to be defined as 'mad' rather than 'tested,' bringing shame to my family name."	At the hospital, they wrote schizophrenia in his book. In our village, that word is the same as *gila* (madness). It means no future, no marriage, just shame. If I agree with that paper, I am agreeing that my son is lost. I cannot do that to him."

Criticality, the research reveals that The Silent Betrayal is not resolved through information provision or rational argument, as these fail to address the profound identity conflict at its core. It is resolved only when trusted cultural authorities, which those embedded within the patient's own web of meaning explicitly grant permission, thereby legitimizing the integration of biomedical care within a spiritual or communal framework. This authoritative validation transforms internal conflict into socially sanctioned coexistence, allowing individuals to accept treatment without feeling they have abandoned their cultural selves.

Table 5 documents the four types of cultural authority identified across the dataset, the nature of the permission each grants, the effect of that authorization on the participant's experience of cultural dissonance, and the frequency with which each type of authorization was reported among patient participants. Taken together, the four authority types account for most dissonance resolution events observed across the twelve months of fieldwork.

The family's decision to finally seek biomedical treatment hinged on a pivotal reinterpretation offered by a traditional authority. They described their turning point as follows: "We refused hospital medicine because we thought she was possessed by a

Table 5. Mechanisms of Dissonance Resolution. The Role of Cultural Authority.

Type of Authority	Nature of Permission Granted	Outcome on Dissonance	Frequency (%)
Religious Authority (*Ustaz*)	"Taking medicine is not weak faith. Allah provides resources for healing."	Patient can take medication while maintaining faith.	14/20 patients (70%)
Traditional Healer (*Bomoh*)	"This is body-sickness, not spirit-sickness. Go to hospital. I will help your spirit."	Patient accepts medical diagnosis as legitimate.	15/20 patients (75%
Family Elder	"We will try hospital medicine. There is no shame in this."	Family consensus permits psychiatric care.	17/20 patients (85%)
Peer/Living Example	"I took medicine and recovered. I still pray, still respect the bomoh."	Living proof that both systems can coexist.	12/20 patients (60%)

Djin". Finally, the third *bomoh*, a very respected person, with forty years of practice had said, "This is body-sickness, not spirits. Go to hospital." His permission changed everything. This statement underscores how the legitimization of psychiatric care by a trusted cultural figure resolved the family's profound dissonance, bridging the spiritual and biomedical explanatory models and enabling their help-seeking journey.

Discussion

Conventional approaches to mental health stigma rest upon the deficit model: the assumption that communities lack biomedical knowledge and hold mistaken cultural beliefs. The ethnographic findings of the present study point toward a fundamentally different interpretation. Cultural dissonance is not a deficiency but an adaptive response to an inherently challenging situation in which patients and families must navigate systems that make competing claims upon their understanding of reality. Recent scholarship in Malaysia confirms that stigma, self-stigma, and delayed help seeking persist despite expanded services and public campaigns, indicating that knowledge provision alone does not resolve the barriers patients face (Rajagopal *et alii*, 2023; Yeap & Low, 2009). The present findings reconceptualize this persistence as a natural consequence of unresolved dissonance, rather than as a simple failure of understanding.

The parallel life practices documented throughout this study, what participants themselves describe as maintaining a clinical self in hospital while preserving a village self-grounded in *semangat*, *angin*, and spiritual causality, mirror broader patterns of medical pluralism documented in other settings, where people rationally employ different logics in different domains (Caldwell-Harris & Ayçiçegi, 2006; Gopalkrishnan, 2018; Rahaman, 2023). This compartmentalization functions not as confusion but as a coherent strategy for navigating conflicting systems of knowledge without sacrificing belonging in either. Such behavior is consistent with ethnographic evidence demonstrating that so called noncompliance often reflects sophisticated relational and cultural navigation rather than any refusal of care (Cubellis, Schmid, & von Peter, 2021; Pushkar, 2025). Similarly, the semantic reframing documented in the second theme, translating for instance "major depressive disorder" into *lemah semangat* to preserve hope and moral worth, parallels cross cultural findings that people transform psychiatric labels into locally meaningful categories to protect identity and maintain the possibility of recovery (Rajagopal *et alii*, 2023). These acts of translation constitute a form of cultural resilience, enabling individuals to integrate clinical care into existing frameworks of meaning without requiring self-erasure.

Importantly, the finding that dissonance frequently dissolves when cultural authorities grant explicit permission for biomedical treatment reveals that the core issue is not simply an absence of correct information but an absence of socially and spiritually legitimate authorization (Rajagopal *et alii*, 2023; Gopalkrishnan, 2018). Studies in collectivist

Asian contexts consistently demonstrate that help seeking decisions are fundamentally relational and embedded in family consensus and cultural validation, rather than arising from individual rational choice alone (Natalia & Fridari, 2022; Yeap & Low, 2009). This reconceptualization carries substantial implications for how mental health interventions are designed and where change efforts should be directed.

The data show that resolution of dissonance is typically mediated by trusted cultural authorities, among them *ustaz*, *bomoh*, and family elders, who translate biomedical recommendations into morally acceptable and religiously permissible action. This aligns with Malaysian and regional research documenting that family members and religious leaders powerfully shape pathways to care, and that the absence of permission rather than the absence of knowledge often explains apparent resistance to psychiatric treatment (Natalia & Fridari, 2022; Rajagopal *et alii*, 2023). When an *ustaz* explicitly affirms that taking medication is consistent with Islamic obligations to preserve life and health, patients and families reinterpret biomedical treatment as religiously endorsed rather than spiritually suspect. Similarly, when a respected *bomoh* distinguishes between body sickness requiring hospital care and spirit sickness requiring ritual intervention, the parallel use of both systems becomes conceptually coherent and morally safe. Scoping review evidence confirms that many healers in low- and middle-income countries regard psychotropic medication as useful and are willing to refer to psychiatric services when shared conceptual frameworks allow meaningful communication (Green & Colucci, 2020; Gureje *et alii*, 2020).

Internationally, several collaborative care models that formally integrate traditional or faith healers with biomedical services have demonstrated feasibility, effectiveness, and acceptability, lending support to the plausibility of similar approaches in Malaysia (Farooq *et alii*, 2023; Nortje, Oladeji, Gureje, & Seedat, 2016). In Ghana, a cluster randomized trial of collaborative shared care between traditional and faith healers and primary healthcare workers for psychosis demonstrated superior symptom reduction and functional improvement compared with usual care, and proved cost effective (Gureje *et alii*, 2020). A recent scoping review from healers' perspectives identifies both enthusiasm for collaboration and significant concerns regarding recognition, referral processes, and knowledge protection (Farooq *et alii*, 2023). These themes resonate strongly with the emphasis Malaysian healers in the present study placed upon both spiritual authority and community accountability.

The convergence of local findings and global evidence points toward a model of culturally embedded clinical practice in which psychiatrists and mental health nurses deliberately engage cultural authorities as essential collaborators rather than peripheral stakeholders. Practical strategies would include training clinicians in cultural humility, in local Islamic idioms of distress, and in the social role of *bomoh* and *ustaz* within community life (Huang & Zane, 2016). Establishing bidirectional referral pathways between clinics, mosques, and healer premises would align with collaborative models tested in Ghana and South Africa (Gureje *et alii*, 2020; Nortje *et alii*, 2016). Integrating explicit discussion of spiritual and traditional beliefs into assessment and treatment planning is consistent with evidence that culturally responsive care improves engagement and outcomes (Rathod *et alii*, 2018; Willis & Neblett, 2023).

This ethnographic and phenomenological study offers richly textured insights but carries several important limitations. The study is geographically and culturally specific, focusing on three districts in Kelantan and Terengganu with strong Malay Islamic traditions and active *bomoh* networks. Findings may not transfer readily to urban, ethnically mixed, or East Malaysian contexts where religious and healing landscapes differ substantially. The small, purposively selected sample, while appropriate for Interpretative Phenomenological Analysis and critical ethnography, limits statistical generalization.

Ethnographic methods are also constrained by observer effects, partial access, and the interpretive filtering of the researcher's own positionality. Translation from Malay and Kelantanese dialect into English inevitably involves some loss of nuance around key cultural concepts such as *semangat*, *gila*, and *angin*. Conceptually, centering cultural dissonance as the organizing frame risks overstating conflict and underrepresenting cases where biomedical and traditional practices coexist with relatively little subjective tension.

Finally, while the analysis attends to structural determinants, it foregrounds cultural mechanisms and may not fully account for material constraints such as poverty, transport barriers, and service scarcity that also shape patterns of help seeking.

This ethnographic study reveals that mental health stigma in rural Malaysia is not primarily a problem of ignorance or irrational resistance to science. Rather, it emerges from cultural dissonance: a profound tension between epistemological frameworks that shapes the everyday lives of patients and families as they navigate competing systems of meaning. Far from being passive or confused, these individuals demonstrate remarkable ingenuity in managing this dissonance through compartmentalization, semantic reframing, and the careful seeking of permission from trusted cultural authorities. The research reveals that the most effective resolution of dissonance comes not through written materials or clinical persuasion, but through culturally embedded, personally delivered permission from authorities whom patients and families already trust and respect. In contrast, educational materials and clinical persuasion alone rarely generate the deep shift in willingness to engage with psychiatry that results from a single conversation with a respected cultural leader.

Mental health systems operating in non-Western contexts should not demand that patients choose between science and culture. Rather, they should work alongside trusted cultural leaders to create space for what patients and families are already doing: living in both worlds, drawing on the strengths of each, and gradually building bridges across epistemological divides. When psychiatry offers genuine collaboration with culture rather than its erasure, stigma loses much of its power and help seeking becomes not a betrayal but a possibility.

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