AN ANTHROPOLOGICAL EXPLORATION OF INDIGENOUS HEALING PRACTICES IN THE DRUG REHABILITATION PROCESS

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MS Applied Anthropology

Enrollment No: 01-251241-004

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2026

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Submitted in partial fulfillment of the requirements for the award of the degree of MS Applied Anthropology at the Department of Humanities and Social Sciences, Bahria University, Islamabad.

Department of Humanities and Social Sciences

Bahria University Islamabad

2026

SUBMISSION FORM OF THESIS FOR HIGHER RESEARCH DEGREE

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I hereby certify that the above candidate's work, including the thesis, has been completed to my satisfaction, that the thesis is in a format and of an editorial standard recognized by the faculty/department as appropriate for examination.

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Name of MS Scholar: Moiza Yousaf

DEDICATION

To my beloved father

ACKNOWLEDGEMENT

I am deeply grateful to Allah, the Most Gracious and the Most Merciful, for His guidance and blessings throughout this academic journey. This accomplishment would not have been possible without His mercy. All praise and glory belong to Him alone.

I would mostly like to thank my elder sisters, Alveena Yousaf and Maleeha Yousaf, who supported my emotional journey through my MS studies. I would like to thank my father, Raja Muhammad Yousaf, and my brothers for supporting me financially throughout my degree.

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Moiza Yousaf

ABSTRACT

This study explores the role of indigenous healing practices in the drug rehabilitation process. The objectives of the research were to identify the indigenous healing practices used within rehabilitation settings, to examine their perceived impact on sobriety and mental well-being, and to analyze the personal, institutional, and cultural challenges associated with integrating these practices into formal rehabilitation systems.

A qualitative research design was employed. Data were collected from 28 participants through purposive sampling, including patients undergoing rehabilitation, healthcare professionals, and indigenous healers such as hakeems and religious scholars. Fieldwork was conducted across three rehabilitation centers in Islamabad, supplemented by interviews with participants accessed through key informants. Data collection methods included semi-structured in-depth interviews, participant observation, field notes, and document review. Key informants such as rehabilitation center heads, therapists, and acquaintances played a crucial role in facilitating access to participants, obtaining informed consent, and providing contextual and cultural insights. Interviews were conducted both in person and remotely, with an average duration of 25–40 minutes, and were audio-recorded with consent.

The present study has revealed that although mainstream rehabilitation largely emphasizes biomedical and institutional approaches, the lived experiences of patients, indigenous healers, and therapists point to significant gaps in culturally responsive care. Much of the existing literature and institutional narratives highlight the effectiveness and structure of formal treatment models; however, this study uncovered that such approaches often overlook indigenous, spiritual, and community-based healing practices that are meaningful to patients.

Participants shared that rigid institutional regulations, strict schedules, and licensing constraints limit the inclusion of traditional practices such as dua, zikr, herbal remedies, and culturally grounded rituals, which negatively affect patients' sense of comfort and engagement in recovery. While therapists and institutional staff reported that adequate care and support were being provided, patients frequently

expressed dissatisfaction and a feeling that their cultural and spiritual needs were not fully acknowledged.

The study further revealed that although most participants recognized the importance of integrating modern therapeutic methods, there was a strong consensus that recovery outcomes could be improved through a balanced approach that respects indigenous knowledge systems. At the same time, some participants expressed concerns about unregulated practices, emphasizing the need for careful integration rather than complete replacement of biomedical models. Overall, the findings highlight the complexity of recovery and underscore the importance of culturally sensitive, flexible, and inclusive rehabilitation frameworks.

Keywords:

Indigenous healing, Drugs, Rehabilitation Process, Addiction recovery, Spiritual healing, Biomedical Healing, Holistic Approach, Sobriety, Relapse

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CHAPTER 1
INTRODUCTION

This research explores the role of indigenous healing practices in drug rehabilitation. It also examines how these rehabilitation practices function and differ from biomedical and psychological treatments. Their perceived effectiveness in the process of recovery was also discussed. The study further investigates the challenges in integrating these healing methods into modern healthcare settings, including issues of credibility, accessibility, and institutional acceptance. This research explores how indigenous healing methods contribute to rehabilitation, particularly in communities where traditional knowledge systems remain vital.

The most important processes of human health across societies are healing and rehabilitation. Societies have evolved with time in their ways of addressing these processes with culture and traditions (Ohajunwa, 2019). The leaders of the medical system have been the biomedical and psychological models within the modern world health care system; however, indigenous or traditional healing systems still hold a significant place across the globe. These traditions exist in holistic philosophies, which understand health as a connection between body, mind, and spirit (Marques et al., 2021).

The healing process is not simply a matter of biology; rather, it is a cultural affair of belief, ritual, and experience. Native medicine draws on the spiritual and natural components, such as ritual cleansing, herbal medicine, prayers, and community involvement (Marques et al., 2021). These practices are established on worldviews that seek harmony with nature, which is usually lacking in clinical intervention.

Biomedical rehab, however, perceives disease as a mere biological anomaly and aims at restoring health and management of symptoms. Although that might be the case with the body, it tends to bypass the social and spiritual reality where individuals really suffer, recover, and heal. Those gaps are easily evident in drug addiction rehab, where the issue reaches a long way beyond biology into the existence of social and cultural worlds.

A scoping review of culture-based programs of addiction treatment among Indigenous communities in North America examined 4,518 records and discovered 19 studies that blended Western and culture-based services. Substance-use issues decreased in 74 percent of them when cultural interventions were incorporated (Rowan et al, 2014). That is in favor of improved results whereby we integrate cultural ritual, identity, and community healing with biomedical measures.

In the same way, in urban American Indian and Alaskan Native populations, a model of the holistic system of care that integrates traditional Indigenous care with evidence-based substance use and mental-health services reduced substance use and associated harms, particularly in residential care (Wright et al., 2011). This implies that there are quantifiable positive effects at physical, psychological, social, and spiritual levels when Indigenous practices are integrated structurally.

In more recent years, the treatment of opioid dependence in Indigenous settings was reviewed as a realist and focused on compassion, self-determination, trauma-informed, and community-based methods as the most important program mechanisms (Henderson et al., 2023). These experiences support the notion that healing is not only about protocols; it is about instilling care within culturally significant settings, regaining agency, and addressing systemic social determinants.

A qualitative study in Pakistan entitled, A Holistic Perspective towards Perils of and Pathways to Addiction Recovery in Pakistan: Exploring Indigenous Factors, interviewed 40 individuals who were in recovery, those who relapsed, and caregivers. The research identified five fundamental groups, including familial, personal, socio-cultural, psycho-emotive, and treatment aspects of the recovery process, in which indigenous and socio-cultural factors influence the behavior of addiction (Afaq et al., 2023). This indicates that culturally based strategies are required in the Pakistani society, where the Indigenous healing practices are still alive and socially applicable.

To begin with, the combination of traditional indigenous healing with the biomedical paradigm has the potential to enhance wellness in the addiction recovery process, particularly in culturally strong communities. Second, healing is multi-dimensional, physical, psychological, social, spiritual, and Indigenous systems

frequently focus explicitly on the social and spiritual aspects that are not adequately considered in biomedical models. Third, they are place and time-sensitive, community-inclusive, and culturally legitimate practices: all of these appear to contribute to effectiveness. To give an excellent example, the scoping review proposed that the practice should be context-related and match the place, person, and time fit to enhance effectiveness (Rowan et al., 2014).

Although this has been evidenced, there remains no serious anthropological research that examines how those practices work, how those involved give the practices meaning, and how they interact with formal rehab systems, especially in South Asian postcolonial situations.

Thus, this study examines the effectiveness of indigenous healing practices in drug rehabilitation, its perceived effectiveness, social meanings, and challenges in integration in the contemporary healthcare system. It is hoped that by doing so, healing can no longer be thought of as a fixed medical practice, but as a cultural practice of belief systems, social organization, and local epistemology, particularly where the indigenous tradition plays an important role but is often marginalized in the mainstream rehabilitation models.

1.1 Anthropological Context

From an anthropological perspective, healing goes beyond a clinical intervention; it is essentially a cultural performance of meaning, a ritualized process through which societies negotiate illness, restore moral and social order, and reestablish cohesion. Anthropology provides a strong, holistic framework that gives central place to the social, symbolic, and moral dimensions of health and moves beyond the biomedical paradigm in this way (Good 1994; Csordas 1994). In this context, as Arthur Kleinman argued, each society produces its own explanatory models of illness and healing, deeply rooted in cultural logics and local epistemologies (Kleinman 1980).

Indigenous healing systems, therefore, cannot be properly understood solely through a biomedical lens of efficacy or pathology. Instead, they should be viewed as expressions of cultural identity, cosmology, and spiritual worldview-practices embedded in the life of a community rather than external add-ons. The work of

Jerome M. Levi on the Rarámuri in Mexico illustrates this: healing rituals involve embodiment, communal performance, spiritual agency, and power as much as they involve alleviation of "symptoms" (Levi, 1999).

More recently, a review in medical anthropology stressed the concept of "symbolic cure", arguing that the so-called placebo effects need to be re-conceptualized as meaning-responses: culturally structured healing modes based on belief, ritual, and social context rather than just neurobiology (Apud & Romani, 2020). This reinforces the anthropological assertion that healing is mediated by symbolic systems, social relations, and embodied practice.

In the area of substance-use rehabilitation and addiction, these anthropological perspectives have particularly high relevance. The challenge of addiction is not only bodily or neurochemical; it is deeply moral, relational, and existential. The legacy of medical anthropology would suggest that treatment that fails to attend to the social and symbolic dimensions of suffering may fail to address critical needs of the person in context. For example, a scoping study exploring culture-based addiction interventions for Indigenous peoples reported that culturally-grounded practices tended to improve wellness outcomes, particularly when well-matched with person-level factors of community, identity, and spirituality (Rowan et al, 2014).

The field has increasingly focused on medical pluralism, which is defined as a configuration in which multiple healing traditions exist side by side in a society, each with its own logic, legitimacy, and domain of practice (Good 1994). Anthropology allows us to examine the power dynamics, contestation of legitimacy, and the hybrid formations of healing that ensue from these two meeting in postcolonial contexts like Pakistan, where indigenous epistemologies and healing systems have been both marginalized and subordinated by mainstream western biomedicine. This, therefore, positions anthropology in this study not just to document "what" indigenous healing practices take place but rather how patients, healers, and institutions negotiate legitimacy, authority, efficacy, and cultural meaning in the interface between indigenous and biomedical systems.

1.2 Cultural and Geographical Context

Pakistan is a country with a very fertile and applicable context to this question. In Pakistan, indigenous systems of healing, including Sufi rite practices, Hikmat (Unani medicine), shrine-based spiritual healing, and folk healing by pirs and hakeems, remain very strong alongside biomedical institutions (Shaikh and Hatcher 2005). They are not merely the historical remnants but are actively incorporated into social and cultural life: individuals can receive several streams of healing at once, which is a symptom of a syncretic model of health-seeking behaviour.

This trend is supported by empirical research. An example of such recent ethnographic work, which examined the Barkat Ali Shrine in Faisalabad, indicated that individuals attended to find healing of mental, physical and spiritual illnesses, and the rituals that occurred at the shrine, including recitation, shared prayer, stay-overs, were as important to emotional and spiritual health as they were to physical health (Rashid et al., 2023). A different study in rural Sindh explored the views of faith healing using shrines and found that most people did not substitute modern medicine but rather worked in parallel with it, as it was a culturally conditioned mechanism, which was conditioned by economic desperation, inaccessibility to formal care, and deep-rooted belief systems (Memon et al., 2025).

The applicability in the rehabilitation setting is obvious: among individuals with substance addiction, such indigenous healing systems offer even more than detoxification - identity, purpose, belonging, and moral reconnection. To a large number, the biomedical model of addiction, its focus on physical withdrawal and medication, may seem culturally foreign or incomplete. The native traditions, in their turn, address more existential levels, like reintegration of the community, spiritual purification, and revitalization of rituals. An example of such a study is a qualitative study conducted about the recovery trajectories of addiction in Pakistan, which identified the significance of socio-cultural and spiritual aspects (Afaq et al., 2023).

However, in the majority of rehab programs, indigenous healing traditions are put on the back burner, despite being dynamic. They are also not always welcomed by institutions, they are not recognized, or they are depicted as rather supplementary to treatment. This work is based on the anthropological perspective, which is concerned

not only with practices but with structural and ideological conditions in which these practices may or may not be incorporated.

The study is located in Pakistan to investigate the ways in which indigenous healing in addiction rehabilitation negotiates a medical-Pluralistic, culturally complicated, and multifaceted historical background in which beliefs, rituals, community, and biomedicine intermingle and occasionally even conflict. Some of the factors that are considered in the study are geography, culture, community structures, poverty, and access to health systems within the larger context of healing and rehabilitation in Pakistan.

1.3 Research Gap

Current studies in terms of drug rehabilitation primarily involve the biomedical and psychological interventions, neglecting culturally appealing healing practices based on indigenous practices. Although biomedical theories focus on detoxification and pharmacological therapy, they fail to have complete appeal to the communities that consider healing as an aspect of cultural, spiritual and communal activity. In most traditional societies, healing involves a physical, social and spiritual health.

The lack of comprehension of how these culturally constituted practices work within or with mainstream rehabilitation centers, especially in the post-colonial in which native knowledge is marginalized of disregarded, is discernible. Their integration casts doubt regarding ethical aspects, cultural validity, and power relations between the biomedical and indigenous knowledge systems.

The majority of the studies that are available are based on the Western context, where the indigenous population is low and their local knowledge systems are frequently torn apart. Very little has been done in other areas like South Africa where the indigenous healing practices are still practiced. Due to this deficiency of attention, little is known about how the indigenous practices are incorporated, altered, or transformed in the mainstream treatment systems. There is also lack of ethnographic and anthropological research that reflects the views of patients and indigenous healers that get involved in these practices.

This study fills these gaps through an anthropological approach to the topic of studying the role, influence, and challenges of indigenous healing practice within drug rehabilitation facilities in Pakistan by looking at the context of culture, personal experience, and ethical dilemmas. The results help to make the approaches to addiction treatment, policy-making and inclusive healthcare delivery more holistic and culturally sensitive. Despite the increasing interest, much research still needs to be done in South Asia and Pakistan, where minimal quantitative or longitudinal research has been done to determine the effectiveness of indigenous healing practices, and a hybrid or pluralistic rehabilitation framework has not been well researched.

Despite the reasons to hope, there nonetheless are significant gaps of knowledge, especially in South Asia and in Pakistan, since not many quantitative or longitudinal studies examine the effectiveness of indigenous healing practices in the rehabilitation (Mansoor et al., 2025). Better qualitative insights on the process of healing are needed, especially in the context of exploration of rituals, community restoration, and spirituality. Moreover, the hybrid or pluralistic rehabilitation strategies are not effectively documented (Bano et al., 2019). The filling of these gaps will enhance our knowledge on policy, program development and to train culturally responsive interventions.

1.4 Statement of the Problem:

Drug addiction is a critical health issue for the public in Pakistan, as it is affecting the physical, social, and mental well-being. The popular method of rehabilitation only focuses on the physical aspect of rehabilitation by detoxification of the body and medicating the patients to reduce the physical symptoms of withdrawal; it tends to overlook the cultural, traditional, and spiritual aspects of healing. This results in a disconnect between the lived experience of individuals and the treatment program, which later on results in a high relapse rate and limited engagement by patients. Due to this, the indigenous aspect of healing has emerged as an alternative; these practices include familial and communal support, cultural values, and spiritual framework. These practices are culturally relevant and offer an alternative path of recovery, particularly in societies where traditional and spiritual beliefs are an important part of identity.

Indigenous knowledge plays an important role in paving the path as the natives approach health and healing; it is a trusted and experiential way that is very much rooted in cultural and spiritual beliefs. However, the incorporation of this knowledge into practices is subject to some difficulties, such as epistemological conflicts, institutional resistances, and ethical concerns.

This study addresses this lack of literature by taking an anthropological approach to understand the lived experiences, symbolic meanings, and challenges of incorporating indigenous healing practices into the drug rehabilitation context in Pakistan. In doing so, it contributes to a larger theoretical discussion about medical pluralism, cultural legitimacy, and inclusive healthcare systems.

1.5 Objectives Of The Study

- To identify the indigenous healing practices utilized in the rehabilitation center.
- To examine the impact of indigenous healing in promoting sobriety and mental well-being.
- To analyze potential challenges and ethical considerations in integrating these practices within formal rehabilitation.

1.6 Research Questions

1. What are the healing mechanisms used in in Drug Rehabilitation center?
2. How do indigenous spiritual healing practices influence sobriety and mental well-being?
3. What challenges exist in integrating indigenous healing within modern healthcare?

1.7 Rationale of the study

The reason why this research is necessary is the increasing recognition that healing and recovery are not only a biomedical process; it is a multifaceted cultural phenomenon that combines social, spiritual, and symbolic elements of life together. Although the global rehab centers and public health systems are increasingly shifting

towards the models that are more standardized and evidence-based, they fail to capture the cultural contexts and local knowledge systems in which people experience illnesses and healing. This is particularly evident in such areas as Pakistan, where native healing practices remain integrated into the daily lives there but are marginalized by the formal healthcare and rehabilitation systems.

In the last 20 years, a group of studies explored the problem of drug addiction and rehab in psychological, medical, and sociological terms (e.g., Marques et al., 2021; Ohajunwa, 2019). Nevertheless, anthropological studies on the role of indigenous healing systems based on spiritual, ecological, and communal philosophy in promoting recovery and reintegration are still wanted. Other studies, including those conducted in indigenous populations in North America, Africa, and Latin America, indicate that culturally based healing programs assist in supporting emotional stability, identity re-establishment, and social integration in individuals with substance use disorder recovery. Nevertheless, these integrative, culture-sensitive strategies are not extensively studied in the South Asian settings.

In Pakistan, the continuation of Sufi shrines, spiritual healers (pirs), and traditional medicine such as Hikmat (Unani medicine) is an example of the social legitimacy of the traditional indigenous healing. Most of the addicts resort to these facilities to get physical treatment, but also spiritual cleansing, moral renewal, and social reintegration. Although they are vital, their role is hardly ever examined in relation to contemporary drug rehab centres, which creates a severe void in comprehending the way the indigenous and biomedical healing models co-exist, overlap, or conflict in the pluralistic health environment of Pakistan.

This paper, thus, seeks to investigate indigenous healing practices as they exist on their own or in conjunction with drug rehabilitation procedures, based on anthropological concepts of the ritual (Turner, 1969), embodiment (Csordas, 1994), and medical pluralism (Good, 1994). It seeks to comprehend how individuals make sense of their recovery experiences using practices that have cultural meaning and how healers, patients, and institutions negotiate legitimacy and efficacy across knowledge systems. Within the anthropological paradigm used to frame the research, the study points out the significance of understanding healing as a culturally engraved act of meaning as opposed to a medical event.

In the end, this study is relevant to the field of anthropology, as well as to health policy and rehab practice. It provides reflections on the ways in which indigenous epistemologies can be applied to more holistic and comprehensive care models that are more in touch with the lived realities of the patients. By doing this, it will help decolonize health discourses and refocus local knowledge when discussing addiction, recovery, and human well-being. In this exploration, the paper aims to fill the gap between the biomedical and indigenous paradigms and demonstrates how being culturally sensitive can enhance the effectiveness, sustainability, and humanity of rehab processes.

1.8 Significance of the Study

The implications of the study are far-reaching in medical anthropology, as it points out a gap in rehab, i.e., the role played by indigenous healing in the rehabilitation today. The study promotes scholarly knowledge of different healing practices by studying these indigenous practices and proposes their adaptation into the mainstream medical care. It is especially called for in the face of an increase in globalization and an ever-increasing demand for culturally relevant and sensitive health systems. Results can be used by policymakers to gain insight into why culturally appropriate treatment programs should be integrated throughout the world.

Greater appreciation and awareness of native healing can help to enhance more comprehensive and efficient approaches to rehabilitation that may be consistent with patient's values, thoughts, and desires. The research will assist in bridging the gap between indigenous healing and biomedical healing and enable partnerships between the health practitioners and indigenous healers to develop more integrated, patient-based rehabilitation models. It also gives practical recommendations to rehabilitation providers such as therapists, mental health workers, doctors, and policymakers on how to incorporate spiritualism and cultural factors into patient treatment to ultimately improve health outcomes and patient satisfaction.

This research also involves the ongoing debate regarding cultural knowledge during healthcare, as the research brings in the notion that culturally relevant information on indigenous and traditional healing methods should also be considered in medical training and in educational institutions. In addition, on a potential for

enhancing the predominant biomedical rationale and requests for a holistic intervention approach combining scientific and indigenous healing practices. By recognizing the validity of indigenous practices, this study fosters a better understanding of these methods and encourages inclusivity, cultural diversity, and competence in the field of medicine.

1.9 Conceptualization and Operationalization

Conceptualization is the meaning of the concept and ideas used in the study, while operationalization means turning those concepts into a measurable form or taking specific steps to observe and collect the data.

1.8.1 Drugs

Psychoactive drugs such as alcohol and prescription drugs that modify the way brain function, resulting in temporary changes in perception, mood, consciousness, cognition, or behavior. It is used to have fun, self-care, cope or cultural rituals (WHO, 2004; NIDA, 2020). Here, the emphasis is on the influence of drugs on the mind, behavior, and the body (Julien et al, 2011).

In this research, the concept of drugs was operationalized by identifying the types of substances used by participants (e.g., opioids, stimulants, cannabis, prescription sedatives), modes of administration (smoking, injecting, ingesting, etc.), frequency and duration of use, and the context of use, such as social, solitary, or ritual settings. These details will be derived from self-reports during in-depth interviews.

1.8.2 Addiction

Addiction is described as a chronic condition where one is forced to involve himself in stimulating things in a compulsive way even when unpleasant effects are exhibited. It entails long-term changes in the brain structure and functioning that undermine self-control, decision-making, and actions (Volkow et al, 2016).

Drug addiction is a chronic relapsing problem characterized by an obsessive desire to consume drugs despite the fact that it causes physical, mental, or even social pain. The alterations in the brain interfere with judgment and decision-making,

feelings, and impulse control (APA, 2013). It has cultural attachments to stigma, morality, and relationships.

Drug addiction was operationalized through interview questions and participant narratives focusing on cravings and compulsive urges to use drugs, patterns of relapse and difficulty maintaining abstinence, withdrawal symptoms during periods without use, and formal diagnosis or indicators aligned with DSM-5 criteria. These indicators will help classify the severity and lived experience of addiction.

1.8.3 Rehabilitation

Rehabilitation is a collection of interventions that is designed to help people resume optimal functioning and improve their quality of life after illness, injury, or drug dependence (WHO, 2017). Regarding addiction, rehabilitation is a comprehensive procedure that should enable the defeat of substance dependence and reintegration into society based on the physical, psychological, and social aspects of recovery (UNODC, 2020). It goes beyond the treatment to include rebuilding the identity, repairing the relationships, rebuilding the confidence, and reinforcing social functioning.

Rehabilitation can take many forms depending on the needs of the individual that require medical rehabilitation, psychological rehabilitation, social rehabilitation and vocational rehabilitation. Medical rehabilitation is concerned with restoring physical health; psychological rehabilitation aims to deal with mental and emotional health; social rehabilitation aims to help those to reintegrate into the wider community; and vocational rehabilitation aims to help people acquire working skills and become independent (WHO, 2017).

Rehabilitation was operationalized by examining types of treatments offered, such as detoxification, psychotherapy, spiritual healing, or herbal remedies; the duration of stay at rehabilitation centers, participant narratives on recovery pathways, relapse experiences, and challenges, and institutional structures, such as routines, therapeutic activities, and aftercare programs.

1.8.4 Healing

Healing is an entire process that encompasses physical healing, emotional stability, spiritual orientation, and social reintegration. It is all about putting a sense of order, control, and harmony in life and community (Kleinman, 1980; WHO, 2014). Healing in anthropology is not only medical, but it is influenced by beliefs, relationships, and moral worlds (Csordas, 2002).

Indigenous healing refers to local medicines that are constructed using collective knowledge, cosmologies, and other practices performed by communities that are transmitted through generations (Dei, 2000). These systems combine religion, herbs, rituals, and community medicine men. They strive to strike a balance between body, soul, and social relations and emphasize on holistic care and cultural meaning in the healing process (Waldram et al., 2006; Langwick, 2011)

Biomedical healing employs scientific, clinical techniques to cure addiction as a neurobiological, psychological disorder (Good, 1998). It is based on evidence-based therapies, such as detox, medication, therapy, and is aimed at the reduction of symptoms, balancing chemistry, behavior change, and measurable results (Helman, 2007; Lock & Nguyen, 2010).

Healing was operationalized through participants' descriptions of: perceived improvements in physical and psychological well-being, changes in social relationships, trust, and support networks, spiritual or emotional transformations, such as increased faith, hope, or resilience, and evaluation of treatment effectiveness, including both biomedical and indigenous practices.

1.9 Organization of the study

This thesis is divided into seven chapters, one of which addresses each of the angles of studying indigenous healing in drug rehab. The design has a good flow of ideas from data to analysis.

The background is discussed in the first chapter, and the reasons why this research is important. It addresses drug addiction in Pakistan and puts it into social, cultural, and health perspectives. It discusses the influx of alternative therapies as a

reaction to biomedical care constraints, and explains why research into indigenous healing in rehab facilities is significant, highlighting existing gaps in the existing literature. This chapter is concluded with the objectives, questions, and the reasons why an anthropological lens was selected.

The second chapter provides a profound exploration of scholarly literature. It examines international and national researches on addiction, recovery, and rehabilitation of drugs. The key concepts of indigenous healing, biomedical healing, spirituality, illness narratives, and cultural perceptions of addiction are addressed. The chapter concludes with the explanation of the theoretical framework.

The anthropological research was conducted in Chapter Three. It presents the qualitative design, such as ethnographic techniques, which were applied to the study of indigenous healing in rehab centers. Purposive sampling was used to select participants: patients, indigenous healers, therapists, and administrators. Semi-structured, in-depth interviews, field notes, and informal conversations were used to capture rich storytelling on the topic of healing and recovery.

Chapter Four Chapter Four contains a detailed analysis of the data collected during interviews to identify and interpret the influence of indigenous healing practices on the rehabilitation process. The chapter presents key themes emerging from participants' experiences and examines how these practices contribute to recovery..

Chapter Five of the thesis discusses personal, institutional, and cultural level challenges of incorporating indigenous healing practices within formal rehabilitation settings.

Chapter Six concludes the main points, discuss the results in light of theoretical framework, then proceeds to limitations and recommendations in this study and provides future research and practice directions.

CHAPTER 2
LITERATURE REVIEW

This chapter is a review of the literature about culture, rehabilitation, and traditional indigenous healing practices with a special focus on their application in substance use rehab. The role of indigenous healing as a source of recovery, strength, and complete wellness in various cultural contexts has been discussed. I have also compared these practices based on tradition with Western practices in biomedical practices and discussed how these two can be used together in a situation such as Pakistan, where the native practices are still considered an important aspect of healthcare.

2.1 Anthropological Approaches to Rehabilitation and Healing

Anthropological approaches involve how cultures understand illness, recovery, and well-being, focusing on social, spiritual, and community-based practices. It also highlights that healing is not only biomedical but also deeply shaped by cultural beliefs, rituals, relationships, and everyday lived experiences.

2.1.1 Healing and Culture

According to medical anthropologists, healing is not just a biological but also a symbolic activity that manifests moral and social order in the community. Arthur Kleinman (1980) emphasized the existence of cultural constructs, known as explanatory models, that frame how individuals define symptoms, causal explanations, and treatment choices. These models vary in different societies; where western medicine is normally considered to be biological in nature, many indigenous health systems consider illness to be caused by a lack of spiritual balance, moral violation, or social disunity. Kleinman assumes that successful healing will be achieved when the explanatory models of both the healer and the patient coincide, and success ceases to be the physical recovery but the meaning. This is expanded by Byron Good (1994), who sees the healing stories as moral and aesthetic plays, in which the suffering is provided with some coherence on a larger moral and cosmological scale. The healing process is therefore a symbolic restructuring of experience which restores meaning and reinstates people into the social world.

Thomas Csordas (1990, 1994) coined the term "embodiment," which stressed the idea that the body is an enacted medium of transformation. New perceptions and spiritual renewal can be activated by healing rituals like drumming, prayer, or chanting, beckoning the attention to bodily and spiritual states.

Theorists Nancy Scheper-Hughes and Margaret Lock (1987) theorized the concept of “three bodies,” including individual, social, and political, and argued that illnesses are biologically, socially, and politically constructed. Their model requires the rehabilitation to consider physiological detoxification and social inequality, exclusion, and stigma. This dual focus is particularly essential in substance use.

Anthropological research from various cultural backgrounds also supports these concepts. For instance, Hahn (1995) stated that healing is ultimately a “symbolic transformation” of meaning that restores balance between the self and the environment. Kirmayer (2004) also referred to how cultural narratives drive emotional healing in situations of trauma and addiction by providing narratives for resilience and continuity. Likewise, Nichter (2008) emphasized how healing rituals can provide “idioms of resilience,” supporting individuals to conceptualize distress in ways that their cultural tradition recognizes as distressful, thereby drawing strength from individuals in their community.

To summarize, healing from an anthropological perspective is a process of interpretation and embodiment that reconstructs meaning, restores relationships, and realigns the individual self with the cultural and spiritual world. Therefore, healing involves more than lifting symptoms and extends into renewal of morale, integration of social aspects of life, and reinstatement of harmony among mind, body, and spirit.

2.2 Medical Pluralism

Medical pluralism refers to the existence, interaction, and sometimes rivalry among many healing systems, biomedical, indigenous, religious, and alternative forms of wellness, within the same cultural context. Medical pluralism signifies the ways people negotiate the complexities of the health care environment to address their illness from alternative epistemologies of healing.

White (1976) and Janzen (1978) were among the early researchers to describe how people in pluralistic societies utilize both traditional and modern systems of care at the same time. In their studies of South Asia and Central Africa, they found individuals would often visit more than one healer, traditional, spiritual, and biomedical. This was not described as contradictory; rather, it is a complementary process that reflects a pragmatic and holistic approach to healing.

In reflecting back on medical pluralism, Kleinman and Benson (2006) claim to have observed a demonstration of cultural competency in practice, that both patients and communities are inherently creating and enacting their own therapeutic assessment based on what they believe in, how accessible the care on their pathway is, and whether they trust that care will help. Lock and Nguyen (2010) asserted that pluralism is not static; rather, pluralism is where historical and political shifts are mirrored even in a smaller conceptualization, whether that is through colonization, globalization, and institutionalism of the Western biomedical body of evidence.

Medical pluralism is particularly prevalent in South Asia, where biomedicine sits alongside Ayurveda, Unani, homeopathy, and faith-based healing systems. In their studies, Langford (2002) and Kakar (1991) demonstrated that many patients self-select a combination of biomedical treatment and religious or spiritual interventions to address different dimensions of health, biological, social, and moral.

Such a combination of indigenous herbalism, Christian prayer, and biomedicine was recorded within African contexts by Feierman and Janzen (1992), which they labeled therapeutic syncretism. Last (1990) noted that the healers incorporated biomedical language into local cosmologies, producing familiar hybrids. Hsu and Hsu (2008) have termed medical pluralism as healthcare bricolage: patients can combine traditions to make their own plans. This bricolage demonstrates creativity in the culture, which justifies known knowledge systems in the world.

The rehabilitation continuum does not provide much information as to the ways in which indigenous healing and biomedical approaches may interface. Indicatively, Gone (2013) established that a combination of Native American spiritual rituals with Western therapy in a substance use rehab resulted in greater cultural responsiveness and client engagement. In Pakistan, Mansoor et al. (2025) and Bano et

al. (2025) report that Sufi healing practices and medicines are complementary to biomedical interventions, enhancing psychological well-being and reducing the rate of relapse.

Hence, it is clear that medical pluralism signifies an ongoing process of negotiating between culture, belief, and medicine. Medical pluralism invites our attention to understand that individuals are not meek subjects to medical systems; they are active agents who are intentionally and creatively negotiating among a myriad of therapeutics to achieve bodily, emotional, and spiritual balance. Understanding medical pluralism is also needed to develop culturally responsive rehabilitation models that incorporate indigenous knowledge and scientific data effectively, while still finding the balance for holistic and integrated approaches and implementation.

2.3 Indigenous Healing Practices

Indigenous healing practices draw on historical context, cultural traditions, spiritual beliefs, and community rituals to restore balance and well-being.

2.3.1 History of Indigenous Healing.

Indigenous healing has a long history, influenced by traditional knowledge, colonial suppression, and contemporary efforts at revival and integration into healthcare systems.

2.3.1.1 Pre-Colonial Systems of Healing.

Prior to colonialism, Indigenous health practices in the world were based on a holistic concept of health, which involves physical, spiritual, emotional, and social health. The healing experts, like the shamans, medical professionals, hakims, and herbalists, as well as the ritual practitioners, served the role of custodians of cosmological, botanical, and ancestral knowledge (Kleinman, 1980). These systems were incorporated in the local ecologies, relational ethics, and communal rites instead of individualistic biomedical systems.

2.3.1.2 Colonial Suppression of Indigenous Knowledge

Colonial governments often relegated, penalized, or alienated Indigenous medicine. They were often branded by missionaries and colonial medical officers as

superstitious, dangerous, or unscientific and were legally banned, erased their epistemology, and displaced their traditional practitioners (Anderson, 2006; Comaroff and Comaroff, 1992). Biomedical institutions were put in a superior position, and this formed long-term hierarchies that persist into modern healthcare systems.

2.3.1.3 Postcolonial Revival Movements

Postcolonialism represents a contemporary movement in political and social life. Postcolonial Revival Movements Postcolonialism is a modern trend of political and social life. Indigenous healing has gained a new profile in postcolonial states, due to cultural revitalization efforts, community activism, and increasing criticism of biomedical constraints (Waldram, 2014). Global systems like the WHO Traditional Medicine Strategy have facilitated the restoration of traditional medicine in national health systems. This revival is not only a cultural pride but also a practical indication of the efficacy and cultural appeal of indigenous healing.

2.3.2 Philosophy and Principles of Indigenous Healing

Indigenous healing systems are based on foundational philosophical tenets that operate differently from many other biomedical paradigms but that also complement those paradigms (Absolon, 2010). The main ideas include balance and harmony (across mind/body, people and land, and human and spiritual worlds), spirituality as one of the primary dimensions of health, and collective responsibility for the health of individuals and their communities. Generally, these systems aim to treat an illness as a disruption to relational balance (socially, morally, cosmologically), not only as the dysfunction of bodily systems; and thus healing is considered relationship restoration through ritual, story, and social connectivity (Scheper-Hughes & Lock, 1987; Csordas, 1990). Both philosophical and empirical work undertaken in recent years has emphasized that for Indigenous peoples, health cannot be separated from self-determination, cultural continuity, and relational responsibility, what some have termed collective responsibility for Indigenous health (Corso et al, 2022).

Anthropological and epistemological scholarship describes how Indigenous knowledge systems conceptualize health in terms of relational ontologies, knowledge produced in relation to land, ancestors, and community memory. These epistemologies serve as foundations for healing practices such as land-based healing,

seasonal and ceremonial knowledge, and embodied ritual knowledge, all of which serve to relay healing from one generation to the next (Gélinas & Bouchard, 2014). Scholars examining indigenous epistemology suggest these knowledge systems are coherent, systematic, and evidence-based within their own internal logic; and should be treated as a valid source of knowledge when constructing culturally responsive rehabilitation programs (Corso et al., 2022).

2.3.3 Preventive and Holistic Dimensions

A significant feature of many Indigenous healing practices is prevention: they utilize community rituals, seasonal practices, rituals, and ethical teachings to preserve conditions of harmony to prevent illness from setting in. While Western biomedical systems tend to focus on detecting symptoms and biomedical interventions after the pathology manifests, Indigenous frameworks emphasize ongoing maintenance of relational balance, social ties, and ecological stewardship as protective factors against substance dependency, misuse, and other harms. Land-based practices, connectedness to place, and involvement in community rituals can bolster resilience, cultural identity, and protective factors; all of which reduce the risk of dependence or relapse (Hatala et al, 2020).

Community rituals and regularized practices, as demonstrated through shared seasonal events, rites of passage, and sharing food with each other, act as social customs: they normalize healthy relations, establish obligations to kin, and offer predictable social support during stress. Several recent scoping reviews and qualitative studies have described how integrating land-based and community rituals into care models enhances engagement, retention, and culturally relevant coping with restoration of spirit and engagement with Indigenous cultural practices as a system/context of care within mental health needs and substance use and dependence programs. These preventative effects are of utmost value in contexts where biomedical services are nonexistent or subject to stigma (Corso et al., 2022).

2.3.4 Categories of Indigenous Healers

Indigenous healers all over the world represent knowledge that is diverse, and they address illness through customs that are embedded in social, spiritual, and ecological systems. These practitioners play an important role in keeping the

communities healthy by offering them a holistic form of care that is accessible and trustworthy.

2.3.4.1 Spiritual and Faith Healers (Peers)

Indigenous healers have a crucial role across the regions of Africa, South Asia, and the Middle East. Drug addiction in these places is commonly attributed to spiritual, moral decline, and in some cases considered as a supernatural cause, such as weak faith and possession, etc. (Dein et al, 2012). faith based healers use different types of healingpractices to address drug addiction such as prayer, exorcism, fasting, and counseling grounded in religion (Kleinman, 1980)In south asian region, spiritual healers are commonly cosidered in drug addiction cases, because addiction is associated with weak faith, stigma and social distress (Dein & Illaiee, 2013; Qureshi et al, 2020)

2.3.4.2 Herbalists and Traditional Medicine Practitioners (Hakeems)

Herbalists and indigenous healers in Africa, Asia, and Latin America have been treating drug addiction through plant-based therapies like detoxification, calming agents obtained through herbs, and restorative tonics (WHO, 2013; Hatala et al, 2020). Hakeems in Pakistan, India, Bangladesh, and unani medicine practitioners, that is rooted in Greco-arab medical philosophy. In unani medicine, drug addiction is seen as body and mind temperament imbalance. Hakeems utilize dietary regulation, herbal formulations, and lifestyle counseling to rehabilitate drug addiction patients, and restores self control (Quddusi et al, 2020; Hussain et al, 2012).

2.3.4.3 Shamans

In many local and indigenous regions of the Americas, Siberia, and Central Asia, shamans commonly treat substance use disorders. Shamans see addiction as spirit intrusion, soul loss, and spiritual imbalance. Many informal methods of treatments, such as Healing rituals, purification ceremonies, and altered states of consciousness ar applied to restore self-control. These practices are also applied in community-based rehabilitation settings to treat addiction (Waldram, 2000; Gone, 2013).

2.3.5 Indigenous Healing Practices across Continents

Indigenous healing is characterized by the use of ritual, symbolism, and the telling of stories, which all work at various levels, psychological, social, and somatic (Struthers et al, 2004). Common symbolic acts include drumming and dancing, purification rituals and rites, storytelling and testimony, and involving medicinal plants in ceremony. Ceremonial acts are used to do a number of things concurrently: they offer a form of collective language for shared suffering; they act out ethical narratives that reframe personal or community crises; and they can produce embodied or lived experiences (rhythmic entrainment, catharsis, attunement) that reduce stress responses, engage emotion, and support cognitive reframing (Vinesett et al, 2015)

There is evidence of measurable psychosocial benefits of using art and cultural, ceremonial, and symbolic activities. For instance, therapeutic drumming programs adapted from ngoma (African music, dance, and drumming) or other ceremonial drumming were established with widespread reports of positive outcomes on mood, social cohesion, and coping for people with trauma or substance-use conditions (Vinesett et al, 2015). Qualitative studies of Native American and Indigenous anxiety illustrated how ceremonial storytelling and ritual assist in restoring a narrative coherence and social identity after addiction and displacement. Art, land, and community-based programs also indicate that participants report improved well-being, reduced isolation, and increased pride in individual and community culture (Koithan & Farrell, 2010)

Across the globe, Indigenous healing practices integrate culture, spirituality, and community, offering holistic approaches that complement modern rehabilitation efforts.

2.3.5.1 North & Latin America

In North America, Indigenous healing traditions tend to be structured around ceremonial forms that heal social relations, restore spiritual balance, and reconfirm cultural identity. Three frequently reported modalities that have been evaluated in substance-use and mental-health settings are sweat lodge ceremonies, talking circles, and the medicine wheel. These healing practices are part of a deeper context of historical trauma, collective, intergenerational injuries resulting from colonization,

forced removal from tribal lands, and assimilation policies, factors that contribute to patterns of substance use and recovery in Native communities.

Sweat lodges are purification ceremonies that use heat and steam, singing and prayer, to achieve physical and spiritual cleansing; studies and program evaluations indicate that these ceremonies provide a symbolic rebirth, a communal setting, and regulation of stress, all of which support recovery. Qualitative program evaluations report potentially positive experiences of catharsis, increased cultural identity, and reduced urges for use among participants in sweat lodge-based interventions, although rigorous randomized trials are not common (Marsh et al, 2018)

Both talking circles and the medicine wheel serve as narrative and structural frames that guide recovery. Talking circles provide safe, egalitarian spaces for people to share their experiences and obtain acknowledgement in a communal way; these are functions that refer to narrative reconstruction and social reintegration. The medicine wheel (a cyclical framework that maps the physical, emotional, mental, and spiritual dimensions) is often used as a culturally grounded assessment and planning tool used in Native recovery programs to link personal healing to community and land. Carefully compiled program descriptions and ethnographic reviews clarify how these processes serve to increase treatment engagement, culturally relevant meaning-making, and relapse prevention (Owen, 2014).

Historical trauma acts as a dominant explanatory frame: studies link forced removal, boarding school systems, and structural violence to intergenerational grief, which increases risk for substance misuse. Healing practices in Native communities, therefore, aim to serve the immediate goal of treating addiction, while also tackling the more complex work of restoring cultural continuity and social roles undermined by colonial histories (Owen, 2014).

Collaborative efforts between tribal healers and biomedical systems, there is an increasing body of literature that documents both formal and informal collaborations, in which tribal healers, elders, and ceremonial leaders partner with clinicians to provide hybrid care, for example, offering sweat lodge ceremonies or talking circles in conjunction with clinical programs, or using cultural consultants on treatment teams. These hybrid collaborations are frequently negotiated through the

use of community-controlled health organizations (for example, tribal behavioral health programs) and stress consent, cultural safety, and respect for ceremony protocols. Evaluations (qualitative and programmatic) indicate better acceptability and retention, while also raising ethical and legal issues (safety of ceremonies, cultural appropriation, and confidentiality). Representative sources include program evaluations and the documentation from the "Gathering of Native Healers" (Moorehead et al, 2015).

In Latin America, particularly Peru, Takiwasi curative village combines ayahuasca rites, shamanic leadership, and group worship with psychotherapeutic therapies. The approaches focus on psychological dependency as well as on spiritual detachment, which is usually related to historical and social traumas (Rush et al., 2023). The participants note that plant-based indigenous medicines can be used in conjunction with biomedical treatment as they experience profound self-reflection, reduced craving, and improved emotional wellness. There are still ethical and legal controversies concerning psychoactive substances, although the Takiwashi Center demonstrates that a safe cultural fit and alignment with evidence-based therapy could produce successful culturally sensitive rehabilitation programs.

2.3.5.2 Australia

Aboriginal healing in Australia emphasizes the importance of the connection with the land, kinship ties, and community to recover. Marumali initiative is one such program that addresses intergenerational trauma via rituals, storytelling, and land-based programs (Atkinson, 2002). The cultural identity, historical awareness, and community support increase resilience and reduce risk of relapse, which is why a holistic and context-dependent approach should be used.

The Maori health practices, such as rongoa (medicine based on herbs), mirimiri (medicine based on massage), and wananga (workshops), are included in the health policy of New Zealand. It is based on the whana (family), wairua (spirit), tinana (body), and hinengaro (mind), hence it is a wholesome approach to health literally (Durie 2003). In cases where Māori practices are combined with Western interventions, there are improved outcomes in terms of mental health, addiction recovery, and emotional resilience. The Te Whare Tapa Whangi model integrates the

physical, mental, social, and spiritual aspects and assists patients in finding the balance and reducing the risk of relapse (Pere 1991; Cram et al., 2013). The combination of the four pillars in the form of this framework is common in the programs that ensure people get entangled and stay on course. Programs that have included elders within the community, cultural activities, and group therapy have enhanced involvement and strengthened cultural belonging and trust in rehabilitation programs. These programs demonstrate the way the local context and support can enhance recovery.

2.3.5.3 Africa

Herbal medicine, divination, and spiritual guidance are used in sub-Saharan Africa by traditional practitioners such as sangomas and babalawos to assist in substance use. Ross (2007) reported that in South African hospitals where psychiatric services were combined with indigenous healers, there was an increased trust in the culturally relevant advice provided by the provider, which enhanced adherence and mental health outcomes. Such attempts demonstrate how therapeutic engagements and biological treatments can be boosted by the spiritual legitimacy and social authority.

In Africa, healing practices among the indigenous people continue to play a significant role in the operations of the healthcare system and all of them are entirely connected to spirituality, ancestral practices, and the sense of community. Traditional medicine in Africa encompasses a wide range of things, such as herbal medicine, spiritual diagnosis, divinations, ritual purifications, and communal healing rituals. These curers are commonly regarded as spiritual mentors and social brokers, who address the issue not only of physical illness but also of mental depression and social conflict. To most individuals, health is perceived as a harmony between the individual, community, spirits of the ancestors, and the spiritual world, and illness normally erupts as a result of social incompatibilities, moral failure, or spiritual discord (Mbiti, 1991; Janzen, 1992).

In relation to the field of mental health and rehabilitation, the African indigenous healing provides culturally based approaches to traumas, substance abuse, and psychosocial distress, particularly in post-conflict and marginalized regions. It is demonstrated that collaborative efforts with biomedical physicians may simplify care

access, reduce the stigma, and increase treatment adherence (Muchemwa, 2023; Nortje et al., 2016). The WHO even refers to African traditional medicine as an important element of primary healthcare and advocates its ethical and regulated insertion into the national systems (WHO, 2019). Now, indigenous healing is regarded as a supportive system that contributes to overall well-being and culturally sensitive rehabilitative systems.

2.3.5.4 Asia

Ayurveda, yoga, shamanism, and Sufi healing practices are among the many indigenous healing systems found in South and Southeast Asia that have been influenced by Buddhism, Islam, and Hinduism. For instance, in Pakistan, Sufi spiritual practices such as zikr and murshid guidance have been used in drug rehabilitation, showing gains in moral reasoning, self-awareness, and emotional control (Rashid et al., 2018). These examples illustrate how syncretic healing systems adapt traditional spiritual practices to contemporary rehabilitation frameworks, blending ritual, psycho-social, and biomedical approaches.

In Asia, indigenous healing practices are extensively embedded in philosophical traditions, spiritual beliefs, and community knowledge, and they present health as a state of holistic balance between body, mind, spirit, and environment. The traditional medical systems (Ayurveda in South Asia), Traditional Chinese Medicine (TCM), and Unani, Siddha, and many shamanistic and folk practices continue to affect healthcare all over the region. Such systems emphasize individualized diagnosis, prevention, herbal medicine, dietary control, meditation, spiritual practices, and energy-based treatment. Health is typically viewed as a disruption of inner harmony or spiritual balance, but not biologically as a problem (White, 1976; WHO, 2013).

Indigenous healing contributes significantly to addressing mental health problems and substance use disorders in most of the Asian societies, particularly where biomedical services are not readily available, do not align with cultures, and are stigmatized. Emotional distress and addiction are usually referred to spiritual healing, visiting shrines, praying, and rituals in the community. It has been found that these culturally grounded strategies foster trust, meaning, and social connectedness, all of which are essential to psychological resilience and subsequent recovery

(Kirmayer and Pedersen, 2014). Understanding of their applicability has even seen some Asian nations formalizing traditional medicine as a part of national health policies, with indigenous medicine being seen as a complement to modern medical and psychological treatment.

2.3.5.5 Europe

Indigenous and traditional healing in Europe is based on the local cultural knowledge, spiritual perspectives, and ancient relations with nature. These practices perceive health as an ever-changing combination of bodily matter, cognitive condition, social relationships, spiritual health, and the natural environment. Traditionally, the indigenous healing practices in Europe became extrinsic to the formal biomedical and were passed through oral tradition, community healers, midwives, shamans, and herbalists. Although they were marginalized and suppressed, particularly after biomedicine dominated, some of these practices still exist and evolve in contemporary healthcare contexts.

In Northern Europe, the Sami community continues to view indigenous healing as very close to spirituality, land, and culture. Depending on the shaman, joik (sacred chanting), prayer, symbolic rites, and nature-based healing can be used to recreate a harmonious relationship between the individual and the environment in Saami healing. Research indicates that the practices play a significant role in overcoming mental health issues, past traumas, and substance abuse as a result of the colonial displacement and cultural erosion (Porsanger, 2011; Sami Council, 2014). These systems emphasize group identity and spiritual endurance, which can be a significant problem in mainstream biomedical health care.

Western and Celtic Europe, such as Ireland, Scotland, and Wales, have combined all of herbal medicine, faith healing, pilgrimages to sacred sites, and rituals of folk healers. Disease is perceived to be a physical and moral-spiritual imbalance, which needs emotional and social restoration and physical care (Helman, 2007). Equally, folk medicine is very powerful in Eastern and Central Europe, particularly in rural territories where herbs, massage, ritual washing, prayer, and symbolic healing are found to be used in treating emotional distress, addiction, and psychosomatic disease (Kleinman and Benson, 2006).

European indigenous and traditional healing has recently received interest in complementary and integrative health models. The regulation and support of traditional medicine in some European countries now take place, via policy, research grants, and professional training. Such systems are formally approved by the WHO as useful components of healthcare, particularly in mental health and rehab, where cultural relevance and patient trust are the main factors of recovery (WHO, 2013; WHO, 2019). According to empirical research, culturally based healing enhances patient engagement, reduces stigmas, and leads to a higher number of people adhering to treatment, especially when it comes to groups excluded by mainstream healthcare (Kirmayer et al., 2014; Hämäläinen et al., 2018).

European indigenous healing can provide holistic models, emphasizing on meaning-making, spiritual coping, identity restoration, and community belonging, in the context of rehab and addiction recovery. These practices can be included in biomedical and psychological interventions to enhance long-term outcomes and consider the social and cultural aspects of substance use disorders (Gone, 2013; Hartmann and Gone, 2014). In this way, indigenous healing in Europe is also viewed not as an alternative but as a complementary system that enhances modern healthcare and leads to a culturally sensitive and patient-centered rehab model.

2.3.6 Spiritual Healing in Rehabilitation

Spiritual and religious healing in rehabilitation emphasizes faith-based practices, rituals, and belief systems that support emotional strength, meaning-making, and recovery.

2.3.6.1 The Role of Spirituality in Addiction Recovery

There is a considerable and growing body of literature that associates spirituality and religious engagement with resilience, improved well-being, and lower rates of relapse among people in recovery from substance use disorders. Spirituality seems to work through several mechanisms: (1) it is a mechanism of intentionality that provides meaning and purpose, and a substitute to drug-related meaning systems; (2) strengthens social bonds and social support (ex., church groups, faith-based recovery communities, 12-step fellowships); (3) coping resources (ex., prayer, meditation, ritual) for emotion regulation; and loses prosocial moral reorienting one's

risk behaviour (Galanter, 2024; Grim, 2019; Pardini et al., 2000). Many studies have found that those with stronger intrinsic religiosity or spiritual engagement are significantly more likely to have a better outcome post-treatment (ex., less relapse, more abstinence), although effect sizes do vary and are frequently mediated through social supports and treatment engagement, not spirituality alone.

Mindfulness and meditation (now often discussed as "spiritual but also psychological" practices) have a stronger evidence base from controlled and meta-analytic studies showing beneficial effects on craving, relapse risk, and emotional regulation (Marcus, 2009; Li et al., 2017). Vipassana and mindfulness-based interventions reduce relapse risk by improving attentional control and altering reactivity to craving.

2.3.6.2 Indigenous and Spiritual Syncretism

Syncretism is the merging of indigenous spiritual practices with world religions and is commonplace in addiction treatment programs across the world. Syncretic strategies can enhance cultural relevance and acceptability by incorporating rituals and symbols indigenous to a group or community. Two exemplary sources are provided:

Dubbini et al. (2019) analyze the Takiwasi therapeutic community (Peru) and discuss how aspects of Catholic religiosity, as well as elements of Amazonian indigenous spiritual practices (including some ideas regarding ayahuasca ritual), can be syncretized in the service of rehabilitation; the authors acknowledge both synergies (meaning, ritual structure) and tensions (ethical and safety concerns, cultural appropriation).

Evaluations and reports on outcomes from Takiwasi describe how ritual, prayer, and mystical experience work together through psychotherapy and collective life to stimulate purpose and reduce relapse, according to the Ayahuasca Treatment Outcome Project (ATOP) (Rush et al, 2023). Researchers warn about appropriation, safety (esp. ritual plant medicines), and informed consent when non-indigenous groups adopt sacred practices. Successful syncretic programs typically include community consent, cultural stewardship, and clinical safeguards.

2.3.6.3 Healing across Religious Frameworks

Comparative religious ideals highlight how spiritual and faith-based practices across Islam, Hinduism, Buddhism, and Christianity contribute to recovery, often complementing biomedical and indigenous therapies.

Islamic Approach

Repentance (Tawba), dependence on God (Tawakkul), and patience (Sabr) are the Islamic treatment methods that are used as moral and psychological means to restrain the desire and reestablish the existence of God. Components of programs involve prayer (Salah), Quranic recitation, congregational prayer, an application of counseling and morality training, and mentorship of a spiritual guide in Islam. Certain descriptive and empirical studies in Muslim settings (and Pakistan specifically) indicate better psychological well-being and reduced cravings in case Islamic psychospiritual modalities are added to clinical treatment (Mansoor et al. 2024). Moral reorientation is based on principles such as Tawba, Tawakkul, and Sabr. The self-control and social accountability are boosted through structured interventions of prayer, Quran recitation, and spiritual mentoring (Zainal Abidin et al., 2022).

Hindu Approach

Hindu approaches conceptualize suffering in relation to karma and balance; recovery tactic includes yoga practices, meditation, chanting/mantras, dietary/lifestyle prescriptions (Ayurveda), and purification rites (Sarkar & Varshney, 2017). Clinical and narrative reviews suggest yoga and Ayurvedic adjuncts to decrease withdrawal symptoms, improve emotional regulation, and support whole-body recovery, although limited robust RCT (randomized controlled trial) evidence is limited (Shukla & Sharma, 2025). Practices grounded in karma, dharma, yoga, and Ayurvedic treatments facilitate purification of mind and body, enhancing holistic recovery (Varambally & Gangadhar, 2012).

Buddhist Approach

Models based on the Buddhist school of thought (mindfulness, non-attachment) address craving by changing a person's relationship to desire and

thought. Models such as mindfulness-based relapse prevention, acceptance-based therapies, and Vipassana meditation programs have empirical research to support their benefits for decreasing relapse or increasing emotional regulation skills (Marcus & Zgierska, 2009; Marlatt & Witkiewitz, 2007). Mindfulness, non-attachment, and Vipassana meditation reduce cravings and withdrawal symptoms while promoting inner peace and awareness, and are increasingly integrated in rehabilitation programs in Thailand and Myanmar (Marlatt, 2002).

Christian and Catholic Approach

Christian models often highlight repentance/repentance, communal accountability, prayer, and sacramental practices (Eucharist, in particular with Catholic settings) as being particularly important for moral reorientation and social accountability (Jayne et al, 2019). Results from programs based in faith rehabilitation (restoration programs, Christian-based residential rehabilitation) reported increased engagement and identity changes. Small qualitative studies have shown that being Catholic also means that attending Mass (in particular, but also sacraments) is important to the recovery process (Wade, 2013). Confessional practices, prayer, and symbolic rituals support moral reflection and self-transformation, especially when blended with indigenous practices in Latin American settings (Dubbini et al., 2019; Martinez et al., 2018).

In many religions, spirituality contributes to recovery primarily through meaning-making, social support, and practices of self-regulation, functions which complement biomedical and psychosocial interventions. Religious and spiritual aspects can be included into the fabric of rehabilitation interventions when cultural safety, clinical screening, informed consent, and cooperation with a trained religious or community leader are ensured. Further discussions about how to incorporate Islamic psychospiritual care into evidence based treatments might be useful in considering Pakistan's health programs, but rigorous program evaluation measures and some ethical vigilance is important (Mansor et al, 2014).

2.4 Comparative Analysis: Indigenous vs. Biomedical Models

The indigenous healing resonates with the holistic well being, which is mind, body, spirit, and community together rather than biomedical models that are more

about cutting down symptoms, doing what is standard and monitoring physiological results that can be measured. Hybrid approaches, They strike the golden mean between the two, which has the potential to increase recovery, make it culturally relevant, and turn the patient engagement up.

2.4.1 Worldview and Philosophy

It is the native health care systems based on such comprehensive worldviews that consider the body, mind, spirit, community, and nature as one web (Csordas, 1994; Gone, 2010). Instead of simply eliminating symptoms, the aim is to restore balance within the self, the ancestors, and also the greater social arena (Kirmayer et al., 2000). They attach much importance to the spiritual aspect of illness and its relation to well-being. Biomedical models, however, are more reductionist and mechanistic in their explanations of disease and are more concerned with biological failure, standardized therapy, and measurably empirical outcomes (Kleinman, 1980; Engel, 1977). Practically, biomedicine narrows down to the diagnosis of the pathophysiology, prescription of drugs, and reduction of clinical manifestations.

2.4.2 Psychological views on the Body and Mind

Indigenous practices combine emotional, spiritual, and community care via rituals, narration, sacred ceremonies, herbal treatments, and meditation to ensure the entire person is held in check (Waldram, 2014). These strategies acknowledge the fact that distress is both social and cultural in nature. Instead, biomedical practices are based on elimination regimens, cognitive behavioral therapy, and psychopharmacology to achieve quantifiable mental and physical outcomes (McLellan et al., 2000). They are good in acute stabilization, but critics note that they are usually missing cultural identity, spiritual needs, and community.

2.4.3 Outcomes of Healing

Natural healing typically conceptualizes healing in terms of increasing identity, resilience, social sense, and cultural persistence, which actually reduce the relapse rates by enhancing cultural capital and social support (Fleming and Ledogar, 2008; Kirmayer et al., 2003). Evidence indicates that culturally based interventions can increase engagement and long-term recovery of Indigenous people (Gone, 2013).

Meanwhile, Biomedical systems highlight short-term reductions of symptoms, abstinence, and measurable results such as retention rates, withdrawal stabilization, and relapse statistics.

2.4.4 Complementarities

However, the two systems are meshable despite philosophical gaps. Hybrid programs, which combine medical detox with cultural or religious practices, boast of greater patient satisfaction, greater engagement, and reduced relapse (Rowan et al., 2014; Venner et al., 2016). An example is the implementation of rituals or culture-specific practices into biomedical rehabilitation to increase motivation, emotional strength, and connection with the community in the stuff that cannot be easily attained by biomedical means. Thus, the multifaceted strategy addresses the physical, emotional, social, and spiritual aspects of recovery.

2.4.4.1 Complementary and Alternative Medicine

Complementary and Alternative Medicine, or CAM approach is a term used in the healthcare system for products or practices that are apart from the standard medical care system. It has been defined by the World Health Organization (WHO) as a broad set of healthcare practices that are not part of the conventional health system practices and are not fully integrated into the dominant healthcare system (WHO, 2023). The CAM approach defines well-being as a balance between physical, psychological, and social prospects of life (Dossey, 2009).

CAM emphasize on client-centred care, cultural relevance, and personal meaning behind treatment. It recognizes that recovery is not just a biological process rather it is a spiritual, emotional, and also a social journey. Application of this approach in drug rehabilitation helps us in understanding healing as a holistic and integrative process. Herbal remedies, meditation, and spiritual treatments are considered a legitimate part of treatment in this approach and can be seen to support emotional and psychological stability, self-regulatory behaviour, and a long-term recovery (Kabat-Zinn, 2003; WHO, 2013).

Additionally, this approach also challenges the dominating role the biomedical system plays by focusing more on integration rather than replacement. It advocates for collaboration and a culturally appropriate healthcare system that shows respect to

local healing practices and traditions; it does not reject the modern biomedical system (WHO, 2013).

According to research, CAM is a great complementary treatment approach due to its promising effect working with modern medicine, but due to insufficient scientific application and evidence it cannot be prescribed as an alternative to modern medicine (Romero-García et al, 2024).

2.5 Integrative and Hybrid Models

Biocultural and holistic frames work modularly through cognitive, emotional, and bodily expressions to comprehend and depict the range of human behaviors (Hills, 1997, p. 56).

2.5.1 Holistic and Culturally Sensitive Approaches

The hybrid models are based on both biomedical instruments and Indigenous beliefs, and they formulate biocultural rehabilitation, which is a combination of medicines, therapy, and behavioral assistance with ritual, spirituality, and community-based interventions (Horrigan, 2010). The model of integrative medicine has been advocating the idea of whole-person care and is emerging as an evidence-based intervention in addiction and mental health (Ring et al., 2014).

In the U.S. and Canada, indigenous residential programs tend to incorporate sweat lodges, talking circles, drum-assisted therapy, smudging, and counseling led by the elders (Gone, 2013; Marsh et al., 2016). Empirical studies indicate that culturally based healing enhances self-esteem, strength, and adherence to treatment among the Indigenous population.

The Takiwasi therapeutic community, located in Peru, assembles ayahuasca rituals with psychotherapy, group work, and traditional Amazonian medicine. Research results are improved psychological functioning, reduction of craving, and deep personal insight (Dubbini et al., 2019; Giove, 2002).

The strategies in Pakistan combine Unani detox programs, Quranic recitation treatment, Islamic psychosoul therapy, and herbal therapy within rehabilitation facilities (Bano et al., 2019). Experts put the emphasis on Sufi healing and

shrine-based strategies that uplift emotional health and coping amid addicts (Ahmed & Raza, 2023). The same trends can be observed in adjacent South Asian contexts, with aboriginal healers collaborating with biomedicine to give assistance to addicted or mentally distressed patients (Bano et al., 2019).

2.5.2 Benefits of Integration

Integrative healing models have various significant benefits for people in rehabilitation settings. First, they support holistic well-being, including the body, mind, emotions, and spirit, in parallel with many Indigenous and culturally grounded approaches to recovery (Marsh et al., 2016). These models are also more effective in improving cultural acceptability because interventions that are compatible with a person's cultural background will increase engagement, treatment adherence, and decrease dropout rates (Venner et al., 2016). Additionally, integrative approaches enhance social support networks through the inclusion of family, peers, and community members; these are the factors that result in resilience and reduce the risk of relapse. Finally, by including familiar healing practices, these models assist in establishing a better therapeutic relationship with higher levels of trust, confidence, and closer connections between the patient and care providers.

2.5.3 Barriers to Integration

Integration barriers are manifested each time biomedical and Indigenous healing systems come into conflict with each other, primarily due to variations in beliefs, practices, and which evidence is acceptable. These obstacles are mistrust, lack of official acknowledgment as well as a plethora of ethical or policy issues.

2.5.3.1 Cultural Bias and Knowledge Gaps

Indigenous knowledge is sometimes believed to be unscientific by biomed patients due to the gap in epistemics and the absence of formal evidence (Campbell-Hall et al., 2010). On the other hand, Indigenous healers do not trust clinical institutions that they regard as dismissive, colonial, or incompatible with spiritual conceptualizations of the illness (Waldram, 2014). These strains turn into actual barrier to cooperation.

2.6.3.2 Insufficient Scientific Foundations and Methods

Randomized controlled trials, systematic records, and standardization of indigenous practices are not common (Kirmayer and Pedersen, 2014). Subsequently, they are rarely found in clinical guidelines or training programs. Such informal evidence prevents institutionalization despite community based success.

2.5.3.3 Policy and Ethical Concerns

Concerns regarding patient safety, informed consent, and possible appropriation of sacred knowledge are real in the situation of the integration of Indigenous practices in biomedical settings (Löytömäki, 2025). Several nations lack regulatory systems that acknowledge Indigenous healers, and this gives gray areas in the scope of practice, accountability, and safety measures.

2.5.3.4 Strategies to Bridge Gaps

Interdisciplinary interventions are widely proposed to bridge gaps between biomedical addiction treatment and Indigenous or culturally grounded healing systems. Collaborative models involving clinicians, mental health professionals, anthropologists, and Indigenous healers allow for the development of ethically sound and culturally responsive rehabilitation programs, particularly in addiction and mental health contexts where mistrust of formal institutions often affects treatment engagement (Kirmayer, 2004; Gone & Kirmayer, 2010; Gone, 2013). Such models have been associated with improved treatment retention and stronger therapeutic alliances.

As a central approach to this integrative effort, ethnographic mediation is a process that converts Indigenous understandings of distress, substance dependency and healing into clinically intelligible constructs without diminishing their symbolic or spiritual value (Csordas, 1994). Indigenous substance -use treatment programme empirical studies show that rituals, storytelling, and prayer are potentially useful with trauma-informed and recovery-focused mental-health systems, thus enabling addiction to be viewed as a relational and historical process; not simply as a biomedical disorder (Walters et al., 2002; Rowan et al., 2014).

These bridging activities are also strengthened by participatory and community-based practices. Community-Based Participatory Research (CBPR) has been demonstrated to increase the cultural relevance and efficacy of the addiction and mental-health-interventions by actively incorporating Indigenous healers, elders, and service users into the programme-design and programme-evaluation (Wallerstein & Duran, 2010). These methods have been associated with a decrease in substance use, enhanced emotional control, and strengthening of cultural identity, which constitute the main components of long-term recovery (Brave Heart et al., 2011; Gone & Calf Looking, 2015).

Pilot studies and outcome assessments are still vital to legitimise hybrid models in evidence-based mental-health systems. A scoping review by Rowan et al. (2014) also documented a decrease in substance use by about 74 percent of cultural integrated interventions especially where the programmes were culturally adapted to the local cultural settings. There is other evidence that culturally-tailored mental-health interventions that focus on historical and intergenerational trauma fend off improved coping ability and lower relapse rates (Heckbert et al., 2012).

Finally, institutional flexibility and policy reform is needed to achieve sustainable integration. The application of spiritual practices or traditional practices in rehabilitation is often hindered by rigid licensing and documentation conventions. The researchers promote, as such, adaptive regulatory systems, clinician training in cultural humility and trauma informed care to facilitate ethical and effective collaboration across healing systems (Tervalon & Murray-Garcia, 1998; Kirmayer et al., 2011). Together, these measures support the construction of pluralistic models of addiction that acknowledge the Indigenous healing as an effective element of recovery.

2.6 Practical Implications and Future Directions

Global recognition has been seen by health authorities of the key role that both indigenous and spiritual healing play in healthcare and rehabilitation. Particularly in low-resource environments and where there is cultural acceptability and viability, the World Health Organization (WHO) plainly recommends integrating traditional medicine into national healthcare systems. By promoting evidence-based evaluation,

training, and cooperation with biomedical services, recognition gives indigenous healing practices legitimacy (WHO, 2014). Indigenous healing has the potential to co-exist with biomedical approaches in the treatment of use disorders, chronic disease management, and mental health treatment (Theodorakis, 2024). There are multiple initiatives to improve the safe, effective, and culturally acceptable integration of traditional medicine into healthcare systems, like the WHO Traditional Medicine Strategy 2014-2023.

Culturally competent care is essential to enhance engagement, treatment adherence, and health outcomes in substance-use treatments, especially in multicultural and indigenous populations. Practitioners should:

- Understand community healing beliefs, spiritual beliefs, and community contexts.
- Understand that patients may use syncretic practices.
- Engage with traditional healers, spiritual leaders, and family systems to provide holistic care.

Training in cultural competence has been shown to increase patients' satisfaction, trust, and likelihood of a successful rehabilitation process. For example, programs that combine cultural competence training with traditional biomedical training have a greater retention rate and lower rates of relapse behaviour in addiction recovery (Gone, 2013; Fleming & Ledogar, 2008).

2.7 Theoretical Framework

This research is based on medical and cultural anthropology, which studies healing practices as culturally relevant phenomena. Two theoretical approaches were used to analyze the data: Critical Medical Anthropology (CMA) and Interpretive Anthropology (Symbolic/Meaning-Centered Approach).

2.7.1 Historical Ecological Approach

The Historical Ecological Approach is an approach in anthropology dealing with the long term relationship between human societies and their environment (Balée, 2006; Crumley, 1994). This approach focuses on the fact that the relationship

between humans and the environment is not static but is ever-evolving and has historical significance and cultural aspects. This approach sees ecological knowledge, landscapes, and cultural practices as co-produced in colonisations, resistance movements, and globalisation processes and political change (Balée & Erickson, 2006).

In the context of drug rehab, the historical ecology approach enables an in-depth look at how indigenous healing practices are based on a long-term relationship with ecology, cosmology, and indigenous knowledge. Many indigenous healing practices - plant-based medicine, ritualistic purification, sacred spaces, etc. are deeply rooted in traditional ecological knowledge and spiritual significance of beliefs (Bennett, 1996). This system views addiction as a spiritual imbalance and disconnection from land, ancestral traditions, and community (Kirmayer et al., 2004).

By using the historical ecology approach, I have been able to examine the effects of disruption in the continuity and credibility of indigenous peoples by colonization, environmental disruption, and modern rehab frameworks (Cajete, 2000). I have also looked at how these practices survived, revived, and integrated into the modern rehab framework.

This approach moves against the ahistorical and depoliticized narratives of intervention and instead situates indigenous healing in broader socio-environmental and historical contexts. It helps us to consider how such healing practices develop cultural identity and resist cognitive disbalance, and aims to recreate the relationship between man, land, and spirit (Johnson-Jennings et al, 2020).

2.7.2 Clifford Geertz's Interpretive Anthropology

This research utilizes the theory of culture developed by Clifford Geertz as a system of symbols - an important concept in interpretive anthropology. Geertz in 1973 tried to argue that the idea of culture is not looked at through a prism of traits or behaviours, but rather it is a web of meanings employed by people to make sense out of life and their world. He also introduced the concept of "Thick Description," which helps anthropologists to interpret the meaning of actions within their context and to be attentive to the symbolic meaning behind the actions (Geertz, 1973). Applying this theory to the situation of drug rehabilitation allows us to examine healing as a

symbolic process. Practices and rituals such as spiritual cleansing, use of sacred plants and herbs, invocation of family ancestors, and storytelling are not merely therapeutic alternatives; they are cultural practices with a significant connection to disease and healing (Turner, 1969; Csordas, 1994).

Clifford Geertz's approach makes this research possible to study the occurrence of symbolic meaning in indigenous healing practices. Concepts like spirit possession, energy cleansing, and ritual rebirth are all part of the community's world view and contribute to their understanding and ability to cope with addiction. These symbolic meanings are mostly not considered in the biomedical model, which pathologizes addiction as a behavioural or neurochemical disorder that has no need for cultural meaning (Kirmayer, 2004).In addition, Geertz also suggested that healing is a personal and communal act. Many indigenous healing practices are not about curing addiction only, but also about restoring social harmony and balancing spirituality within the whole community. This makes healing a place for cultural resiliency and moral restoration (Waldram, 2000).

Through the use of Clifford Geertz's interpretive anthropology we can construct a thick description of the perception, interpretation and narration of healing by participants. It emphasizes that it is not enough to understand indigenous healing in the rehabilitation process, or it needs to be translated culturally, not clinically.

2.8 Toward a Holistic Model of Rehabilitation

Moving ahead, we suggest a pluralistic rehabilitation model encompassing indigenous healing, spiritual care, and biomedical approaches. Patient-centered care that honors the customs, beliefs, and cultures of marginalized populations (WHO, 2014). Collaboration and coordination between clinicians, traditional healers, spiritual mentors, and community networks. Multidimensional outcomes of physical detoxification, mental health, social inclusion, reintegration, and growth of meaning and spirituality. Inclusive policy and evaluative frameworks that encompass safety, consistency, and data collection to assist with longitudinal advancement (Dubbini et al, 2019)

Emerging evidence suggests hybrid models of care may increase engagement, reduce relapse, and produce better overall treatment outcomes, especially in countries

like Pakistan, where Indigenous and spiritual healing approaches continue to have cultural relevance. The pragmatic implications of this body of literature indicate rehabilitation models must move beyond exclusively conducting practice with a biomedical framework, to one where interventions are culturally-informed, spiritually-based, and community-supported. Future research therefore must prioritise the evaluation of empirical practice, be ethnographically-informed, and propose integrative models for practice and policy in order to respond effectively to the needs of their service users in substance-use recovery.

CHAPTER 3
RESEARCH METHODOLOGY

This chapter discusses the research design and method used to investigate traditional healing practices in the context of drug rehabilitation. The dissertation is an anthropological study, and the focus of the study is to understand how traditional healing practices interface with modern addiction treatment and recovery options. The methodological choices made for this study prioritize studying lived experience, cultural meanings, and the therapeutic experience of indigenous traditional healing modalities for the individuals in rehabilitation.

Given the study's focus on understanding social meanings and lived realities, a qualitative ethnographic approach is used. This method allows a deep understanding of the narratives, practices, and interactions of participants in the social and cultural contexts of their real lives (Creswell, 2003). Rooted in an interpretivist paradigm, the design also emphasizes and considers participants' perspectives and the culture-laden approach to healing and recovery.

3.1 Research design

For this thesis, I went with a qualitative approach, as I wanted to study the way participants feel about and use Indigenous healing in rehab centers. I used a combination of in-depth interviews, participant observation, and field notes. The qualitative approach felt appropriate to learn about their mindsets about the healing methods, experiences, and thoughts with participants (Creswell & Poth, 2018).

3.2 Research Methodology

I employed an exploratory sequential mixed-methods design to comprehensively investigate the research problem. The exploratory approach is particularly appropriate when limited prior research exists, when contextual understanding is required, or when culturally grounded insights are necessary before measurement tools can be developed (Creswell & Plano Clark, 2018).

3.3 Sampling Technique

Purposive sampling was applied to recruit participants with firsthand experience of indigenous healing in rehabilitation contexts. This method ensured the

inclusion of participants who were capable of providing detailed, rich information for the purpose of the study.

3.3.1 Sample Size

The selection of the correct number of participants was imperative. As this was a lengthy, in-depth study, I decided on 28 interviewees. Thirteen patients were undergoing rehabilitation (ten male and three female). Eleven were health care professionals (six females, four males). Four interviews were obtained from indigenous healers (two hakeems and two religious scholars).

3.3.2 Respondents

The population of this research consisted of patients undergoing rehabilitation, indigenous healers, and healthcare professionals. The respondents included 13 patients undergoing rehabilitation, 11 healthcare professionals, and 4 indigenous healers. All respondents were from the premises of Islamabad. Patients undergoing rehab were selected on the basis of their ability to demonstrate a basic understanding of the interview questions, provide coherent responses, and pose no risk of harm to themselves or others. While out of 11 healthcare professionals, 2 were also the owners of the rehab, the rest were therapists working inside the rehab center. Out of 4 indigenous healers, 2 were Islamic scholars working part-time at the rehab, and the other 2 were hakeems.

3.3.3 Sample Frame

I conducted the research in a sample of rehab centers in Islamabad and Rawalpindi. I also obtained some data from acquaintances who were key informants and assisted me in finding people who met study criteria to participate. I picked and chose people based on a thorough check and talking to the healthcare providers working at those centers. The last group consisted of people who met the requirements of my study. Sample frame consisted of three categories: Patients Undergoing Rehabilitation, Healthcare Professionals and Indigenous Healers,

3.3.4 Demographic Profile of Patients Undergoing Rehabilitation

This category comprises patients currently undergoing treatment, including those receiving a combination of clinical intervention and indigenous or spiritual healing practices.

There were 13 rehabilitation patients (RP1 to RP13) whose age was between 22 to 41 years, which is a relatively young adult sample. The majority of the participants were between their early and late twenties, although there were few representatives of people in their thirties and one in their forties.

Geographically, most of the respondents were inhabitants of Islamabad (ISB) and a few were found living in Rawalpindi (RWP), which suggests that this sample was urban based in the twin city area.

In terms of gender, the sample was majorly male with 10 male participants and 3 female participants. Such gender distribution is an indication that there is higher representation of male patients in the rehabilitation environment where the sample was collected. It has been identified during the data collection that female rehab patients were less likey to be admitted at rehabilitation centers due to culture stigma and lack of separate facilities for females.

The sample size had a fairly high education level as indicated in table 1. The majority of them were undergraduate with degrees of BS , BBA, BS-IT, BSCS, BS-ENG, and BSA-IR, and some of them were postgraduates in MBA, MS Project Management, and MS Psychology. There was some educational diversity in the group, as one of the participants had finished their studies as far as matriculation.

Occupation-wise, the participants were doing various occupations. Some were students, and others were working as office workers, businesspeople, salespersons, human resource managers, and a chef as shown in table 1. One of the female subjects said that she was not working during the data collection period. This shows that most of the Rehab Patients were mostly wee-settled even after suffering through Substance use disorder and the in-facility Patients were taking breaks from their workplaces or universities, and the others were making it work by managing their social life and their disorder.

Regarding religion, most of the respondents were Muslim, with two respondents being Christian, because of the data collected in Pakistan, which is a Muslim-dominant country and also because the areas where these rehabs were located were also muslim- majority areas.

In general, the demographic picture indicates that the rehabilitation patients were mostly male, young, and urban and had different professional profiles, which is significant in the context of learning about their experience of rehabilitation and their perspectives that on the study that was conducted.

Table 1: Demographic table of Patients Undergoing Rehabilitation

Participant	Age	Location	Gender	Qualification	Occupation	Religion
RP1	22	ISB	M	BS	Student	Muslim
RP2	25	ISB	M	BBA	business	Muslim
RP3	34	ISB	M	MBA	Human Resource	Muslim
RP4	25	ISB	M	BS-IT	Office worker	Muslim
RP5	28	ISB	M	BSCS	Office worker	Muslim
RP6	35	ISB	M	BBA	Office worker	Muslim
RP7	24	ISB	M	ACCA	Business	Muslim
RP8	25	ISB	M	MS- PM	Office worker	Muslim
RP9	27	ISB	M	BS-ENG	Sales Representative	Muslim
RP10	41	ISB	M	Matric	Chef	Christian
RP11	27	RWP	F	BSCS	Unemployed	Muslim
RP12	23	ISB	F	BS-IR	Student	Muslim
RP13	26	RWP	F	MS-PSY	Student	Christian

Source: Field Data

3.3.5 Demographic Profile of Healthcare Professionals

This group consists of physicians, psychologists, therapists, counselors, and other healthcare workers in rehabilitation centers who integrate or collaborate with indigenous healing practices in treatment.

The research involved 11 health professionals (HP 1-HP 11) working in various rehabilitation centers, such as Irada Clinic, Lifeline Rehabilitation Center, Shifa Caring Center, and New Hope Rehab and Caring Center. This variety of institutional representation gave a wide view on the rehabilitation practices in various clinical settings.

Gender-wise, the sample was six male and five female healthcare professionals, respectively, and this is quite a balanced representation of genders in the rehabilitation workforce as shown in table 2.

In the aspect of professional qualification, most of the participants had advanced academic degrees in psychology. The majority of the healthcare professionals had master's degrees in psychology (MS-PSY), and some of them indicated that they had other professional certifications, which were related to the field of rehabilitation and therapeutic practice. The percentage of people with doctoral education (PhD) is high, which means that the sample is highly qualified academically and clinically. A lower percentage had attained bachelor-level training in psychology (BS-PSY).

Regarding occupational roles, most participants practiced as therapists, one of whom was a primary therapist, which means that they were directly involved in the processes of patient care and rehabilitation. Two of the participants were also owners or administrators of their respective rehabilitation facilities and provided both managerial and policy-level information in addition to clinical input.

In general, demographic features of the healthcare professionals suggest a well-qualified and experienced sample since most of the individuals in the sample were trained in psychology and actively involved in the delivery of rehabilitation services in various institutional settings. This description enhances the legitimacy of the professional experiences and views that were examined in the paper.

Table 2: Demographic table of Healthcare Professionals

Participant	Gender	Rehabilitation	Qualification	Occupation
HP1	F	Irada clinic	Ms-Psy & Certifications	Therapist
HP2	M	Lifeline Rehab Center	PhD & Certifications	Owner
HP3	F	Shifa Caring Center	Ms-Psy	Therapist
HP4	M	Lifeline Rehab Center	Bs-Psy	Therapist
HP5	M	Irada clinic	Ms-Psy & Certifications	Therapist
HP6	M	Lifeline Rehab Center	PhD	Therapist
HP7	F	Lifeline Rehab Center	Ms-Psy	Therapist
HP8	M	Irada clinic	PhD	Owner
HP9	M	New Hope Rehab and Caring Center	Ms-Psy	Therapist
HP10	F	Shifa Caring Center	Ms-Psy & Certifications	Main Therapist
HP11	F	Lifeline Rehab Center	Bs-Psy	Therapist

Source: Field Data

3.3.6 Demographic Profile of Indigenous Healers

This category includes spiritual healers, faith-based practitioners, and individuals who conduct ritualistic or indigenous healing methods within rehabilitation settings.

Four indigenous healers (IH 1-IH 4) were involved in the study and were practicing traditional and religious healers. The sample included the representatives of both religious and traditional medicinal backgrounds who gave culturally based views that are applicable to the indigenous healing systems.

Both Islamic scholarship and traditional healing (hikmat) in Pakistan are predominantly male-dominated fields, shaped by patriarchal social structures.

Religious authority is largely controlled by men through madrassa systems that privilege male leadership and public legitimacy. Similarly, hikmat is commonly transmitted through male family lineages, while women's healing knowledge remains informal and unrecognized.

Two respondents described themselves as Islamic scholars, as far as the occupation is concerned, and the other two were Hakeems, with one also remarking that he was a teacher.

In terms of education, the participants had mixed degrees of formal education as indicated in Table 3. Two of them had finished their education up to the matriculation level, one of them had a bachelor's degree in Islamic Studies, and the other had a master's degree (MA). This spectrum points out that there is no assurance of standardized formal qualification in indigenous healing practices; rather, practices are usually enlightened by experience, religious education, and community acknowledgement.

To conclude, the demographic image depicts that the native healers who participated were male healers whose educational background was quite broad, were religious researches and traditional healers. Their incorporation provides priceless information of health behaviors practiced culturally that dictate treatment-seeking behaviors and belief systems in the context of the study.

Table 3: Demographic table of Indigenous Healers

Participant	**Occupation**	**Qualification**	**Gender**
IH 1	Islamic scholar	BA ISLAMIC STUDIES	Male
IH 2	Islamic Scholar	MATRIC	Male
IH 3	Hakeem	MATRIC	Male
IH 4	Hakeem/teacher	MA, BUMS	Male

Source: Field Data

3.3.7 Participant Distribution

The pie chart shows the general distribution of the study participants in the three groups included in the research. Among 28 respondents, the greatest number of respondents was that of rehabilitation patients (RP), who were 13 in number, which is the majority within the sample. This was then succeeded by healthcare professionals (HP) that included 11 participants, which constituted a large percentage of the study population. The smallest group was comprised of indigenous healers (IH), which had 4 participants. On the whole, the pie chart indicates that the research is based majorly on the views of the rehabilitation patients and professionals but also includes the opinions of indigenous healers to offer a culturally based and comparative insight into the indigenous healing practices in the rehabilitation process.

This chart also reflects the gender dominance of the field. We can see that both healthcare professionals and indigenous healers were predominantly male in the study; this shows the broader patterns of male dominance in the formal and informal healing roles available in Pakistan.

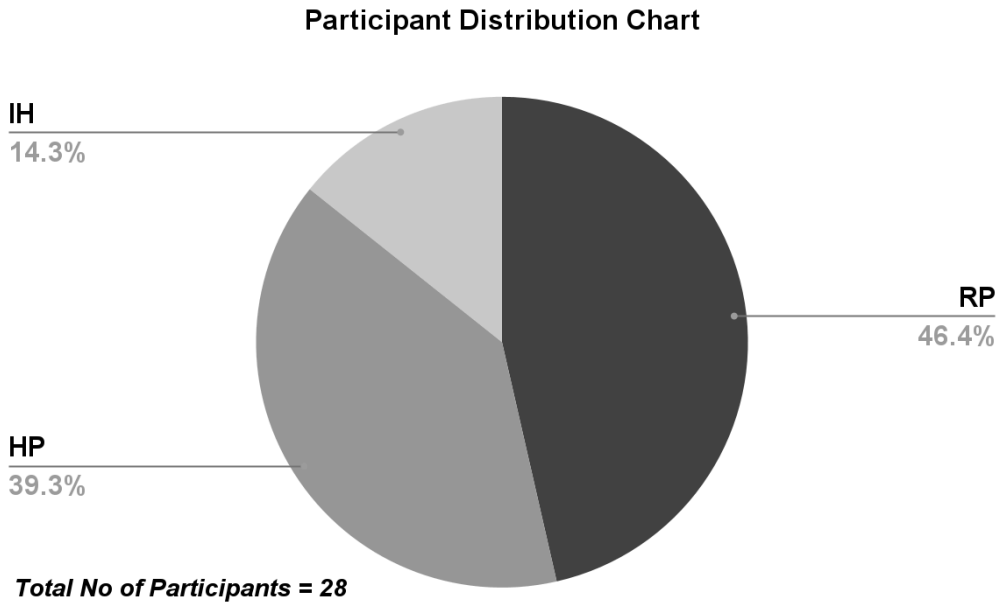

Figure 1 Graphical Representation Of Participant Distribution. a) Rp as Rehabilitation Patients, b) HP as Healthcare Professionals, c) IH as Indigenous Healers

Source: Field Data

3.4 Key Informants

Key informants in this study included the heads of rehabilitation centers, who facilitated access by assigning a therapist to assist in identifying and connecting me with patients who matched the study's participant criteria. In addition, two religious scholars and Hakeems served as valuable key informants, providing cultural and spiritual insights relevant to the research context. Furthermore, my friends, colleagues, and former classmates also played a significant role by connecting me to individuals currently undergoing rehabilitation, thereby expanding the reach and diversity of my participant pool.

3.5 Data Collection Tools

3.5.1 Interview Guide

I employed semi-structured, open-ended interviews in order to deeply explore the experiences, beliefs, and perceptions of the participants. The questions covered in the guide were related to indigenous healing practices, their impact, and challenges in integrating them into drug rehabilitation. The guide helped me to keep consistent with the interviews and, at the same time, let participants tell their own unique stories that gave me a better understanding of the topic.

3.5.2 Audio Recording

All interviews were audio-recorded with the consent of the participants in order to ensure accuracy. I recorded the recordings word-for-word to ensure accurate data analysis. Audio recordings made my data collection efficient and provided me with a good record of the data for future reference.

3.6 Data Collection Methods

I collected data using an interview guide, which covered all of the major research questions. I developed three different guides, one for health care professionals, one for indigenous healers, and one for patients in rehab. All questions were open-ended and dealt with experiences, challenges, and views on indigenous healing. I did a few pre-test interviews to ensure that the tool worked as expected. After pretesting, I added questions to finalize the guide. My key informants were

instrumental in getting the informed consent of respondents. Interviews usually lasted on average 25-40 minutes.

The data collection process posed several challenges and demands. Throughout the first phase of selection of rehabilitation centers, I found myself having to repeatedly email, message through social media, and contact different people to get permission to conduct interviews. I contacted 17 different rehabilitation centers, private and government-owned, in Islamabad. It took me from a week to a whole month to get permission to conduct interviews. Two out of three rehabilitation centers that I visited required a reference letter from my university, which I got signed and submitted to the head of the rehabilitation center.

I used probing too to increase my understanding. I explained the reason for the audio recording to participants to reassure them about privacy, and I got their explicit consent before recording.

I took the time to emphasize to my participants the extraordinary value of their perspectives in contributing to my study. Initially, some professional healers and even indigenous healers displayed hesitancy about participating in my research and expressing themselves openly, but over time, they became more comfortable.

3.6.1 Rapport Building

Building rapport with healers, patients, and healthcare workers was instrumental to the success of my study. I began the research with casual conversations prior to the formal interviews. I employed culturally relevant techniques, including simple language and the right gestures, to comfort the participants and encourage them to tell their stories. I followed ethics such as confidentiality, informed consent, and cultural sensitivity in formal and informal conversations. Before each interview, I explained the purpose of the study, informed them of their rights, and obtained consent for audio recording. I presented myself and why I was there and asked a few personal questions to build a personal connection and collect data for case studies.

3.6.2 Participant Observation

During fieldwork, I sat down with healthcare professionals, indigenous practitioners, and patients and saw healing techniques and interactions in real time. These observations took place during my in-depth interviews, allowing me to observe how participants responded to questions, how healers were explaining their methods, and how patients were describing their experiences. I recorded detailed field notes throughout and documented verbal responses, non-verbal cues, settings, and dynamics. I wrote notes discreetly not to interrupt the natural flow. Spending a lot of time with participants allowed me to observe routines and social interactions, as well as individual reflections on healing and rehab. This immersion allowed me to know each participant not simply as a data point, but as a person in a greater social and cultural context.

3.6.3 In-depth Interviews

28 semi-structured interviews were carried out among patients under rehabilitation, indigenous healers, and healthcare professionals, with the aim of finding their perception of healing and rehabilitation. The use of open questions helped me to adequately explore the experiences, beliefs, and attitudes of the subjects on the healing practices. Use of in-depth interviews enabled me to discover the personal accounts that supported their engagement with indigenous healing practices.

Such a method, as stressed by Kvale and Brinkman (2009), provided the flexibility in data collection since it allowed the participant to delve into their experience profoundly, yet they also made sure that all required data was obtained. The open question facilitated the occurrence of new themes in the conversation.

The interview was done in person as well as on call, depending on the choice of participants and their availability. The interviews were conducted in a relaxed setting, in a non-confidential way, and with ease for the respondents.

3.6.4 Field Notes

I used a journal to keep field notes to record detailed observations of interactions and contextual information of the fieldwork. These notes were a mix of

descriptive and reflective content and helped me to have a better grasp of participants, their behaviors, and the research setting (Emerson et al., 2011).

3.6.5 Case Study

I used case study method to gain an in-depth understanding of the research context and the lived experiences of participants within their real-life settings. The case study method enabled me to explore complex social processes, institutional dynamics, and individual perspectives holistically rather than in isolation (Yin, 2018).

3.7 Ethical Considerations

I have conformed to the principles of ethical conduct of informed consent, voluntary involvement, and confidentiality as a researcher, being culturally sensitive and respectful to the beliefs and practices of the participants. During the research, I concentrated on the acquisition of information related to the indigenous healing practices, keeping in mind that all personal information would be considered confidential. The participants had received information on the aim of the research, and their entitlement to pull out of the study at any point was made known to them. These ethical guidelines helped me to improve the validity and credibility of my work and make sure that the findings were reliable and valid as well as ethically sound.

3.8 Area Profile

Islamabad and Rawalpindi together form the Islamabad–Rawalpindi metropolitan area on the Pothohar Plateau in northern Punjab, Pakistan. According to the 2023 census, Islamabad Capital Territory has a population of approximately 2.36 million, while the wider Rawalpindi District nearly 5.7 million, making the twin cities a major metropolitan center. Both cities are ethnically diverse, with Punjabi, Pashto, and Urdu commonly spoken, and have experienced rapid urban growth (Wikipedia, 2025).

National estimates indicate that approximately 7.6 million people in Pakistan use drugs, with men constituting nearly 78% of the affected population (UNODC, 2023). Although city-specific prevalence data are limited, urban centers such as Islamabad and Rawalpindi are recognized as high-risk areas due to rapid urbanization, population mobility, and socioeconomic stressors. Islamabad Capital Territory

reportedly has around 50 registered addiction treatment and rehabilitation centers, including public, private, and faith-based facilities, while Rawalpindi largely relies on shared services within the twin-cities framework (Pakistan Today, 2023).

Figure 2: Map of Islamabad and Rawalpindi

Source: Internet

I selected three rehabilitation centers in Islamabad as the main research locations: the Lifeline Rehabilitation Center in the Gala of Bani, the second was Irada Clinic in the Ghauri Town, and the third was the Shifa Caring Center in Faizabad. One of the healthcare professionals who was an acquaintance whose interview was from New Hope Caring Center. The selection of these centers was due to the availability of therapeutic environments and different methods of drug rehabilitation between clinical and faith-based methods. Before carrying out the in-depth interviews, I observed the setting, met the employees, and picked up general demographic data about the residents. Moreover, some of my information was gathered by the use of key informants who introduced me to people who were in rehabilitation in various institutions. Some of these participants were also met in person at different places in Rawalpindi, and others were called by telephone, which guarantees the representation of data is wide and inclusive.

3.9 Reflexivity

My position as a student of anthropology has influenced the way I approached this research on indigenous healing practices in drug rehab settings. I brought a

combination of academic interest and personal interest in cultural knowledge systems into this field, knowing that my background, education, and understanding of the world, which was built up in a modern, globalized setting, could affect my interpretations and interactions with participants. Though I had limited direct experience with rehab centres before the study, my training in anthropology had me critically considering how my assumptions about the concepts of healing, addiction, and spirituality might color the research process. To be conscious of these influences, I continued to engage in self-reflection and sought input from mentors, peers, and even participants throughout the study.

Getting access to rehab centers and practitioners of indigenous healing provided a series of challenges, which made me question my role and positionality. Initial efforts to try to get into the field through formal institutional channels often flopped, and so I relied more heavily on my personal networks, colleagues, and friends who served as key informants. Their support opened the door for me, and I remained aware of how their presence and recommendations might affect how participants would perceive me as an outsider, a student researcher, or a trusted visitor. Building rapport with patients, therapists, and healers requires lots of patience, transparency, and sensitivity. Many participants experienced emotional and physical vulnerability, so I kept respectful engagement and ethical considerations central in my data collection.

Power dynamics were an inevitable part of this research. As a researcher, I was in a position of relative privilege in relation to participants undergoing rehab or practicing indigenous healing within a set of institutional constraints. I tried to balance these imbalances by being an attentive listener instead of an authority figure. I tried my best in creating a non-judgmental and safe environment that allowed participants of this study to open up and share their stories about addiction and recovery. As data collection progressed, my understanding of indigenous healing practices and its role in rehabilitation changed a lot. Dialogue with healers, therapists, and patients raised questions about my own assumptions concerning the dichotomy between biomedical and spiritual models of care. Instead, I found that participants often navigated these systems simultaneously, revealing a complex and dynamic landscape of healing. This realization forced me to re-evaluate my analytical

framework and remain open to other explanations that emerged from the field rather than impose theoretical ideas too quickly. Returning to the field notes, reflexive journaling, and discussing emerging themes with my supervisor helped me identify and address potential biases in my analysis.

Unexpected moments in the data analysis process, such as conflicting narratives, emotionally charged accounts, or profound symbolic meanings associated with healing rituals, demanded flexibility and humility. These challenges encouraged me to think outside academic categories and have more meaningful relationships with the lived realities of participants. The process ultimately enhanced my awareness of cultural diversity in healing traditions and reinforced the importance of being respectful and patient when addressing such topics and being culturally sensitive.

Doing this research has been life-changing to my personal and academic development. It helped me to better understand the intersection of the indigenous knowledge systems, addiction recovery, and the institutional practices in Pakistan. More importantly, it strengthened the importance of reflexivity in working with vulnerable people and culturally embedded practices. While I recognize the limitations of this study, especially the small sample size and unique nature of the cultural context of each rehab center, I believe the insights gained add meaningfully to the larger discourse of cultural competence in healthcare, the importance of indigenous healing, and the value of holistic models of rehab in Pakistan.

3.10 Data Analysis

The collected data underwent analysis using the thematic data analysis technique by Braun and Clark, involving all six major steps: Familiarization with data, coding, theme generation, reviewing the themes, defining and naming themes, and the write-up phase. Initially, after collecting the data, I familiarized myself with it, including the transcription of the collected data. Subsequently, the data were coded, and specific themes emerged. These themes were then defined and appropriately named. Data with similar responses were grouped together to generate meaningful discourses on the topic. Themes were constructed across participant groups to capture shared cultural meanings rather than segregated professional roles. (Braun & Clarke, 2006).

CHAPTER 4

IMPACT OF THE INDIGENOUS HEALING PRACTICES ON THE REHABILITATION PROCESS

Chapter four of the thesis contains a detailed analysis of the data collected during interviews to identify and interpret the influence of indigenous healing practices on the rehabilitation process. The data were gathered from 28 respondents at three rehabilitation centers in Islamabad. The participants include 13 patients undergoing rehabilitation, 11 healthcare professionals, and 4 indigenous healers. The following discussion and verbatim used in the data analysis chapter are taken from interviews, which were transcribed and analyzed. The identities of all the respondents will be held in reserve for the purpose of this study, as most of them did not give permission for their names to be used; therefore, I shall be using only the initial letters of the category they belong to with an assigned number. The data has been analyzed in the form of themes using the method of thematic analysis, which has been divided into 2 themes and 8 subthemes in total. These themes will discuss the identification and impact of indigenous healing practices. This chapter gives the demographic characteristics of the participants in the study, rehabilitation patients, healthcare professionals, and indigenous healers, and then proceeds to explain the thematic framework on which the data is going to be analyzed.

In this chapter, I shall be looking into the insights provided by the participants regarding the impact of Indigenous healing practices in drug rehabilitation under the following themes and subthemes:

1. Identification of Indigenous Healing Practices
    - Quranic Recitation, Dua, and Spiritual Practices
    - Group Prayers and Community Support
    - Generational Knowledge
    - Herbal and Hikmat Practices
    - Holistic Approach towards Healing
2. Impact of Indigenous Healing Practices
    - Emotional Relief and Coping
    - Spiritual Empowerment and Motivation
    - Short-term Impact
    - Long-term Impact

4.1 Identification of Indigenous Healing Practices

This theme identifies how the participants narrate and identify the traditional practices they follow in the healing process. It documents their interpretation of spiritual practices and cultural rites as well as their knowledge acquired across generations. The theme depicts the way the traditional healing practices are perceived and known throughout the community. Participants identify practices that are local and rooted in their culture and faith. These practices are rooted in tradition and are generally accepted because people have long-term trust. Identification of such themes shows how people's health-seeking behaviors are shaped.

4.1.1 Quranic Recitation, Dua, and Spiritual Practices

The Quranic recitation, dua, and other spiritual practices became the main indigenous remedies of the healing process. These practices were repeatedly reported by the participants as the means of short-term emotional relaxation, reassurance, and inner balance. Repeated chanting of certain Surahs and brief prayers was considered to alleviate impatience and to give one a feeling of spiritual security. Religion was not considered as separate from the treatment but complementary to the medical and therapeutic intervention. Prayer and regular recitation also assisted in setting up structured routines, which were beneficial in supporting discipline and behavioral change. On the whole, these spiritual activities served as emotional coping strategies, as well as long-term habits with addictive behavior prevention.

When the topic of spiritual practices was introduced, I observed some tremendous changes in the participants emotionally. The most common reactions when talking about their Quran reciting or listening experiences were a feeling of calmness and reflection most of the participants were very satisfied with their religiosity and would go into great detail as to how these experiences made them feel lighter in their emotions. These remarks show that spiritual involvement is not only a religious practice but also effective emotional and psychological support to the rehabilitation setting. One participant shared directly with me that he had renewed his faith while being at the center and had come to understand aspects of deen that he had not known before, describing how learning new practices and insights gave him a deeper connection and personal clarity. In another instance, a healthcare professional

recounted that a patient from a different religious background had approached staff members to express interest in converting to Islam, citing the spiritual environment and communal practices as inspiring factors. This shows that spiritual involvement in the rehabilitation setting functioned not only as a religious practice but also as a powerful source of emotional, psychological, and personal transformation, with participants engaging deeply with faith in ways that extended beyond formal therapy sessions.

While talking about the identification of healing practices expected by patients, Respondent (HP 6) mentioned, *"Most of our patients immediately request Surah Rahman or Surah Yaseen. They believe it settles their heart and mind. Many of them say the recitation itself changes their emotional state."*

Another Respondent (RP 11) shared their insight, *"Sometimes I just ask someone to read a dua for me because I feel restless. When they recite Ayat-ul-Kursi or even a small prayer, I feel protected."*

Respondent (HP 7) explained, *"To most clients, prayer is usually a form of healing. This is what they say: that I should get better, in case Allah wills. They are really convinced that faith is capable of assisting them in recovering. Spirituality is not an independent treatment aspect for these clients. The faith in Allah makes them feel better, have hope, and are reassured when they are too overwhelmed. Religion and medicine are complementary and enable them to continue onward."*

While sharing their insights, Respondent (HP 10) mentioned, "I *mainly focus on Islamic-style gratitude journaling and dua. Herbal detoxes or teas are only optional. Having patients recite dua over water also helps a lot for inner peace. We place greater emphasis on spiritual and cultural routines."*

A healthcare Professional Respondent (HP 6), had the following to say when they talked about identification of indigenous healing practices has impacted patients well-being, Respondent (HP 4) stated, *"Surah Rahman therapy provides relaxation. The difference comes when it is consistent; if a person listens to it daily for 120 days, the impact develops. The aim of addiction treatment is to create habit loops, and these indigenous practices also help in forming new habit loops."*

Respondent (HP 1) mentioned,*"We help them establish a prayer routine starting with two (prayers), then moving to three, four, and eventually five."*

The direct therapeutic effect of Quranic recitation is reflected in the fact that patients report that listening to Surah Rahman or Surah Yaseen will offer them some immediate emotional relief and a feeling of mental calmness. Even the short recitations or prayers, such as Ayat-ul-Kursi, provide some sort of protection and relief to the restlessness of the patients and focus on the reassurance and comfort of faith in little things. Regular Surah Rahman therapy can be used to create relaxation and new habit loops over time, and this shows how structured and routine spiritual practices can be used to facilitate behavioral change as a part of addiction treatment.

Patients also embrace faith in the healing process as they believe that the recovery process is associated with the will of the God, which demonstrates the main role of religious beliefs in the willingness to receive treatment. Spiritual practices like Islamic gratitude journaling and reciting dua over water are promoted in favor of herbal remedies; this highlights the culturally acceptable methods of inner peace and holistic healing.

The progressive development of an organized prayer practice (two to five prayers per day) can assist patients in providing disciplined spiritual practices, which connects the practice of religion and the development of routine practices in the healing process.

4.1.2 Group Prayers and Community Support

Findings of group prayers and community-based spiritual practices worked out as important native healing processes in the recovery process. The participants said that shared prayer rooms were emotionally soothing and psychologically supportive, even though the people were silent or passively present. The common spiritual atmosphere has created a sense of belonging, trust, and emotional lightness, which lessened feelings of isolation. The therapist-led groups emerged slowly to form their identities, friendships, and peer support groups and strengthened community-based healing and not individual treatment as such. Group activities, like dua, zikr, and common reflection, enhanced faith, enhanced responsibility, and inspired one another

among patients. In general, community support was a stabilizing factor that promoted emotional control, spiritual bonding, and extended recovery.

As I stood by the sitting area where the participants were carrying out their daily business in the rehabilitation centre, I noticed that multiple people were sitting informally on the sofas together reading and listening to the Quran. A variety of age groups were represented and the communication between the participants seemed to be natural and easy. Others read silently the Quran and some were conversing about verses or reflecting on their meaning. Interestingly, these communications were done without staff supervision. The participants were relaxed, cool and at ease to share the space, which implied that the collective spiritual space had created a feeling of trust, respect to one another, and emotional stability between the participants.

A healthcare Professional Respondent (HP 6), had the following to say when they talked about how Group Prayers and Community Support has impacted patients well-being, *"We gather patients for a group dua. When they sit together, there's a sense of community. One patient told me, 'When everyone prayed together, I felt lighter.'"*

Respondent (RP 12) stated,*"In group prayers, even if I don't talk, just sitting there makes me feel calm. The environment heals you."*

Another Respondent (RP 7) shared their insight mentioned, *"Group activities refresh my mind."*

While interviewing, Respondent (HP 4) explained,*"There are six psychologists here. Each psychologist has their own group. The group develops its own identity, friendships are formed which is also an indigenous-style healing mechanism like it creates a community, a sense of belonging, and association."*

"Qari Sahib's session is collective, there are no group differences in it. However, the topics in my group are different from those of other groups.

Respondent (HP 3) mentioned, *"One patient told me, 'When I sit with others who pray like me, it strengthens my own faith.' So I think Community is powerful."*

During the Interview, Respondent (HP 5) stated,*"Group sessions and*

community support are very important. Patients see each other's struggles, and a kind of peer encouragement develops. In zikr and dua sessions, people feel motivated to focus on their goals. Isolation decreases and a sense of belonging is created."

Respondent (HP 9) mentioned, *"Group prayers are an anchor for patients. When they recite dhikr or practice forgiveness exercises together, their stress is reduced and a sense of togetherness is felt. Patients say that with peer support and group guidance, they feel more accountable."*

While sharing their insights, Respondent (HP 10) mentioned,*"I consider group prayers and community activities to be very crucial in recovery. When patients follow spiritual routines together, such as dua, zikr, and combined journaling they feel emotional support. They receive feedback and encouragement from one another, which helps in preventing relapse."*

Respondent (IH 3) explained, *"Some spiritual guidance and the peace of home are also very important; only then does the patient stay well."*

"Without spiritual peace, no treatment provides long-term benefit."

During the Interview, Respondent (HP 7) mentioned, *"Behavioral conditioning, relaxation techniques, and group support, only when all three are combined does the patient become stable."*

Recovery is found to be stable in combination with relaxation, mindfulness, and behavioral conditioning. Excessive focus on rules at the expense of reflective spiritual consciousness restricts emotional control, which underscores the need to have a combined strategy.

Sharing of spiritual space and prayers in groups brings emotional lightness, tranquility, and psychological renewal to patients. Passive involvement, even mere sitting, is a part of healing and indicates that being a member of a spiritual community is therapeutic in itself. Groups that are led by therapists acquire their own identity in which they build friendships and social relationships. This belonging and identification serves as a native healing process based on community healing support and not individual treatment. Collective religious sessions, like those conducted by a

Qari Sahib, go beyond group differences and offer a common spiritual foundation, and therapist-directed groups offer thematic flexibility to balance commonness with individual group attention.

Engaging in the common spiritual practices, such as dua, zikr, and shared journaling, provides emotional support and feedback, which is essential in maintaining the recovery and preventing the relapse, as people get supported and encouraged together. A sense of faith, stress reduction, and accountability are strengths of collective prayer and zikr due to peer presence. Seeing how people struggle and go forward motivates the patients, and this implies that collective spirituality encourages them and makes them responsible and less isolated. Spiritual rest and the emotional feeling of being at home are offered as the basis of long-term recovery, implying that the spiritual roots of treatment are not sustainable.

4.1.3 Generational Knowledge

The generational knowledge and faith became one of the primary sources of indigenous curing methods. Participants explained such practices accusing the elders of passing down the practices to their descendants and the continuation of these practices within the family, instead of being taught in a formal way or written. The knowledge of healing was frequently passed on through observation, experience, and practice in the home and community. There was a lot of trust and cultural legitimacy brought about by this generational transfer, especially when it came to moments of emotional distress. The authority of the knowledge was also strengthened by faith-based teachings, to such an extent that it was emotionally confident and spiritually significant. On the whole, these results indicate that generational knowledge is a reliable and sustainable source of healing that still defines the treatment decisions and coping behaviors.

While talking about the Generational Knowledge, Respondent (IH 3) mentioned, *"These practices are from our elders. People say, 'My dadi used to recite these verses for healing, so I still follow them.' It's faith mixed with family tradition."*

Respondent (RP 4) explained, *"In our home, we've always done it this way. So when I'm stressed, I go back to what my elders taught, like some duas and some*

verses."

While talking about the identification of healing practices expected by patients, Respondent (HP 11) mentioned, *"Clients trust what their elders practiced. They often say, 'Our elders knew better.' That generational trust shapes their healing choices."*

While interviewing, Respondent (IH 4) stated, *"It wasn't just about reading books or formal training; it was through hands-on experience, seeing how people respond, and learning from the older practitioners and family members who passed down this knowledge. In many ways, the skills I use today are a combination of what my elders taught me and the lessons I learned directly from the people I treat."*

The elders of the family continue to transmit generations to generations through the healing practices with an amalgamation of faith, family tradition, and daily experience. "Respondent (IH 3) said as follows: These practices are of our elders…" It is religious and continuity, how the healing knowledge is an interior to family tales and spiritual lineages, and not an exterior learning regime. Another aspect noted by the respondent (RP 4) was how the practices become the instinctive reaction to distress, as he said that in our house we have always did it in this way, which shows how faith-based healing becomes an ordinary part of our homes. When individuals are experiencing stress or experiencing emotional pain, they resort to reciting duas and verses that they already know well not only to get relief but also due to the emotional comfort, cultural legitimacy, and strong belief in the wisdom of the ancestors.

The authority of the generational makes these practices even more credible. Respondent (HP 11) indicated that customers tend to lean towards "our elders knew better," which means that the knowledge of the elder is perceived as something that has been tested over time and is considered morally sound. This confidence influences the healing decisions by making them a safer, more genuine, and more meaningful indigenous practice as opposed to that which is introduced or institutionalized by outsiders. This continuity through the generations, in this regard, appears like a confirmation of the efficacy that enhances the faith in these techniques without any formal confirmation.

Native healing knowledge is not acquired primarily through books,

certifications, and formal training but by observation, involvement, and through the process of long-term involvement in families and communities. Respondent (IH4) emphasized the fact that learning occurs via the experience, observation, and learning of the older practitioners and family members who imparted this information. Today, the skills that healers have are a combination of inherited knowledge as well as experience with patients, and, therefore, lived practice is the primary source of authority. Therefore, faith-based healing-related practices are not rituals only, but rather relational-experiential, based on trust, continuity, and collective memory.

4.1.4 Herbal and Hikmat Practices

Herbal and Hikmat practices were culturally appropriate and facilitative treatment of recovery. Herbs like mint, chamomile, kalonji and ajwain, prepared usually by the family member, gave an immediate emotional relief and gave a familiar feel to the patients. These rituals were occasionally accompanied with spiritual rituals like dam or taweez thereby associating physical and spiritual attention. Although they brought some short-term relief, the participants also said that they were not cures and might be hard to wear regularly. Guidance was usually encouraged by family but distrust or bad encounters restricted their use in the long term. In general, herbal and Hikmat use served as adjuvant therapy, which did not cure the underlying recovery issues but provided emotional and cultural resources to the patients.

A healthcare Professional Respondent (HP 6), had the following to say when they talked about Herbal and Hikmat Practices, *"Some patients ask if they can drink mint or chamomile tea. They believe it helps with anxiety. Many bring homemade mixtures their families prepared."*

While talking about the Herbal and Hikmat Practices, Respondent (IH 4) mentioned, *"In our culture, we use kalonji, ajwain, and certain oils. Not as intense treatment, just supportive healing. People feel comfort from it."*

During the Interview, Respondent (RP 11) mentioned, *"We use herbal things at home, like warm oils, mint water (for stomach issues related to drugs), ajwain. These things have always been in our family, so they give us emotional comfort."*

While interviewing, Respondent (RP 1) stated, *"No… I never directly went to a hakeem. But my mother had me take kalonji, ajwain water, and had a local imam perform dam (spiritual healing). It would give some relief for a short while, really. But the real problem are the cravings and anxiety that still remained the same. I had issues with concentration… nothing could be followed consistently for long."*

Respondent (RP 8) described, *"Yes, I did. My cousin told me, 'Try a hakeem's medicine, many people get better.' So I went. They gave me an herbal mixture, but the taste was so bad I couldn't take it daily. Then my father took me to a baba jee who performed dam and gave me some water."*

While discussing Herbal and Hikmat Practices, Respondent (RP 9) mentioned, *"Oh, many times. My uncle considers a hakeem the solution to every problem. He sent me to three different hakeems. I tried herbal remedies, powders, strict dietary rules… everything. Then a friend gave me a peer sahab's taweez. Well, it gave a little relief like slightly better sleep."*

Herbal treatments like mint, chamomile, kalonji, ajwain and warm oils are usually applied as an adjuvant or comfort-based therapy as opposed to a primary treatment. These solutions are based in traditions of a family and a familiarity with the culture, and provide an emotional relief and a perceived relief of anxiety and not a curative effect. They also play a role in giving normalcy and routine in the day to day life hence strengthening the family relationships and sense of culture. Regardless of the psychological and emotional advantages of these interventions, the drawbacks of the latter prove the need to have other evidence-based methods. Besides, a sole utilization of these remedies can sometimes delay the involvement of formal rehabilitation or systematic therapeutic programs.

Herbal remedies and spiritual healing (dam) done by family members helped temporarily but could not overcome underlying problems like cravings, anxiety and lack of concentration. This demonstrates the immediate calming effect of the practices and their inadequacy to maintain recovery. Often the respondents mentioned that these approaches relieved distress in the short-term but the absence of a structured follow-up or monitoring undermined the longer-term effectiveness of such approaches. The ritual aspect of spiritual healing though reassuring was not able to

solve physiological addictions or even mental difficulties. Moreover, relief in short term could create illusion of healing and postpone intense treatment. These results highlight the difference between clinical and emotionally guided interventions.

Suggestions by family members resulted in his interaction with the herbal medicine and in contact with spiritual healers, but the mistrust in them due to the uncomfortable state of the surrounding spaces, inability to comply with herbal medication, and the absence of any significant effect decreased their confidence in these practices. the sampled participants pointed out that the dosing schedule was inconsistent, the instructions were not clear, and the improvement could not be seen, which all led to skepticism. The familiarity to culture was not enough to maintain the adherence in the presence of difficult recovery symptoms. Such experiences highlight the need to erudite the cultural sensitivity approach with professional guidance so as to grow the trust and effectiveness. Finally, these observations indicate the absence of an overlap between traditional care and systematic rehabilitation approaches.

4.1.5 Holistic Approach towards Healing

The holistic approaches towards recovery incorporate the use of the combination of body, mind, emotions, and spirit as opposed to biomedical approaches. Respondents explained healing to be a blend of psychological therapy, spiritual healing which involves zikr, Quranic recitation and prayer, physical activity and social or family interaction. The routines entailed meditation, physical activities, mindfulness and group activities or recreation, forming a continuous and organized setting that promotes general wellness. The engagement and emotional balance were preserved even without formal therapy in spiritual and activity-based sessions. This model focuses on the fact that everything in life is interlinked, and thus recovery is best achieved when all of the needs, emotional, physical, social, and spiritual, are met simultaneously.

While discussing Holistic Approach towards Healing, Respondent (IH 1) mentioned, *"we don't treat only the body. We treat the heart, mind, soul, environment and everything. When a person sits with us, we look at their emotions, their worries, their spiritual condition, all together."*

Respondent (RP 12) stated, *"Healing for me isn't one step. It's prayer, talking to someone, drinking something warm, and being around people who understand me. It all works together."*

Respondent (HP 1) mentioned, *"We run holistic therapy. spiritual, social, economic area of a persons life every is addressed."*

While interviewing, Respondent (HP 4) mentioned, *"We don't only have zikr or only exercise… both are done together so that the patient's overall system is calm. Walk, yoga, breathing, counseling, all of this is a holistic process where both body and emotions learn balance."*

While talking about the Herbal and Hikmat Practices, Respondent (HP 6) explained, *"Our approach is holistic in the sense that the patient is given psychological therapy along with spiritual grounding… meditation, zikr, Quranic recitation all together create a complete healing environment."*

During the Interview, Respondent (HP 8) mentioned, *"Here, the approach was holistic. detox, therapy, Surah Rahman, activities, grounding, family sessions, it wasn't just the biomedical model."*

While interviewing, Respondent (RP 3) described, *"On the days when psychologists are not available, Qari Sahib conducts a proper session… it happens throughout the week. In the evening, there are daily activities such as cricket, volleyball, walking, running, gym and all of it."*

Respondent (RP 2) mentioned, *"Mindfulness and spiritual practices were also provided here."*

The conceptualization of healing is a holism that focuses on the body, mind, emotions, spirituality, social life, and environment as one holistic process. Instead of focusing on a biomedical approach, patients and practitioners focus on how the treatment should be combined with spiritual practices (zikr, Quranic recitation, prayer, and meditation), physical activities, and family or social engagement, and recommend that the balance of all aspects of life is necessary to recover. Respondents observed that this integrative method allows more personalized healing experience where

individual needs and cultural values are considered and observed. A sense of agency is also developed by the holistic model, which allows patients to actively participate in the practices that do not contradict their beliefs and daily practices. In addition, it offers a set of approach to symptoms as well as the underlying emotional or spiritual suffering that are typically not considered in biomedical paradigms. This viewpoint puts the recovery not only as the reduction of symptoms, though a more all-encompassing restoration of harmony and well-being on several levels.

The implementation of holistic care is based on the daily routines, which are structured and continuous, comprising psychological sessions, spiritual guidance, mindfulness activities, and physical activities. The continuity of care is even in the absence of formal therapy as a result of the spiritual and activity-based sessions, which support the notion of healing as a multi-dimensional, continuous process, as opposed to a single intervention. These habits strengthen the consistency and predictability, stabilizing emotional states and creating resilience in the long run. According to the patients, a sense of purpose and meaning that spiritual and physical practices provided in everyday life reinforced recovery motivation. The strategy also helps in social support using group activities or family involvement, thus pointing out to the relational aspect of healing. Together, this shows that recovery is a dynamic process, in which several interventions work in a synergistic manner, and not independent methods.

4.2 Impact of Indigenous Healing Practices

The indigenous healing practices have valuable emotional, spiritual, and social impacts among the patients, the healers, and the therapists. They give patients hope, comfort and a feeling of agency especially when used together with usual therapies. There are short-term advantages such as stress relief, emotional regulation and decreased cravings, and spiritual practices are resilience and motivation in the long term. The long-term effects often include increased self-efficacy, moral foundation, and community social cohesion because patients can be assisted through practices that are familiar to them culturally. However, their efficacy requires patient interaction, consistency, and the integration with modern medicine.

Practitioners have noted that unstandardized or improperly applied indigenous

practices sometimes may confuse patients or slow down formal care. These practices are supportive adjuncts as they make therapy more adherent and holistic well-being is promoted when properly directed. They facilitate the cultural requirement versus clinical treatment, offering patients a chance to overcome the recovery phase in a setting that does not dismiss their beliefs. Altogether, the policies of indigenous healing are crucial concerning not only emotional restoration but also the creation of culturally sensitive rehabilitation programs.

4.2.1 Emotional Relief and Coping

Dua, zikr, Quranic recitation, and meditation were some of the spiritual practices used by patients with immediate emotional relief and feeling of lightness associated with light physical activities and counselling. The practices enabled them to release guilt, trauma, and anxiety, which helped them cope within the short term without the use of substances. The activities of daily living and the common group activities strengthened a sense of belonging, self-discipline, and emotional regulation and therapeutic connection provided a sense of comfort and support. In the case of no formal therapy, the presence of spiritual and mindfulness classes ensured the interest and relaxation, allowing patients to control their emotions. The combination of spiritual activities with physical and social ones allowed establishing a balance and improving psychological and emotional resilience.

While discussing the impact of indigenous healing practices, Respondent (HP 6) explained, *"In my view… belonging is the greatest therapy. When patients feel they are not alone, their pain is halved."*

Respondent (RP 2) mentioned, *"It felt very positive; my self-control and discipline improved. Going outside and practicing these things gives a person calmness and a sense of connection."*

While talking about the impact of healing practices on patients, Respondent (HP 6) mentioned, *"Look… honestly, when patients feel very overwhelmed, we first give them simple spiritual grounding, like light breathing and then dua. This immediately provides emotional relief. They might cry, open up, or just remain silent but feel lighter inside. When I worked in Murree, after group dua, people felt so calm*

that they would say, 'Sir, it feels like my mind has stopped for the first time.' This is very powerful for coping."

While interviewing, Respondent (HP 9) stated, *"When a patient spiritually connects, they temporarily let go of guilt and shame. Emotional relief comes. I tell them, 'Pray, but also share your pain.' They confess, share traumas… things they have never spoken about. This catharsis strengthens coping."*

While discussing the topic of Emotional Relief and Coping as an impact of indigenous healing practices, Respondent (HP 1) stated, *"See, many clients use drugs to escape. They are running from emotional pain, stress, or guilt. When we guide them towards cleanliness, routine, and namaz, they realize they can find peace without escape. This becomes a new coping mechanism for them."*

"Even in some cases, I have even heard from patients from a different religious background say that they feel a calmness after listening to the Quran."

While discussing the impact of indigenous healing practices, Respondent (HP 2) mentioned, *"When a person is cut off from reality, ultimately they exist in a reality where they do not feel comfortable… everything feels fearful, so they cling to a higher power. This automatically becomes their coping mechanism; they become religious."*

Respondent (HP 8) mentioned, *"Look… here we focus more on spiritual practices. I mean… we take patients to meditation, zikr, Quranic recitation. Herbal or hikmat remedies are only occasional… but patients get immediate relief."*

Respondent (RP 1) explained, *"When I recited the Quran or dua, I felt a softness within… like the anxiety would ease a little.*

During the Interview, Respondent (RP 8) mentioned, *"When I prayed or did tasbeeh, I felt immediate lightness. Stress reduced. In the long term, my belief strengthened, and my confidence improved. I remained emotionally a bit more stable. But yes, medical treatment was also necessary alongside."*

Respondent (RP 7) shared their insight while talking about Emotional Relief and Coping, they stated, "The *Quran is such that no matter how many times you read it… it coats the heart. Allah says, 'Do not come before Me in a state of intoxication.'*

So how would they go before Allah? And once you swear by the Quran, there is nothing above it, not even Allah's own essence."

Respondent (HP 4) mentioned, "We *don't just have zikr or only exercise… both are done together so that the patient's overall system is calm. Walking, yoga, breathing, counseling, all together form a holistic process where body and emotions both learn balance."*

Therapeutic connection, belonging, and shared practice are formulated as one of the key tools. The sense of being with enhances control, discipline, and relaxation, which strengthen the emotional strength by means of social and spiritual connectedness and not isolation. Light breathing, dua, and collective prayer are simple spiritual starting-point methods that allow catharsis and emotional release during extreme emotional stress. Patients can cry, express, and communicate the guilt and trauma that were never mentioned before, which means that the spiritual connection allows them to express their feelings and relieve some of the sense of shame, albeit temporarily, which will increase the ability to cope.

The use of substances is perceived to be a way of escaping emotional pain, fear, and guilt. As a substitute coping mechanism, the gravitation of itself towards religious practices (namaz, cleanliness, structure, and being dependent on a higher power) is a way of gaining peace but not avoiding stress, especially when people do not feel a connection to the reality. Zikr, Quranic recitation, dua, meditation, and the use of herbs at times are also mentioned as giving instant emotional responses by alleviating anxiety, cravings, and inner agitation. The practitioners as well as patients point to a sense of lightness or softness that assists short-term emotional control and coping despite biomedical intervention alongside the practices. Quranic activity is seen to be possessing control over behavior both morally and spiritually, acting as a shaper of behavior utilizing reverence, accountability, and internalized moral limits. This is an indication of a belief system where spiritual dedication frowns upon intoxication and strengthens restraint.

Coping is an integrated strategy that entails the combination of spiritual activities and physical exercise, inhaling, counseling, and mindfulness. This perfect harmony allows not only relaxation of the body but also emotional control to maintain

balance instead of depending on one specific approach.

4.2.2 Spiritual Empowerment and Motivation

Religious and spiritual interconnection was a key factor in giving strength to the patients and raising their self-esteem, hope, and inner strength. Daily dua, Quran recitation, moral guidance, and cleanliness were some of the practices that strengthened a sense of purpose and self-efficacy and belief in a higher power gave them a sense of assurance in moments of hopelessness.

Orders and religious education assisted the patients to take charge again, restore dignity and form anti-drug behaviour patterns. Spiritual empowerment encouraged perseverance in recovery, revived self-esteem, and elevated fortitude so that the patients felt directed, supported and able to persevere in overcoming challenges. It was found that with time this long-term grounding minimized the risk of relapse and stimulated stability and this is where faith-based practices play a vital role in maintaining recovery.

When sharing their recovery experiences, some of the participants were seen to be very confident and optimistic when talking about faith and spiritual practices. I realized that participants often spoke about spiritual practices with a sense of determination and pride. These observations indicate that this level of spiritual engagement brings not just emotional relief but reinforces motivation and personal responsibility in the rehabilitation process.

A healthcare Professional Respondent (HP 11), had the following to say when they talked about Spiritual Empowerment and Motivation as an impact of indigenous healing practices *"When a patient connects to their roots, their confidence increases. They feel more in control of their life.*

Respondent (RP 5) mentioned, *"There is no better treatment than belonging. Whenever you associate with your identity, you think that you are capable of taking care of yourself. You are conscious of I can cope, I can handle and this sense of belonging and familiarity brings power and assurance in everyday living."*

During the Interview, Respondent (HP 8) described, *" the spiritual side is*

highly empowering to the patient. They believe that Allah is at their side as long as the way. This faith enhances their drive and provides the inner power, the feeling that they are not alone, that some higher power governs them and makes the difficulties easier and more rewarding."

While talking about the impact of healing practices on patients, Respondent (IH 1) mentioned, *"When a person truly believes that Allah has goodness planned for them, a drive awakens inside. Many patients say, 'Allah brought me this far, so He will also take me out of this.' This reliance on Allah gives them the passion to get up every day, no matter how many times they break down."*

Respondent (IH 2) mentioned, *"The warmth of faith makes a person feel alive from within; it gives them the sense that they can start a new life again."*

While interviewing, Respondent (RP 11) described, *"When I listen to the Quran, my heart feels a kind of strength. It feels like Allah is with me and that I can get through this difficult time. Otherwise, sometimes I completely lose hope."*

Respondent (RP 2) mentioned, *"My self-awareness has improved, and by following a routine and offering prayers an positive pattern has developed."*

Respondent (HP 1) explained, *"Our first effort is that once a client comes out of detox, we guide them towards cleanliness. The concept of 'cleanliness is half of faith' is usually completely lost in them. When they start making their bed, brushing their teeth, and maintaining their surroundings, for the first time they feel they can take control of their life again. This gives spiritual empowerment."*

Respondent (HP 1) on another occasion also stated that *"When our Qari Sahib or Maulana Sahib comes, they give proper religious instruction. The client feels that someone understands and guides them regarding their moral issues. This spiritual support gives them very strong motivation to rebuild their life."*

Respondent (HP 10) mentioned, *"When a patient is connected with dua, they become hope-driven. Addiction creates hopelessness, but spirituality gives them direction. When they say, 'If Allah has saved me, I will not destroy myself again' that motivation is something we can literally see."*

Respondent (RP 7) shared their insight while talking about Spiritual Empowerment and Motivation, they stated, Respondent (RP 12) mentioned, *"Since I started regular dua and Quranic recitation, I feel my life has gained a purpose. Earlier, I was completely broken; my self-worth was zero. But now I have been fully stable for one year. Faith in Allah has made me strong from within, which greatly reduces even the thought of relapse."*

Spiritual and faith-based empowerment are characterized as highly empowering and it increases confidence and hope as well as inner strength. The convenience that Allah is with them and that they have a purpose in the suffering gives a person back the drive, lessens the feeling of hopelessness, and develops some mechanism within to continue the recovery. This faith-based reassurance provides emotional anchoring during moments of despair. Heightened self-consciousness and conformity to disciplined practices lead to the establishment of anti-drug behavior patterns, which implies that the spiritual knowledge grounded in discipline aids self-control and stability in the long term.

The daily religiously based practices such as cleanliness, order, and moral education are useful as a means of reestablishing control and dignity following a detox. Minor self-care activities are metaphoric re-unions with faith, and these reinforce the empowerment of the patients and their readiness to restore life through formal discipline. Spiritual practices like daily dua, Quranic recitation, gratitude journaling, and faith-based challenges restore self-worth and also give one a new sense of purpose. Patients do not only change their perceptions of worthlessness to the perception that they are valued and responsible, but this will act as a great driving force that will eliminate relapse.

The continued practice of spiritual practices builds internal resilience in the long term, which makes the risk of relapse considerably lower. Faith is not only provided as an emotional support but also as a long-term source of stability and meaning that grounds long-term recovery.

4.2.3 Short-Term Impact

Practices like the dua, dam, wazifa, and Quran in recitation offered instant emotional comfort to the withdrawn, anxious, or anxious patients. The respondents

reported being relaxed, relieved, and temporarily relieved, and that their emotional release was achieved by crying, confession, or introspection. The talks with Islamic scholars, or spiritual classes, were reassuring and gave hope, which allowed the patients to overcome critical situations, including the night when they were alone and experienced withdrawal.similarly the herbal remedies also reduced anxiety, cravings, and inner agitation in the short run; however, practitioners pointed out that they are facilitating but not curative. The short-term gains predominantly involved the relaxation, emotional stabilization, and temporary coping, which underscored the importance of the indigenous practices as supplementary resources in the conditions of acute distress.

A Indigenous Healer Respondent (IH 1) , had the following to say when they talked about Short-Term Impact of indigenous healing practices on patients sobriety,*"When a person is quitting drugs… at that time their mind is unsettled, they feel restless and anxious. But when we have them perform indigenous practices like Surah Fatiha dam or a wazifa their senses stabilize immediately. They say, 'Maulana Sahib, I feel a little hope now.' This small hope lets them get through the night. This is the biggest short-term benefit."*

Respondent (HP 6) mentioned, *"I feel that our local spiritual or indigenous methods like dam, dua, or talking to a pir sahib provide immediate emotional relief. The patient feels the burden lighten, I often saw that for a day or two they feel calm, their anxiety eases, and their condition temporarily stabilizes."*

While interviewing, Respondent (HP 3) described, *"When we have people do Surah Rahman or wazifa-based calming, in the short term emotional meltdown occurs, which actually converts into relief. People cry, confess, or remain silent but they immediately feel peace."*

During the Interview, Respondent (RP 2) mentioned, *"It feels good to sit with the Islamic scholar who comes in the morning. Sometimes I skip due to my mood, but overall it is positive."*

While sharing their insights, Respondent (RP 7) mentioned, *"When they recited Quranic verses and blew over it, it felt like Allah's support was coming and maybe my suffering would lessen. At that moment, an emotional calm was felt."*

Respondent (RP 5) stated, *"When we listen to Qari Sahib's session… the religious guidance gives peace to the heart. I feel completely at peace at that time. This is the best part of my day. My mental state feels very light."*

Respondent (RP 12) shared their insight while talking about, Short-Term Impact they mentioned, "*When I listened to Surah Rahman, anxiety eased. The mind's restlessness stopped for a short while."*

While discussing the Short-Term impact of indigenous healing practices, Respondent (HP 5) mentioned, *"For long-term stability, indigenous healing alone is not enough. It gives meaning, faith, and continuity, but does not manage clinical symptoms by itself. Some clients who perform rituals regularly have reduced chronic anxiety, but if core trauma, addiction, or mood disorder exists, indigenous methods can only provide short term results. That's why I always say these are complementary supports, not primary treatment."*

The incidence of dam, wazifa, hikmat and Quran recitation (particularly Surah Rahman) and meetings with Islamic scholars lead to instant emotional regulating even when one is in withdrawal and undergoing high distress. The participants always report about the short-term relaxation, reassurance, less anxiety, and temporary relief of cravings. Emotional discharge is natural, and it happens through crying, confession, or silence and is perceived to be therapeutic as the patient manages to survive such critical moments like withdrawal-filled nights.

Practitioners underscore the idea that indigenous healing provides meaning, faith and emotional continuum but cannot be used independently as a long-term recovery intervention. Although ritual practice can alleviate background anxiety, it is not sufficient to treat underlying trauma, pathology of addiction, or mood disorders, which confirms the concept of ritual practice as a complementary but not an initial treatment approach.

4.2.4 Long-Term Impact

Indigenous healing effects in the long term were manifested in regular spiritual practice, such as dua, azkaar, Quranic recitation, and astaghfar in combination with lifestyle change, ethics, and psychological counseling. Such

practices over time resulted in spiritual discipline, emotional balance, moral consciousness, and enhanced self-worth, which slowly diminished the risks of cravings and relapse.

The patients also claimed that they managed their temperament, benefited themselves with better coping, and became more motivated with faith and routine. Nevertheless, this only happened on a long-term basis if it was combined with formal treatment; otherwise, it would restrict the benefits, and chronic addiction or mental distress would continue. In general, indigenous practices assisted in slowing the behavioral change, spiritual orientation, and small changes in self-calming and confidence, but did the most useful work alongside organized rehabilitation.

A Indigenous Healer Respondent (IH 1) , had the following to say when they talked about long-Term Impact of indigenous healing practices on patients sobriety, *"Well, the deepest impact is over the long term. When a person continues indigenous practices for months, such as morning and evening dua routines, a little Quranic recitation, and astaghfar, it creates spiritual discipline. And when discipline comes into life, it becomes difficult for addiction to take hold again. This effect solidifies over time… not immediately."*

During the Interview, Respondent (IH 2) mentioned, *"When a person makes deen a part of their routine, after a few weeks they themselves say, 'My temperament is no longer restless like before; I manage anger and tension better.'*

While discussing the Long-Term impact of indigenous healing practices, Respondent (HP 4) mentioned, *"The difference comes when the practice is consistent. For example, if a treatment program lasts 120 days, and they follow it constantly, including Surah Rahman therapy, it becomes effective. The aim is to form a habit loop. Addiction strengthens drug-related neural pathways."*

"The discipline taught by religion… initially the biggest challenge is to get them back on track… gradually their routine and identity stabilize."

While sharing their insights, Respondent (HP 2) mentioned, *"If there is consistent Surah Rahman practice for 120 days, it becomes effective… relapse decreases because their coping mechanism becomes religious, they keep clinging to a*

higher power."

Respondent (RP 11) mentioned, *"I am still not completely free from addiction… but over the long term, indigenous practices gave a bit of control. Earlier, cravings were daily; now they occur every 2–3 days."*

While discussing the impact of indigenous healing practices, Respondent (IH 4) mentioned, *"Long-term effects occur when the patient understands their temperament and what worsens or improves it. The true benefit of the hakeemi system is seen over time: liver cleanses, temperament balances, and spiritual stability comes from duas. Relapse decreases when addicted patients make hikmat a routine. Otherwise, without biomedical treatment, many cases revert.*

Respondent (HP 10) mentioned, *"The long-term impact of indigenous healing is mainly seen in self-worth and self-forgiveness. When a person spiritually realigns, their relationship with addiction weakens. They start understanding their triggers better. Long-term, these practices develop moral discipline and internal control. And yes—the relapse rate clearly decreases among such patients.*

Respondent (HP 3) mentioned, *"Long-term results are very promising if the patient incorporates spirituality into their identity. They become emotionally more stable, improve relationships, and break the shame cycle. Relapse prevention becomes real through long-term spirituality. Patients say, 'I want to keep my soul clean.' This mindset itself reduces the probability of relapse."*

While interviewing, Respondent (HP 7) mentioned, *"The biggest long-term issue I see is that people reach actual treatment very late. In many cases, their anxiety, depression, or trauma becomes so chronic that stabilization is difficult. I have seen clients who spent 6–7 years going from peers to various treatments, and by the time they came to me, their condition had severely deteriorated."*

While discussing the Long-Term impact of indigenous healing practices, Respondent (RP 10) mentioned, *"I experienced moderate long-term impact. Some things, like spiritual motivation, kept me positive for a long time. But real change, like routine, withdrawal management, and relapse prevention, I gained from rehab and therapy. Indigenous methods were only a support system, not primary treatment."*

During the Interview, Respondent (RP 13) mentioned, *"Long-term, I didn't notice any major impact of indigenous healing… only that I realized I can calm myself if I choose to. My self-worth improved slightly."*

"Honestly, there was no long-term difference. I want scientifically proven therapy. Indigenous methods didn't give me any long-term benefit."

Spiritual discipline and routine programs are developed through long-term participation in indigenous spiritual activities, e.g. daily dua, azkaar, Quranic recitation (e.g. Surah Rahman), and astaghfar. With time, this practice helps develop habits too, which makes one less restless, more emotionally self-contained, and less addictive, which is why the changes may not happen at once but may be gradually built up.

In the long term, indigenous habits bring about partial control of behavior wherein the frequency of cravings is decreased as opposed to the session of cravings. This implies a small long-term coping effect, which is pro-gradual control, not full recovery.

There are long-term gains of indigenous healing in the case of the incorporation of spiritual practices with lifestyle modification, psychological support, and behavioral change. Those practitioners focus on self-worth, self-forgiveness, moral discipline, awareness of triggers, emotional stability, and functioning of the relationships, which all lead to a decreased risk of relapse. In the absence of such integration, long-term effectiveness is restricted.

The lack of access to the structured treatment is a detrimental factor to the long-term recovery because only by being dependent on the indigenous or informal approaches, the psychological distress and the severity of addiction be made chronic. Intensive care makes it late, making it difficult to stabilize.

Long-term impact is both positive and negative. There are reports of small psychological benefits including long-term motivation, self-calming and minor changes in self-worth, whereas there are reports of no significant lasting effect and preference of scientifically proven therapies. Indigenous practices have often been put in a supportive context as opposed to a transformative one.

4.3 Analysis

The results of the study show that the indigenous healing practices are not perceived as an undertaking that is isolated by the participants but as a system of meaning, an established routine, and a form of care that is embedded in the cultures of the people. In healthcare workers, rehabilitation patients, and indigenous healers, the process of healing is always viewed as moral, spiritual, emotional, and social in nature, strongly influenced by faith, family tradition, and environment, as well as common life. These results are quite close to the anthropological approaches to healing as a culturally contextualized practice instead of a biomedical treatment.

The descriptions of Quranic recitation, dua, zikr, communal prayer, inherited practices, and supportive herbal practices by participants show how the indigenous healing is being identified due to the shared cultural meaning and not through official classification. Based on Geertz interpretive anthropology, these practices are symbols that make suffering intelligible and controllable. The Quranic verses like the Surah Rahman or the Ayat-ul-Kursi are not just religious texts but they are culturally significant symbols which are reassuring, divine, protective and embodied moral order. In several instances, patients report emotional composure, internal lightness, and encouragement when practicing such practices, meaning that the process of healing initiates at the meaning-making as opposed to the level of eradicating the symptoms.

Historically speaking, ecologically, these practices can also be viewed as the evolution of an adapted response to a particular religious and cultural context. Sacrifices, prayer times, and religious discipline have developed through the generations as the means of controlling the distress, behavior, and belonging in the social setting where formal mental health care has traditionally been constrained. Consistency (e.g., listening to Surah Rahman every day or progressively developing prayer practices) demonstrates that indigenous habits form habit loops, which may be modeled on behavioral conditioning theories, and which may be based on spiritual cosmology, instead of utilizing clinical language.

It is in group prayers, shared zikr, and therapist-guided spiritual groups that one can see that healing is very much a relational one. Whenever participants are

asked about the feelings and emotions of being in a group, such as merely sitting in a group, even without speaking, they mention that it is calming and emotionally safe. This is in line with the anthropological definition of the healing process as a social practice where recovery is solidified by belonging to the community, shared identity, and witnessing of suffering by one another.

Traditionally, group worship and shared rites have served as social controls and minimized the sense of isolation and brought back moral and emotional equilibrium. Whereas, in rehabilitation contexts, these indigenous practices of grouping individuals recreate the feeling of a home-like safety, which is needed due to the alienation that prevails during detox and withdrawal. The heightened accountability and motivation of patients in group-based situations exemplify the way in which the presence of communities tends to convert the responsibility in individuals into the moral engagement of the communities, and the recovery process is supported by the expectation of the group rather than the coercion.

The high dependency on the practices of elders, including practices of inherited duas, family practices, and ancestral medicine, proves the fact that the indigenous healing is authority-based on continuity and trust rather than institutional validation. The knowledge has been passed on by way of observation, lived experience, and faith-based inherited knowledge, which supports its validity in families and communities. According to the interpretive anthropological approach, this generational transmission offers emotional familiarity and symbolic security, especially in times of distress.

In the past, these systems of knowledge have existed regardless of the colonial and postcolonial relegation of indigenous medicine. Their continued use is not only a sign of resistance but also of cultural resiliency, in which individuals revert to what they feel is morally correct, emotionally secure, and socially acceptable. The belief patients have in practices taught by the elderly underscores the fact that the healing decisions are defined not by the efficacy per se but rather by cultural coherence.

The experiences that the participants had in the field of herbal remedies and hikmat practices suggest sensitivity in the way they understood their role. As much as these approaches are comforting, familiar, and offer temporary relief to patients,

patients and practitioners accept their weaknesses in the treatment of the underlying psychological and neurological aspects of addiction. Historical ecological perspective treats such remedies as low-intensity interventions that were available in the household settings rather than overall treatments of multifaceted substance use disorders.

The disillusionment that some of the patients have, especially about the recurrent visits to hakeems or other spiritual healers who have not visibly changed their lives, demonstrates the negotiating approach to belief and lived outcome, which is pragmatic. This is the working aspect of medical pluralism wherein people switch systems, keeping what gives them a sense of alleviation and abandoning that which does not bring any actual change.

The most convergence can be seen in the participants' agreement in the holistic approach. Healing has been stated as effective when there is cooperation between spiritual grounding, psychological treatment, physical activity, and environmental arrangement, as well as family participation. This resembles the indigenous epistemologies that consider the person as a whole, body, mind, soul, and social world rather than a set of symptoms.

The historical development of holistic patterns of healing was the result of lived realities in which the distinction between spiritual, emotional, and physical life was unnecessary and senseless. This combination in the rehabilitation context enables Aboriginal customs to supplement biomedical therapies in providing emotional stability, identity repair, and moral discipline in addition to clinical services.

Findings also explains how the effect of indigenous healing exists on various time scales. Short-term methods like dua, dam, Quranic recitation, and spiritual grounding offer immediate alleviation when the person is withdrawing, anxious, and emotionally overwhelmed. Crying, confession, silence, and emotional release are also mentioned as therapeutic over and over again, which means that these activities can help to achieve catharsis and temporary stabilization.

The influence of long-term involvement into indigenous practices leads to the spiritual discipline, identity reconstruction, and better emotional control in the long term. Patients that incorporate faith in their daily life experience less craving,

increased self-esteem, moral responsibility, and increased relapse prevention motivation. Nonetheless, respondents are also categorical that indigenous healing should not be used alone. Spiritual practices are most effective as part of a structured rehabilitation, psychological therapy, and lifestyle change to achieve long-term recovery. This is a moderate position that supports the complementary component of indigenous healing, which adds meaning, motivation, and continuity to clinical stabilization by depending on biomedical and psychological interventions.

When combined, the results indicate that indigenous healing methods are not used as alternative medicine but as cultural coping, discipline, and belonging technologies. By using the prisms of historical ecology and interpretive anthropology, indigenous healing becomes a regulator that restores sanity to suffering by helping people to recover their faith, daily life, community, and their sense of purpose. It does not treat an addict, but it establishes emotional, spiritual, and social environments that allow recovery and its maintenance.

4.3.1 Discussion of Findings

The foremost aim of this research is to identify the indigenous healing practices included in the rehabilitation process. Rather than functioning as separate or alternative systems, these practices operate as interdependent cultural frameworks through which addiction, suffering, and recovery are understood. These practices can be interpreted through Geertz's interpretive anthropology as symbolic systems of meaning, while the historical ecological approach situates them within long-term relationships between people, spirituality, environment, and intergenerational knowledge transmission.

The important component of indigenous healing in rehabilitation is Quranic recitation and dua. In interpretive anthropological terms, the practices serve as symbolic cleansing, redirection of morality, and reconnection with God. According to Geertz (1973) and Mansoor and others (2024), religious rituals are interwoven in cultural webs of meaning that help people to make sense of suffering and act. Addiction in this context is viewed as a clinical disorder but also as a spiritual failure; rehabilitation is viewed as the recovery of moral discipline and religious conformity.

The given interpretation is reinforced by the literature that suggests that spirituality is an important factor in the regulation of emotions and coping in the course of recovery (Rudolfsson et al., 2014; Pardini et al., 2000). Islamic psychospiritual approaches stress self-accountability, repentance, and moral responsibility, and all these aspects are closely related to rehabilitation objectives (Zainal Abidin et al., 2022). We thus find the Quranic recitation and dua giving culturally identifiable processes through which people become emotionally stable and spiritually motivated.

According to the historical ecological understanding, such practices show that the religious knowledge has been upheld in the generations, even in the face of colonial and modern disruptive forces (Anderson, 2006; Waldram, 2014). The fact that they are included in rehabilitation shows how indigenous religious practices can be incorporated in the contemporary health environment without losing cultural or historical value.

Indigenous healing is essentially a group practice, which is manifested in group prayers and group spiritual practices. Geertz defines meaning in his framework as being socially constructed, and thus, healing is a cultural process and not an individual process. The group prayers encourage ethical unity, community accountability, and healing, making rehabilitation a social process.

The role of communal spiritual practices to enhance emotional resilience and social connectedness is supported by literature (Good, 1994; Csordas, 1994). Shared rituals are also applied in substance-use rehabilitation to deal with isolation and stigma through establishing a sense of belonging and offering moral support (Kirmayer, 2004). This insight fits into the native and religious healing practices, where healing cannot occur outside of social bonds.

Historical ecology also puts these communal practices into historical contexts of collective healing entrenched in the community life (Balee & Erickson, 2006). The fact that group prayers continue to be practiced in contemporary rehabilitation contexts can be interpreted as a sign of the struggle of communal curing traditions to remain intact through time.

One of the characteristics of indigenous practices is the intergenerational passing of healing knowledge. Through faith-based counseling and guidance, moral, spiritual, and therapeutic wisdom is transmitted to the elders, Islamic scholars, and hakeems. In his view, this kind of knowledge offers interpretative models, which define perceptions of disease, guilt, and recovery.

The current literature focuses on the fact that indigenous healing knowledge is organized and epistemologically sound instead of anecdotal or informal (Absolon, 2010). Religious paradigms treat addiction as a spiritual and moral problem and provide their accounts of disciplining, redeeming, and changing, which are deeply imbued in the cultural structures (Kakar, 1991).

In the historical ecological approach, knowledge is conceptualized as historically based and as the product of the long-term interaction among communities, belief systems, and local circumstances (Crumley, 1994). The fact that these practices still persisted through the colonial hurdles proves that the cultures are resilient in the rehabilitative settings (Comaroff and Comaroff, 1992).

Herbal medicine and hikmat practices are the ecological aspect of indigenous healing. These are practices that are based on the local environments and evolved through the decades of relationship with land, vegetation, and ecosystems. According to the historical ecological approach, herbal healing reflects the combination of ecological observation, spiritual faith, and cultural practice (Balée & Erickson, 2006).

These practices are symbolic in that they lay stress on unity between the natural environment and the body. Rituals of healing are designed to restore balance and not to only remove symptoms, as Hahn (1995) points out, which positions recovery as a process of restoring balance.

These practices are still applicable in the pluralistic healthcare systems where people mix traditional and biomedical care (Janzen, 1978; Langford, 2002). Hikmat practices in rehabilitation environments offer culturally credible care and increase involvement, especially when biomedical intervention is viewed as impersonal.

One of the common aspects of all the indigenous healing practices is a holistic approach. Instead of disintegrating physical, psychological, and spiritual spheres,

native healing covers recovery as a multi-faceted process in which the body, mind, spirits, people, and the environment are all considered. This realization can be compared with the conceptualization of indigenous healing as holistic and relational, developed by Koithan and Farrell (2010).

The interpretive approach by Geertz emphasizes the integration of culture as a whole in terms of suffering, morality, and healing within the cultural narrative. In the same way, historical ecology also stresses that addiction is a result of cultural and ecological imbalance and not merely a pathological state (Kirmayer et al., 2003). The research findings invariably indicate that culturally based and holistic rehabilitation strategies boost engagement, emotional stability, and recovery (Hatala et al., 2020; Corso et al., 2022).

In general, the discovery of indigenous healing practices shows that there is a complicated, historically sketched, and symbolically dense care system. The experiences of addiction and recovery are shaped by Quranic recitation, communal practices, intergenerational learning, herbal medicine, and holistic practices. Techniques like them, understood through interpretive anthropology and historical ecology, are not alternative; they are foundations of cultural importance that underlie emotional, spiritual, and social healing.

The second aim was to explores the influence of the native healing methods on the rehabilitation process. These practices do not only lead to the generation of symptom reduction but also affect recovery at the emotional, spiritual, cultural, and temporal levels. Under interpretive anthropology, recovery entails transformation of meaning, identity, and moral orientation. Regarding the historical ecological approach, these effects are placed in the context of culturally constructed systems with a focus on balance, continuity, and overall well-being.

It is indicated in the literature that the holistic approach to intervention and cultural aspects promotes better engagement, emotional stability, and long-term recovery results (Hatala et al., 2020; Corso et al., 2022). In this paper, indigenous healing serves as an intermediary between the traditional wisdom of the indigenous and modern rehabilitative service, which focuses on short-term healing and long-term well-being.

Emotional relief is one of the most direct effects of indigenous healing practices. Cultural practices including the Quranic recitation, prayer, and ritual attendance give culturally significant avenues to the management of anxiety, guilt, fear and emotional distress caused by addiction and withdrawal. On Geertzian view, such practices can be described as symbolic resources that enable individuals to culturally reinterpret suffering in culturally intelligible and emotionally acceptable forms (Geertz, 1973).

The literature justifies the importance of spirituality in the regulation of emotions and coping. Galanter and others (2024) define spirituality as a sense-making process that stabilizes emotions when one is in distress, and Gone (2013) explains the importance of cultural narratives that allow one to find suffering within common moralized contexts. In the research, indigenous healing provided emotional containment that made participants be engaged in the stages of rehabilitation when they were vulnerable.

Traditionally, these coping mechanisms have been enshrined in the life of the community and religion. The historical ecological approach considers such emotive reactions to be culturally learned adaptations that are acquired through long-term social and spiritual experience and not the clinical design of the short term (Balée & Erickson, 2006).

In addition to the emotional relief, indigenous healing practices create spiritual empowerment by redefining recovery as a morally and spiritually directed one. Addiction is not only the loss of control; but it is also seen as the lack of harmony, which can be cured by discipline, regret, and rehabilitation (Ajluni, 2025; Mclellan et al., 2000). With this re-created understanding, this reframing allows people to see recovery as moral change and not punishment through the prism of Geertz's interpretive approach.

This perception is consistent with the available literature on religious and spiritual healing. According to Wendy Wade (2013), religiosity stimulates coping and minimizes the risk of relapse, whereas Islamic psychospiritual programs focus on accountability, self-control, and moral reformation (Zainal Abidin et al., 2022). With

the help of such structures, internal motivation and commitment are enhanced because recovery goals are in line with the religious values.

On a Historical Ecological perspective, spiritual empowerment is the extension of ethical structures that have long dominated behavior, self-discipline, and social responsibility, although the process of rehabilitation has moved into the context of modern institutions (Crumley, 1994; Pardini et al., 2000).

Group prayers, spiritual meetings, and ritual cleansing practices constituted the cultural practices that had a strong influence on the experience of participants in the recovery. Such practices do not only serve as supportive platforms but also as performance processes that change identity and status (Rowan et al., 2014). Based on Geertz (1973) and Turner (1969), rituals develop liminal spaces in which people are initiated off addiction and on to the recovery path through common participation and shared symbolism.

It is mentioned in the literature that rituals help to bring order to the suffering and that they reorganize people into moral and social life (Good, 1994; Hahn, 1995). Such rituals also minimized isolation and stigma and strengthened common beliefs on patience, repentance, and renewal in this research. In the past, community life has been manifested through healing rituals, which have been part of reestablishing balance when it is lost.

Indigenous healing methods improved the rate of acceptance and participation in the treatment process because the practice contextualized recovery within recognizable cultural and spiritual stories. These frameworks that were culturally congruent helped control, accept, and interact, especially in the initial stages of rehabilitation. The observation is consistent with the explanatory model proposed by Kleinman (1980), which indicates that compliance and participation are enhanced when the interpretations of illnesses are culturally consistent.

According to a Geertzian approach, these practices provide short-term symbolic instructions and moral insight to assist people in their struggles to make sense of early recovery. In the past, such adaptive responses to crisis have been retained in the collective memory and cultural practice (Crumley, 1994).

As time passed, the effect of indigenous healing was not limited to sobriety but also to identity rebuilding, cultural healing, and resilience. Those who participated did not simply quit using substances and instead re-identified themselves in spiritual, family, and moral contexts. Anthropologically, recovery was the assumption of new identity narratives, which were based on cultural meaning (marques et al., 2021)

Literature supports these long-term outcomes, indicating that culturally grounded practices enhance resilience and reduce relapse risk (Hatala et al., 2020; Corso et al., 2022). From a historical ecological perspective, cultural identity and moral belonging persist beyond institutional rehabilitation, supported by intergenerational continuity and collective memory. Overall, indigenous healing practices exert a positive and multidimensional impact on rehabilitation by promoting emotional regulation, spiritual empowerment, identity transformation, and culturally meaningful recovery pathways. Through symbolic practices and spiritual histories, these approaches reshape attitudes toward addiction and strengthen motivation. Viewed through interpretive anthropology and historical ecology, recovery transcends clinical outcomes and emerges as a holistic, culturally embedded process.

CHAPTER 5
CHALLENGES OF INCORPORATING INDIGENOUS HEALING METHODS

Chapter five of the thesis contains a detailed analysis of the data collected during interviews to identify and interpret the challenges of indigenous healing practices on the rehabilitation process. The data were gathered from 28 respondents at three rehabilitation centers in Islamabad. The participants include 13 patients undergoing rehabilitation, 11 healthcare professionals, and 4 indigenous healers. The following discussion and verbatim used in the data analysis chapter are taken from interviews, which were transcribed and analyzed. The identities of all the respondents will be held in reserve for the purpose of this study, as most of them did not give permission for their names to be used; therefore, I shall be using only the initial letters of the category they belong to with an assigned number. The data has been analyzed in the form of themes using the method of thematic analysis, which has been divided into 3 themes and 12 subthemes in total. These themes will discuss the challenges of incorporating indigenous healing practices.

In this chapter, I shall be looking into the insights provided by the participants regarding the challenges of incorporating of Indigenous healing practices in drug rehabilitation under the following themes and subthemes:

1. Personal-Level Challenges
    - Skepticism
    - Confusion Between Religion vs. Totkay/Hikmat
    - Extreme Religious Reliance and Overdependence
    - Engagement and Consistency Issues
    - Fear, Anxiety, and Personal Discomfort
    - Economic Limitations Leading to Reliance on Hikmat
2. Institutional-Level Challenges
    - Institutional Restrictions and Policies
    - Clash Between Medical and Spiritual Approaches
    - Lack of Standardization in Indigenous Practices
3. Cultural-Level Challenges
    - Cultural and Belief System Differences
    - Stigma, Family Constraints, and Social Pressure
    - Over-Reliance on Cultural Remedies Delaying Medical Care

5.1 Personal-Level Challenges

Personal-level issues reflect on the inner barriers that patients face in the process of rehabilitation, namely, emotional instability, being full of fear and guilt, and lack of motivation. There is a significant percentage of patients who are distrustful of indigenous or spiritual care, viewing them as a placebo effect or not having a scientific foundation, further decreasing the participation and weakening trust. Others have overdependence on religious practices that expect faith to be used in place of traditional medical care, and this may hinder the healing process.

In addition, the occasional use of various practices, like meditation, group dua, or the use of herbs, often reduces the effectiveness of recovery programs. Given the psychological stress that is added by fear and anxiety, the physical problems that accompany some remedies, and the financial limitations that force one to resort to cheaper treatments that are available at home, compliance is complicated further.

There is further complexity of internalized stigma, social guilt, and inconsistency of personal beliefs. All of these contribute to the willingness and the confidence of a patient to participate in the process of holistic recovery. To overcome these obstacles, individualized care, psychoeducational interventions, and evidence-based practices and belief validations are required. Finally, personal-level barriers explain the degree of psychological, cultural, and socio-economic variable effects on recovery.

5.1.1 Skepticism

A minority of the patients reported strong distrust of indigenous and spiritual interventions, which they often treated as a placebo-like or symbolic treatment instead of an effective one. Healthcare professionals also noted that the skepticism is common, especially in cases where people have repeat relapses or have had bad experiences, which causes ambivalent participation. Although the doubt may be relieved by emotional release or incremental physical gains, the effectiveness of spiritual and cultural interventions may be hampered by initial resistance.

This case highlights the importance of aligning recovery plans with the epistemological concept of patients to maintain trust and encourage participation.

Case Study – RP 13

RP 13 is a 26-year-old female patient in Rawalpindi who intermittently used psychiatric services related to substance use and comorbid anxiety-related issues. She is a Christian and is currently doing an MS in psychology. Her involvement in substance use started in early adulthood when the use of stimulants in the social environment dominated by peers began.

"To be honest, I never fully trusted indigenous methods from the start. When people said, 'You have to fast or have this water blown over,' I internally felt it was all meaningless stuff. I would go along so as not to offend anyone, but I always doubted that there was no scientific proof for these things. I kept thinking, If addiction is such a strong thing, how could any phoonk (blow) really fix it?"

(RP 13)

The case has been monitored through a series of unstructured questions in the form of in-depth interviews. The experience of RP 13 reveals the strong distrust of indigenous and non-biomedical methods of healing, which predetermined the way of her recovery. Although her family and social circle occasionally tried to prescribe common solutions, such as herbal treatments as well as belief-based healing methods, RP 13 always expressed doubts about their effectiveness. She considered such methods to be unscientific and saw them as having the potential to create barriers to recovery instead of being complementary.

RP 13 also showed a lot of confidence in the idea of a psychiatric intervention, and thus medication compliance and directed therapy are the only sure directions to improvement. This skepticism did not lie in cultural rejection as such, but it was her emphasis on evidence-based medicine. She expressed dissatisfaction upon being instructed to use traditional or faith-based interventions, citing the fact that the proposal made her feel more frustrated and further agitated instead of comforted.

The main problem with this is that, nevertheless, RP 13 showed good results due to the active interaction of psychotherapy, mindfulness, and the use of pharmacological therapy. She said that she had started to feel more emotionally steady and more self-controllable and had gained confidence again.

The present case highlights the practical and ethical significance of patient mistrust in culturally pluralistic healthcare facilities. It shows how recovery can be reinforced when clinical practices are consistent with the epistemological beliefs of the patient, which support autonomy and therapeutic trust and warn against universal incorporation of indigenous practices.

While discussing the issue of skepticism, Respondent (RP 5) mentioned, *"I was a bit concerned from the beginning. I didn't understand how a hakeem or home remedy could fix such a big thing as addiction. I considered the doctor's advice more credible. But when my family pressured me, I tried it, though doubt remained in my heart. I felt it was just passing time; the real treatment would still be medical. I kept thinking, 'Will this really work or not?'"*

During the Interview, Respondent (RP 7) mentioned, *"I've seen the same at hakeems' places, that it's more about drinking certain things. We've seen many people like that (who go to hakeem's and get addicted to other stuff). Because what Qari Sahib teaches are mostly things we have already heard. I haven't personally attended a full Qari Sahib session, but when the session happens, we recite the Quran, and my cousin brother explains the translation properly."*

A healthcare Professional Respondent (HP 1), had the following to say when they talked about the challenges of incorporation of identification of indigenous healing practices, *"Many clients are very skeptical when they first arrive. They say, 'We've tried a lot before; maybe this is the same.' They feel that spiritual practices are just talk and don't actually bring change."*

Respondent (HP 6) mentioned, *"Look... many patients are initially very skeptical. They ask, 'Sir, what will dua or zikr do?' They feel either only medicine works, or nothing will work at all. Especially patients who have relapsed many times before, their trust level is very low. They view indigenous or spiritual practices with doubt. But as they gradually feel a little emotional relief, their skepticism decreases. At first, resistance is very high."*

While discussing the topic of Skepticism as a challenge, Respondent (IH 2) mentioned, *"The first thing that comes is doubt. People say, 'Maulana Sahib, how can dua make a difference?' And honestly, I don't blame them. When someone has been in*

addiction for years, their trust is broken. But the problem is that with doubt, the person's practice is incomplete. They pray half-heartedly and do dua just to try."

Respondent (IH 4) described, *"Often, patients are doubtful at first. They say hakeemi treatment is slow and only modern medicine works. I think this happens because people want immediate results, whereas hikmat gradually corrects the body's temperament. When they notice a difference after 10–15 days, their trust grows."*

Some of the patients are skeptical about the indigenous and spiritual practices by nature, challenging their scientific quality and efficacy in addressing such a serious disease as addiction. Although a few of them do this out of family pressure or social influence, they internally make sense of these practices as placebo-like, short-term, or symbolic but not curative. This distrust is observed even throughout the participation and restricts the emotional involvement and efficacy. Respondents frequently claimed that, despite their recognition of the comforting or symbolic value of such practices, the lack of visible through measurable change supported their cynicism. This impression sometimes resulted in the selective involvement, where the patients did not engage in rituals in a wholesome manner, but instead did it in a superficial way which did not bring it into the healing process. The incompatibility between the culture and the individual belief brings out a very important hurdle to achieving the desired therapeutic achievements. Moreover, this cynicism identifies the necessity of the interventions that can be used to connect the cultural practices to the evidence-based strategies in order to ensure credibility and patient engagement.

High resistance and skepticism are always reported among the practitioners, particularly when dealing with patients who are repeatedly attacked by the disease. Skepticism is a result of the broken faith, the willingness to obtain immediate outcomes, and the previous failures. Although the doubt decreases in some patients due to the emotional alleviation or slow physical changes, the half-hearted involvement is regarded as an obstacle which impedes significant therapeutic or spiritual influence. Healthcare professioanls also reported that long-term skepticism can influence the patients as well as the overall progress of the treatment process thus making it difficult to establish successful holistic or culturally integrated intervention. The current distrust may also hurt the healer-patient relationship, and it does not leave much time to build trust and collaborative healing. These results demonstrate the

significance of cultural sensitivity in addition to structured monitoring and quantifiable outcomes so that patients, as well as practitioners, are able to identify incremental improvement. Dialogue, as well as education, can be an important factor in establishing meaningful interaction with traditional and spiritual practices, consequently addressing the issue of skepticism.

5.1.2 Confusion Between Religion vs. Totkay/Hikmat

Patients often face the problem of distinguishing between formal religious practices, e.g. dua and Quranic recitation, and culturally based totkas or hikmat remedies. This uncertainty can slow down the interaction with the effective therapeutic modalities, misrepresent patient expectations, and create an internal conflict. Clinicians emphasized that religious practices provide discipline and ethical support, but that totkas are supposed to provide symptomatic relief in the moment; however, patients may mix the two. Accuracy of direction is essential to reduce confusion and promote informed involvement in spiritual and clinical recoveries.

Case Study – RP11

The case study under evaluation involves RP 11, a 27-year-old urban-based female substance user born in an urban area of Rawalpindi, Pakistan. Even after constant confusion between religious practices and the totkay and hikmat embedded in the culture, RP 11 had not been to a well-organized rehabilitation center and instead sought informal healing avenues when dealing with her substance dependence on her own. Her experience is an indication of a larger cultural scenario in which religion, indigenous healing, and medical care often intersect with each other without distinct delineations.

Respondent (RP 11) mentioned*, "My biggest problem was that I could never understand what is actually part of religion and what people have made up themselves. Like someone would say, 'Recite this verse so many times and you'll quit smoking,' or, 'Drink this arq, do this totka'... I would get confused. I would think, if I don't follow all this, am I going astray? Or am I losing faith in Allah? There was always a sense of guilt about which path I was on."*

The case of RP 11 demonstrates that confusion of the religious practice with cultural totkas results in guilt, anxiety, and decisional paralysis. She also had trouble distinguishing between religious practices (dua, Quranic recitations) and culturally transmitted assertions (particular wazifas, brews, or remedies that ensured immediate healing). This confusion caused her to be afraid that by not abiding by some of these practices, it would be seen as a sign of lack of faith, whereas by doing all that, it seemed too much and conflicting. Consequently, internal conflict opposed her recovery process.

RP11 indicated that she had trouble separating what she considered a real religious practice and what she viewed as culturally made-up cures. She had a variety of sources of advice, which included those of her family members, community elders, and informal healers, all of whom packaged their advice as religiously approved. Religious practices like repetition of ayat, dum, and prescriptive herbal preparations were brought out as a religious remedy, and RP11 was left in a dilemma about whether rejecting some totkay was a sign of poor religious adherence. The lack of official guidance that would explain the difference between spiritual coping strategies and non-religious cultural actions contributed to the further increase of the situation. Such belief postponed her desire to visit medical or psychological assistance since she was compelled to deplete culturally oriented remedies before moving on to other medical or psychological treatments.

However, with time, RP11 saw that this confusion of religion and totkay was affecting the decision-making process in a negative way and it was a cause of emotional distress. Although it was emotional relief and gave people a sense of hope, the uncertainty about their role in treatment brought about confusion instead of long-term recovery. The case indicates that there is a necessity to have culturally aware systems that distinctly draw the line between spiritual care and unregulated indigenous medicine through which people will be free to participate in balanced recovery journeys without any fear or guilt.

A healthcare Professional Respondent (HP 11), had the following to say when they talked about the challenges of incorporation of identification of indigenous healing practices, *"Uh… this confusion is very common, honestly. Many patients cannot differentiate what is religion and what is totka or hikmat. They put everything*

in the same category. Like someone says, 'Ma'am, dum is also worship,' or, 'This hakeem's remedy is also part of religion.' Because of this confusion, sometimes they go to the extreme or completely reject practices. It takes us a lot of time to explain that spirituality and cultural practices are different, and both should be used in balance.

While discussing the issue of Confusion Between Religion vs. Totkay/Hikmat, Respondent (HP 8) mentioned, *"Many times, patients do not clearly understand the difference between religion and totka or hikmat. They categorize everything together. This affects their understanding and delays the therapy process."*

Respondent (HP 4) mentioned, *"For many patients, everything ends up in one category. They mix Surah Rahman, dua, totkas, dam, and hikmat. They do not realize that religion is for discipline and grounding, while totkas create shortcut expectations. This confusion sometimes leads them to perceive therapy itself as just another totka."*

During the Interview, Respondent (RP 12) mentioned, *"My personal belief is that Allah is the greatest healer, but I couldn't figure out what was right according to modern society's expectations. Sometimes I felt I was following my culture and religion, but society was judging me."*

While discussing the topic of Confusion Between Religion vs. Totkay/Hikmat as a challenge, Respondent (IH 1) stated, *"People often ask me, 'Maulana, is this or that wazifa part of religion or a totka?' I explain that in religion, it is important to avoid shirk and bid'at. Not everything that seems spiritual is Islamic. When clear guidance is missing, a person either abandons everything or follows the wrong practices."*

A lot of people get religion, totkas, dam, and hikmat mashed together; hence, they are confused about the worship, cultural material, and therapy. As Respondent (HP 8) indicated, patients put everything in one pile, which makes the therapy slow and disorganized and is their way of receiving the recovery process. The same was viewed by respondent (HP 4) that Surah Rahman, dua, totkas, and hikmat are placed in the same bin, and therefore the patients regard therapy as another totka and want to be offered quick solutions to their problems rather than working hard.

This confusion becomes even more difficult in the case of social and moral pressure. The reason respondents become stuck on how to reconcile religious faith and the expectations of modern society results in doubt and indecision in the choice of treatments. Practitioners caution about the sense of discipline and rooting caused by religion and unrealistic expectations caused by totkas. Respondents cautioned that without a clear direction people can abandon spiritual practices or turn to the wrong practices. Put differently, this mess impedes recovery and disorganizes informed interaction with spiritual and clinical care.

5.1.3 Extreme Religious Reliance and Overdependence

Some of the patients were too over-reliant on religious approaches and assumed that prayer or wazifa or recitation should replace medical or psychological therapy. Most notably, participants reported a tendency to give more importance to ritual worship than therapeutic processes, which, consequently, instigated the emergence of feelings of guilt, anxiety, and barriers to recovery processes. Practitioners recognized that although spirituality is a useful coping mechanism, overdependency may hamper emotional and behavioral problems. The best rehabilitation should be the combination of the religious practices with the formal therapeutic practices, self-managing work, and habit-forming instead of replacing the professional guidance with religion.

During an interview with a healthcare professional, the respondent shared an incident that illustrated how strong religious reliance can sometimes shape treatment decisions. The respondent said that he had previously picked up one of the Christian patient from their residence. When he arrived, he found that the family of the patient had already congregated around him sprinkling him with holy water as they prayed, because they thought this would look after the withdrawal symptoms of the patient. The medical practitioner referred to the case as one of the illustrations of how families can put all their faith in spiritual or religious beliefs in dealing with addiction. This interactiont points out that the system of religious belief may have a strong effect on the treatment response and may even prompt the family to seek spiritual help first before formal medical treatment.

While discussing the issue of incorporation at personal level, Respondent (RP 12) mentioned*, "I had become so religious that I felt just turning to Allah would be enough. I thought that if I listened to Surah Rahman daily, did dum, and recited wazifa, I could control my addiction on my own without any medical help."*

A Rehab patient as a Respondent (RP 4), had the following to say when they talked about the challenges of incorporation of indigenous healing practices, *"For some time, I became extremely religious, thinking that dua, wazifa, and recitation would fix everything. I sidelined medical treatment. I looked for every problem's solution in 'maybe my faith is weak.' This over-dependence got so strong that if I missed a wazifa one day, I felt guilty and thought I would relapse. Later, the therapist explained that religion provides support, but it cannot replace the whole system."*

Respondent (HP 1) mentioned, *"Some clients get very religious with the addiction. They believe that prayer and remembrance are sufficient, and they do not need any therapy or self-work. This excessive reliance makes it difficult for them to overcome emotional or behavioral problems. We describe that religion is about moderation, not radicalism."*

While sharing their insights, Respondent (HP 10) described, *"The extreme reliance develops in some patients. When their family bring them to us "They say I do not need therapy; I pray". They perceive everything in spirituality, and they do not want to be responsible for behavior."*

Respondent (HP 7) mentioned, *"There are patients who only resort to prayer, reciting Surah Rahman, or attending to the mosque. At times they repeat their wudu or make their practices so strict to the extent of missing therapy sessions. This excessive reliance impedes the recovery process, and hence we incorporate balanced practices and mental approaches.*

During the Interview, Respondent (IH 3) explained*, "They trust dua so much that they abandon treatment midway. Later, when the problem worsens, they come back and say it would have been better if they had listened earlier."*

There are patients who completely rely on the religious materials, believing that prayer, wazifa, dum, or reciting Surahs will correct addiction. Respondent (RP

12) responded that they believed they can get out of addiction if they believe in Allah and recite Surah Rahman without any medical assistance. Respondent (RP 4) talked about becoming extremely religious, where they did not get treatment and perceived struggle as lack of faith, and this caused them to feel guilty and fearful of relapse when they missed rituals.

The practitioners indicate that this excessive reliance results in rejection of therapy and personal responsibility. Respondent (HP 1) clarified that there are those clients who believe that prayer and remembrance are sufficient to them, and they do not need emotional or behavioral work, whereas Respondent (HP 10) has heard patients saying they do not need therapy; they pray. Even attending sessions can become a tedious affair through that rigidity. Health professionals stressed that such attitude may hinder the process and establish a conflict between advice to the patient and their expectations. It also involves extra work to establish a rapport, and promote even partial involvement in treatment. This dependency can ultimately contribute to future avoidance and hindrance of developing effective coping mechanisms to avoid relapse. Filled interventions that respect spiritual activities without compromising the professional directives can be used to fill this gap.

In general, religion provides moral grounding and emotional support; excessive dependence leads to guilt, false security, and decreased involvement in rehab. Good recovery should be a balanced combination of spiritual practices, psychological assistance, and medical care with religion as an added advantage, not as an alternative to professional care. Participants who managed to combine spiritual practices with formal therapy stated that they were more motivated, had better emotional regulation, and were more in control of their recovery. This balance enables spirituality to work in a supportive way, which strengthens resilience, but does not replace structured interventions. As a result, the results emphasize the value of a multi- dimensional model, which incorporates faith, use of evidence based psychological methods, and medical management, in order to enhance patient outcomes.

5.1.4 Engagement and Consistency Issues

Participation consistency proved to be a critical impediment. Respondents complained of difficulty with maintaining structured schedules of therapy and spiritual life, as well as herbal regimens, frequently missing morning or repetitive sessions. Lack of consistency weakened motivation, emotional regulation, and consolidation of the habit, hence constraining the effectiveness of the indigenous or spiritual modalities. The practitioners have also highlighted the need for well-organized but adaptable engagement strategies to help achieve a long-term recovery, but active and continuous engagement of the participants was noted as crucial to achieving both short-term relief and long-term behavioral change.

Case Study – RP 2

The case study considers RP 2, who is a 25-year-old male patient at Lifeline Rehab, which is a residential rehabilitation center with an emphasis on substance use recovery. RP 2 possesses a history of drug use dating back to adolescence, with numerous efforts at quitting both with medical and informal assistance. RP 2 was in an organized environment at the time of the study, combining medical care, counseling, and spiritually oriented activities.

RP 2 had a good and bad experience with the rehab program, particularly with consistency. There was a regulated routine of the program, including therapy, group discussions, and recreational activities, in which RP 2 was not able to keep up. The recovery program entailed the daily attendance of therapeutic and spiritual programs. Although RP 2 knew that he might actually benefit, he struggled to remain committed to it, particularly to early-morning or group practices. He observed that on low motivation days he would desire to be isolated or sleep, which discontinued recovery.

This was detrimental to the progress of RP 2 as observed throughout the course of treatment. Disruptions in the engagement were associated with increased cravings, emotional instability, and worse self-regulation. On the other hand, the long-lasting engagement, particularly in organized exercises and physical workouts, appeared to enhance concentration, emotional regulation, and compliance with recovery outcomes.

Considering his experience, RP 2 pointed out engagement and consistency as some of the hindrances of long-term recovery. He also understood that recovery needs to be an active process and cannot be achieved through passivity and dependence on treatment. This change in self-image marked the necessity of an individual approach regarding pacing and encouragement in the form of institutions.

On the whole, the case demonstrates the significant impact that the problem of engagement and consistency may have on the results of rehab. Experience of RP 2 indicates that institutions are important, but the engagement strategies could be flexible and individualized as a means of sustaining recovery.

Respondent (RP 8) mentioned, *"Everyone gave advice: take the hakeem's herbs, follow totkas, pray, everything. But the real problem was that I couldn't maintain consistency. Sometimes my routine would break, or the taste was so bad that I'd quit after a day or two. Then, when I didn't feel any effect, my motivation would drop even further."*

While discussing the issue of incorporation at personal level, Respondent (HP 4) stated, *"Engagement is a huge issue. In the beginning, patients are very motivated; they attend zikr sessions and join group dua. But maintaining consistency is difficult. As soon as a little improvement happens, they abandon the routines. Indigenous practices are only effective if followed regularly. But in addition, attention span and commitment are already weak, so consistency becomes a real challenge."*

Respondent (HP 2) mentioned, *"The real benefit of indigenous practices comes when they are followed consistently. But many patients are engaged only short-term. For two or three days, they are highly motivated, then gradually start missing sessions."*

While sharing their insights, Respondent (IH 2) explained, *"Many people are highly motivated in the beginning, but after a few days, they get distracted or quit. They say, 'I don't have time today; I'll start tomorrow.' I explain to them that consistency is the most important factor in recovery and spiritual practices."*

Lack of consistency in practice is a major obstacle to indigenous and spiritual healing. Respondent (RP 8) replied that she was overwhelmed with herbal heals,

totkas, and prayer tips but had a problem following any routines because of strange schedules, negative experiences, and being demoralized when she did not see the immediate results. Practitioners also notice that patients arrive pumped and attend zikr or group dua but the enthusiasm tends to die off. Respondent (HP 4) indicated that routines are abandoned by people when they feel some slight change but the practices of the indigenous people require uniformity to be effective.

This temporary affair is revealed in various discussions. Respondent (HP 2) observed that patients remain dedicated at most a few days before falling out whereas Respondent (IH 2) observed that continuity is shredded to bits by distraction, procrastination, and day-to-day demands even with the constant reminder that continuity is essential. The bottom line: there is no long-term practice that makes building the habit weak, emotional regulation weak, coping skills weaker, and relapse prevention more dismal. On top of that addiction-related attention deficit, unstable motivation, and being socially nervous of rituals, consistency turns out to be one of the toughest battles in faith-based and indigenous healing.

5.1.5 Fear, Anxiety, and Personal Discomfort

Initial experience with native or spiritual treatment at times provoked fear, anxiety, or unease, particularly when physical side effects occurred (e.g., gastrointestinal upsets caused by herbs) or previous trauma was rekindled. Practitioners noted that stepwise, person-centered care, including coping skills, including physical exercise or directed spiritual mindfulness, could reduce distress and improve adherence. It is thus important to address individual anxiety to create an effective and safe environment of engagement.

While sharing their insights, Respondent (RP 1) mentioned, *"Many times I felt scared of indigenous practices. Some of the hakeem's medicines caused stomach pain, which made me even more anxious. I felt that I was already unstable, and these things sometimes increased my fear instead of providing relief."*

While discussing the issue of incorporation at personal level, Respondent (IH 1) mentioned, *"A good number of patients are frightened of spiritual or cultural practices. One may say, "Sir, I am anxious of the remembrance of Allah, because at*

prayer time strange things enter my thoughts.? Others are reminded of previous trauma or guilt, and this causes anxiety. There is no standard way to treat everybody. Lack of comfort may make even indigenous practices distressing."

The first exposure to indigenous practices also may instigate fear and anxiety, particularly when there are physical outcomes (e.g., stomachache caused by herbal medications) to build on the emotional instability of patients. Fear, intrusive thoughts, trauma, or guilt can also be the results of spiritual practices. All people do not react equally, and improperly selected practices may increase suffering. Participants highlighted that sudden or intensive engagement with unfamiliar rituals as the cause of resistance, withdrawal, or even emotional pain. These reactions prove the necessity of adopting a cautious approach to the introduction of traditional or spiritual intervention based on the tolerance and previous experiences of the patient and his or her psychological condition. Practices designed to comfort might backfire to increase anxiety and lessen the intention to adhere to the recovery programs. The results indicate the significance of adapting indigenous practices to personal abilities and emotional preparedness.

The combination of religious and psychological techniques is associated with nervousness. Slow, gradual support would also work to overcome fear and enhance patient comfort and interaction. Practitioners reported that pacing interventions according to patient readiness improved trust and engagement, allowing patients to integrate spiritual and psychological strategies more effectively. Slow exposure decreases the experience of being overwhelmed and enables the patient to face minor achievements that lead to confidence in oneself and the treatment process. This practice is also a means of promoting the principle of patient-centered care, as recovery is not instantaneous and consistent. Finally, close coordination of religious and therapeutic approaches creates a safer and more successful way of approaching the whole person healing.

5.1.6 Economic Limitations Leading to Reliance on Hikmat

Low-cost solutions often beckon patients to totkas, hakeem, peer-based spiritual interventions, or other low-cost remedies due to financial constraints. Rehab patients stated that they made the choice because the cost of physicians, therapy, or

rehabilitation programs was prohibitive. Practitioners realized that some of the culturally recognized practices can provide temporary relief, but they do not produce long-term results. The pressures of the economy thus determine the accessibility and adherence to treatment, and in many cases, the ready availability of low-cost spiritual or home-based care as an option of default, rather than formal evidence-based care that would be more effective.

Respondent (RP 8) mentioned, *"Honestly, I couldn't even afford a doctor or therapist in the past. Running a household system was tough. That's why whenever an issue arose, we would turn to totkas or hakeem remedies. People said, "These are cheap, home-based solutions, so try them…, but due to lack of money, I had no other option."*

While sharing their insights, Respondent (RP 10) mentioned, *"If a hakeem treats a fever for 500 rupees and a doctor charges 3,000, where will a poor person go? Sometimes financial constraints forced me to try totkas. I knew deep down they might not work, but when your pocket is empty, what else can you do?*

Respondent (HP 1) stated, *"Most of the clients and families are unable to afford professional treatment because of money. They go to a hakeem or adhere to home remedies, or go to a peer since treatment is costly and time-consuming, whereas remedies can be administered conveniently and at low costs. This restricts sustainable treatment."*

While discussing the issue of incorporation at personal level, Respondent (HP 11) mentioned*, "Financial issues are a significant factor that makes patients seek simple solutions and wisdom. Some of them cannot afford to get regular therapy or even lifelong rehabilitation, thus seeking cheap and easily accessible fixes."*

Respondent (IH 2) described, *"I have heard many people say that they lack money to use in modern approaches or doctors and thus resort to using cheap remedies. I teach them duas and wazifas from the Quran and the Sunnah these are highly effective and do not require any cost. This financial constraint is the reason why they are content with cheap solutions, yet we tell them that the real strength lies in the mercy of Allah."*

While discussing the topic of Economic Limitationsas a challenge, Respondent (IH 4) mentioned, *"Many patients do not receive the right treatment because they do not have the money. They depend on the affordable solutions or just prayers. Their incomplete treatment is as a result of economic pressure, which influences recovery."*

Financial issues can have a very strong impact on the extent to which patients are dependent on totkas, hakeem remedies, and peer-religious cures. According to the respondent (RP 8), the lack of available cash prevented him/her from accessing professional treatment. Respondent (RP 10) responded by saying that, when a hakeem charges 500 rupees to treat fever and a doctor requests 3,000 rupees. Practitioners attest that majority of individuals opt to do cheap or home repairs due to the cost and time involved in therapy or long-term rehabilitation. Respondent (HP 1) replied, this impedes long-term treatment; Respondent (HP 11) replied that the financial strain drives patients to rushed and inexpensive solutions rather than extensive healthcare.

There are other low-cost avenues provided by indigenous and spiritual people as well. Respondent (IH 2) answered that he teaches them duas and wazifas by the Quran and the Sunnah... They are hyper-efficient and free of charge. Nevertheless, Respondent (IH 4) cautioned that treatment should never be completely reliant on cheap cures or prayers, since it slows down recovery. Economic constraints influence the utilization of seeking help in patients, which involves making a trade-off between convenience and quality care, which means that primary care is more visible in direct medical care than in informal spiritual/cultural care.

5.2 Institutional-Level Challenges

The obstacles at the institutional level are based on the limitations of the healthcare and rehabilitation systems in terms of structure and procedure. The rigidity of policies, unresponsive time schedules, and bureaucracy of documentation impede the introduction of indigenous or spiritual treatment like group dua, zikr services, or herbal treatment. The lack of alignment between medical and spiritual staff often leads to the provision of conflicting advice, and patients are confused about whether they should follow evidence-based treatment options or faith-based ones. Moreover, indigenous practices are not generally standardized; the doses, rituals, and procedures

used by different practitioners and different regions differ, making it more difficult to standardize them.

The scarcity of resources and poorly skilled staff also limits the ability of the system to provide culturally sensitive care. The patients have a general perception that institutions are not sensitive to their cultural or spiritual needs, thus reducing the level of engagement and trust. These structural gaps have the potential to slow down recovery, decrease adherence, and decrease the effectiveness of holistic intervention. The challenges at the institutional level therefore highlight the need to have flexible policies, interprofessional awareness, and standard procedures to attain a unification between medical and cultural approaches to healing. The inability to respond to these factors puts the patients and practitioners at risk of experiencing barriers that undermine continuity of care.

5.2.1 Institutional Restrictions and Policies

The regulations, set schedules, and the procedural restrictions that are standard regulations in institutions often limit the introduction of indigenous and spiritual practices. Respondents described that group dua, herbal treatments, or zikr sessions were sometimes not allowed to be conducted freely because of the licensing, safety measures, or documentation requirements. Respondents were at times frustrated when their spiritual needs remained unattended to and it was the staff who were forced to work within the confines of the institution. Non-institutional context, on the other hand, has more options of cultural and spiritual intervention. Such limitations result in a conflict between the expectations of patients and the strict organization of rehabilitation centers, which restricts access and perceived care responsiveness.

During an interview in the spacious office of HP 2, the owner of Lifeline Rehabilitation Center, the researcher observed a setting filled with shelves of books, certificates, and notes documenting over 20 years of experience in addiction treatment. HP 2 spoke in a measured and reflective tone about the challenges of introducing new treatment plans into the existing rehabilitation process. He told he was keen to adopt new methods but the institutional procedures and anticipations of employees and patients were challenging to introduce the change in a short period. He gave the example of how he intends to apply Sufi dance in therapy, saying that the

rhythmical and immersive experience of the dance has a psychedelic-like effect that can be quite therapeutic. He also described that the practice has traditionally been done in mizaars or shrines which by virtue of itself draws people nearer and builds cultural recognition. HP2 was clear that it has been proved to be effective in documented evidence, however, its implementation in the structured rehab setting is to be planned carefully and implemented gradually. Ethnographically, such interaction brings out the conflict between institutional limits and the need to incorporate culturally resonant evidence-based indigenous practices into formal treatment programmes.

Respondent (HP 2) mentioned, *"The biggest limitation, in my opinion, is policies and protocols. We are not in a position to exercise free will in everything, even an indigenous or a religious practice. There are licensing, medical ethics, and safety regulations that the institutions should follow. An indigenous practice can sometimes be clinically useful, but it is hard to incorporate it formally in policy. This compels therapists to be extremely cautious and restrict everything within a systematic framework."*

While sharing their insights about Institutional Restrictions, Respondent (HP 7) mentioned, *"At the institutional level, the biggest challenge is that everything we do has to operate under rehab's policies. Every activity has a fixed time and a set routine, and we cannot offer much flexibility from our side."*

During the Interview, Respondent (IH 2) explained, *"I can state that in the modern setting, we encounter various limitations when we attempt to cooperate with an institution or a center. They claim that everything has to be done by the written policy. It is due to this that we are unable to establish Quranic recitation, spiritual healing (dam), and to sit with the congregation to provide guidance or counsel without it receiving approval by the people."*

Respondent (HP 2) mentioned, *"The biggest limitation, in my opinion, is policies and protocols. We are not in a position to exercise free will in everything, even an indigenous or a religious practice. There are licensing, medical ethics, and safety regulations that the institutions should follow. An indigenous practice can sometimes be clinically useful, but it is hard to incorporate it formally in policy. This*

compels therapists to be extremely cautious and restrict everything within a systematic framework."

While discussing the topic of Institutional Restrictions as a challenge, Respondent (HP 6) stated, *"Honestly, when we bring indigenous or spiritual practices into a formal rehab system, the first challenge is policies.*

Respondent (RP 6) mentioned, *"Indigenous practices are severely constrained by institutional constraints. I need permission and strict documentation in case I want to use herbal treatment or some type of dua session."*

Respondent (IH 3) shared their insights during interview, *"At a shop, there is no trouble; there are no limitations. However, in the hospitals, individuals only know about medicine and injections. There are totkas, and dam cannot go. This may also mislead patients as well."*

Respondent (RP 8) described*, "There are strict rules and policies. Even if I may feel like practicing spiritual practices or totkas, personnel indicate that it can disrupt treatment. I listened to them in the short run, but in the long run, the limitations put pressure on one."*

Respondent (RP 3) mentioned, *"I think hospital or rehab center rules can sometimes be restrictive for patients. Timing is fixed, session duration is fixed… sometimes patients need more support or flexibility, but the system doesn't allow it. Policies are necessary, but they can sometimes ignore the patient's personal needs during the process."*

Rigid schedules, regulations, and medical routines typically remove the flexibility out of the equation for indigenous or spiritual practices. The therapists and staff observed that group dua, zikr, herbal therapies, or culturally prescribed rituals cannot always fit in because of the licensing, safety and documentation necessities. Patients frequently complain of such strict schedules, short session times, and the impossibility of practicing other methods of healing that they perceive as neglect and disrespect of their cultural and spiritual requirements. Although there are rehabs where certain faith-based support is allowed, some rehabs remain very strict and biomedical only, which provides the conflict between patient expectations and

institutional policies. Practitioners also notice that the non-institutional environments, such as community centers or home-based care, are much more liberal towards including spiritual and indigenous practices which provide personalized schedules, constant interaction, and culturally familiar healing practices. These disparities emphasize the way institutional inertia may decrease patient satisfaction, decrease compliance with holistic recovery methods, and prevent the realization of the potential benefits of integrating indigenous approaches into official care.

5.2.2 Clash Between Medical and Spiritual Approaches

There are a lot of conflicts between medical treatment and spiritual healing. As observed by practitioners, clinicians are concerned with the management of the symptoms, detoxification, and the evidence-based treatment, and spiritual facilitators are concerned with the prayer, recitation, and moral guidance. Patients are also torn between the medical and spiritual instructions, and thus they become confused, stressed out, and demotivated. One participant outlined uncertainty in the situation when psychiatric advice was in conflict with molvi advice because incompatible strategies could interfere with treatment. In order to balance emotional, moral, and clinical needs and to provide patients with holistic support, coordinated care is necessary without creating conflict.

An indigenous healer as a Respondent (IH 2), had the following to say when they talked about the challenges of incorporation of at Institutional level, *"Many times, doctors and we fail to understand each other. Doctors say that only medication is enough, and when we talk about prayer, recitation, or reliance on God, they consider it unnecessary. I always say that we are not against medicine, but treating the soul is equally important. When both approaches clash, the patient suffers."*

During the interview, Respondent (HP 4) mentioned, *"There is a distinct conflict between medical and spiritual practices. Evidence-based interventions have been more concentrated on by doctors. On some occasions, medical personnel believe that spiritual practices are not scientific, and spiritual facilitators believe that medical treatment only covers symptoms. This parting also leaves the patient in a dilemma on which method to follow."*

Respondent (HP 1) said, *"There is a conflict between the medical team and the spiritual approach. Physicians are concentrated in terms of medication, detox and symptoms, whereas spiritual healing is concentrated on moral and emotional issues."*

while discussing the issue of Clash Between Medical and Spiritual Approaches Respondent (RP 12) mentioned, *"The biggest challenge was that the approaches to medical and spiritual are at times incompatible. As an illustration, the psychiatrist recommended medication every day and other practices should be avoided, whereas the molvi or totka practitioners stated that ruqya and wazifa are sufficient. I didn't know whom to follow. On the one hand, dependence on Allah, and on the other, modern medicine the tension between the two was extremely high."*

Respondent (RP 4) mentioned, *"Medical treatment included detox and counselling, but when I followed spiritual practices, it went against staff rules. Sometimes it felt impossible to manage both. This clash caused me stress and confusion."*

While sharing their insights, Respondent (RP 5) stated, *"I didn't understand when spiritual practices could go along with the medical plan and when not. Doctors and therapists said any alternative practice could create a risk. Because of this clash, I felt unsure, and my motivation dropped."*

The medical and spiritual practices are in conflict with each other as complained by the practitioners. The physicians are compulsive towards evidence-based intervention, medication, and symptom control, but the spiritual facilitator is focused on prayer, recitation, and moral/emotional support. This conflict may at times lead to conflicting advice being given to the patients and the staff may get confused in an attempt to coordinate care. It was observed by practitioners that these clashes may undermine the trust in both systems and patients are not sure which way to focus on at all. The perceived credibility of interventions can also be reduced by the lack of clarity in communication and congruence between the medical and spiritual teams. This scenario presents a strong case of the need to organize this collaboration and deliberation between all care providers to provide coherent patient-centered guidance. In the absence of such integration, the patient outcomes and the efficiency of the staff can be negatively influenced.

A patient is usually confused on which form to observe when the advice of medical practitioners comes in conflict with the spiritual guidance. They will have a problem with the balance between medication, therapy, and faith-based practices, which leads to stress, lack of motivation, and confusion about the process of recovery. It was noted that due to this confusion, the participants tend to have uneven compliance to prescribed interventions, missed therapeutic sessions, or selective involvement to spiritual practices. Grief of having to balance out conflicting advice can increase anxiety and guilt levels making recovery a nightmare. The patients can be advised through proper counseling and decision-making in order to learn how to combine these and how to be safe with both faith and evidence-based care. It emphasizes the significance of effective communication and patient education in intermodal therapy.

When medical and spiritual care are not combined, the patients might have a disjointed experience, as emotional, moral, and clinical components of healthcare will not be covered evenly. Care coordination is necessary in order to avoid confusion and the possibility of addressing both medical and spiritual needs. It was highlighted by the healthcare professionals that coordinated care can help relieve the stress of patients and also provide a sense of holistic engagements, whereby different parts of the treatment do not necessarily conflict with each other. Integration enables the patient to experience psychological comfort and clinical efficacy through integration that enables them to feel that recovery is a coherent process. Concerted efforts on medical and spiritual teams can see to it that interventions are mutually supporting to generate an environment conducive to the simultaneous care of body, mind, and spirit. The results highlight that the effective rehabilitation requires sealing the gap between these areas, as opposed to treating them independently.

5.2.3 Lack of Standardization in Indigenous Practices

Indigenous medicine, including totkay, hikmat, and herbal therapy, has no standard procedures, creating confusion for patients and organizations. Every healer or practitioner has his or her own way, dosages, and procedures, making it difficult to be formally integrated into rehabilitation programs. The respondents indicated that the patients have been given conflicting pieces of advice, thus becoming frustrated and doubtful. This variability hinders the safety and efficacy evaluation in the institutions,

which compromises the trust and compliance of patients. To enable reliability and an opportunity to be more widely accepted, as well as maintain cultural and spiritual relevance, the methodology has to be standardized to document methods.

Respondent (HP 8) shared their insight while talking about Lack of Standardization, they stated, *"The biggest issue with indigenous practices like totkay, hikmat, or herbal treatments is that they lack standardization. Every family or region has its own method. Someone says one thing works, another person says something else, but there is no proper guideline or scientific protocol. Within institutions, we cannot formally include these practices without evidence. As a result, patients and families remain confused about what to trust and follow."*

Respondent (IH 4) explained, *"See… I agree that our indigenous treatments face a standardization problem. Every hakeem, peer, or elder has their own method. Some give more herbs, some less, and some a completely different recipe. The disadvantage is that institutions don't trust us. They ask, 'When the same thing has ten different methods, whom should we follow?' If indigenous healing is to become part of institutions, we must document and regulate our methods ourselves."*

While interviewing, Respondent (HP 4) explained, *"The biggest challenge of indigenous healing is that it has no standard framework. Every place has a different approach; some focus only on Surah Rehman, some mix in totkay, and some have no trained practitioner. When there is no standardization, it becomes difficult for institutions to properly integrate these practices and measure outcomes."*

Respondent (IH 3) stated, *"Every hakeem gives their own recipe or totka. It works in shops because people trust it, but if this system is to be implemented in hospitals or rehab centers, there is no standard rule. People get confused."*

Respondent (RP 7) mentioned their experience during the interview, *"Indigenous practices are quite unstructured and inconsistent. Every peer or healer follows their own rules. One peer's sessions and totkay are completely different from another's, and each patient receives different instructions."*

During the interview, Respondent (RP 4) mentioned, *"Every hakeem or baba suggests something different. Dosage, procedure, and ingredients all vary. Sometimes it's unclear which method is reliable and safe."*

While sharing their insights, Respondent (RP 1) explained, *"I have been to many different hakeems, and every one gave me a different herb or oil, and that started affecting my belief system."*

The problem indicated by the practitioners and institutional staff is the absence of a unified framework. Each healer, peer, or family is different in its approach, doses, and rituals, and it is challenging that the institution cannot assess effectiveness, promote safety, and ensure that indigenous practice can be officially integrated into the formal programs. It is also complicated by the absence of standardization, because it is impossible always to state what kind of interventions are helpful and which one can be dangerous to the staff. The participants said that without a well-organized procedure, the effectiveness of traditional approaches is doubted, and its possible role in the recovery process is undermined. Institutions might use the cultural and emotional strengths of indigenous healing and preserve patient safety by developing clear guidelines and evidence-based practices. Finally, a single system would tie up the disparity between the informal cultural activities and the formal clinical procedures, forming the consistent system of care.

The inconsistent instructions given to patients by different practitioners lead to confusion and uncertainty in patients. Diversity in totkas, herbs, and rituals erodes trust, confidence in what works, and makes it difficult to follow the treatment or recovery regimen. The unpredictability of unstandardized practices is what renders the process of recovering frustrating and inconsistent. Patients are not able to adhere to the routine, to doubt the rightness of their behavior, and can become skeptical; this fact can undermine long-term trust and the desire to adhere to the advice given by the therapist or spirituality. Practitioners pointed out that such inconsistencies tend to increase anxiety and decrease engagement because patients do not know the practices that are necessary or effective. These difficulties and barriers could be addressed through organized assimilation, clear instructions and communication among all practitioners to enhance adherence and confidence of patients to the recovery process.

5.3 Cultural-Level Challenges

Cultural-level issues explain the role that societal beliefs and norms as well as communal pressures play in determining the course of recovery of patients. The

decisions concerning treatment are often determined by family demands, social stigma, and ingrained traditional values so that the patients will hide their addiction or cause themselves to be cured by totkay and spiritual prescriptions rather than by formal systems.

The difference in belief systems among the patients, their families, and practitioners may generate conflict and internal tension where the patients struggle to tie the belief in religion, cultural norms, and medical recommendations. Excess use of cultural or indigenous treatment is often a delay in medical treatment, leading to a more complex or lengthy healing process. Participation is also affected by gender roles, moral expectations and community perceptions, which at times adds weight to secrecy, shame, or avoidance of formal treatment. Misconceptions between patients and healthcare practitioners might also diminish the trust and therapeutic involvement. Such obstacles have shown that cultural attitudes may either support or hinder the recovery process based on their alignment with the evidence-based practices.

To overcome cultural-level barriers, it is important to use culturally informed communication, education, and flexible adoption of indigenous practices. It points to the necessity of interventions that would not violate social norms and guarantee access to professional care on time.

5.3.1 Cultural and Belief System Differences

There are a wide variety of cultural and belief systems among patients and families which influence perceptions towards addiction and recovery. Addiction is considered a medical condition by some and immoral by others; some of them are guided by religious practices, whereas others prefer using herbs or medications. According to the respondents, these differences may be helpful or a hindrance to recovery depending on their consistency with the treatment approach. Patients often get stressed, feel guilty, and get confused when individual beliefs are in conflict with family demands or the norm. This strain affects self-rule in decision-making, compliance with treatment, and trust in healthcare interventions. Cultural and religious beliefs are important knowledge areas to guarantee effective, respectful, and acceptable care.

During the interview, Respondent (HP 7) mentioned, *"The family has its beliefs towards addiction, in which some believe that it is an illness, and others believe that it is because of poor character. There are very religious families, and there are families that are oriented towards herbs or totkay. It is important to be aware of patients' cultural and religious beliefs when treating them, to ensure that the treatments they are administered to are acceptable to them. In some cases their belief system helps them to heal, whereas in other cases it limits them."*

An indigenous healer as a Respondent (IH 2), had the following to say when they talked about the Cultural and Belief System Differences as a challenge, *"There are cultural beliefs among many people, which do not conform to the teachings of religion. There are occasions that family members tell us, "It is our tradition, and it is going to be better with home remedies," and we tell them that it is better to adhere to the Quran and Sunnah."*

While sharing their insights, Respondent (IH 4) mentioned, *"Some people follow only spiritual or religious practices and avoid herbal or modern medicine. Cultural differences create challenges in compliance and trust."*

Respondent (RP 2) stated, *"When I came to a rehab or therapy center, initially I felt that the people and methods there did not match my family and cultural approach."*

Respondent (RP 4) stated their insight, *"I believe that the greatest difficulty was my cultural beliefs and the perspective of the modern medical system were dissimilar. My family told me that all that was curable through spiritual healing, but I knew that I needed medical rehab."*

While talking about the challenges faced by patients, Respondent (RP 1) explained, *"Culture and belief systems leave a person hesitant. I was not able to convince my family about medical treatment, and I felt guilty, but I have to do what is best for me."*

Addiction and healing are surrounded by very different beliefs among patients and their families. Some perceive it as an illness requiring medical intervention, while others view it as a moral failing or vice. Many families rely on religious rituals such

as prayer or spiritual healing, whereas others prefer herbal remedies or biomedical treatment. These variations strongly influence how patients interpret their condition and whether they accept professional help. Engagement and motivation are likely to encourage when treatment is consistent with their belief system, whereas resistance, doubt, or early withdrawal can be detected when there is a discrepancy. Therefore, belief systems are very important in determining the outcome of the treatment and the process of recovery as a whole.

The medical or structured therapeutic ways of treatment usually conflict with cultural and community norms. The standardized rehabilitation programs might focus on clinical procedures, personal counseling, and pharmacological therapy that might not be compatible with spiritual or community-based healing practices. Such a collision may confuse patients on what practices to give priority or rely on. Consequently, patients might have a problem with compliance as they are caught up between professional recommendations and culturally endorsed methods. This conflict within one may promote a psychological burden, decrease trust in medical services, and eventually impact a barrier to regular treatment involvement.

The patients are often torn between their own beliefs and the demands of the family and society. Family views are very influential in decisions relating to pursuit of treatment. When family wills are not in line with the will of patients, in terms of spiritual healing, medication, or therapy, patients become guilty, ashamed, or pressured to be like their family. Such a strain may impair their feeling of self-efficacy and independence in healing. As a result, they might participate in the treatment process only partially, which is not the case based on their lack of the desire to heal but rather the strong impact of religious, cultural, and social norms influencing their decision.

5.3.2 Stigma, Family Constraints, and Social Pressure

Social pressure and stigma play an important role in determining patient behavior and seeking treatment. Families tend to hide addiction from the community, promote self-treatment at home, or isolate and make patients unwilling to visit rehabilitation, which makes them more isolated and guilty. The patients could hide their condition, wait, or resort to culturally approved treatments out of fear.

Respondents noted that autonomy and engagement in structured recovery programs may be hampered by social norms, gossip, and moral scrutiny. Resulting emotional weight and indecisiveness in the healing process and decreasing compliance with medical or treatment procedures.

While talking about the challenges faced by patients, Respondent (RP 5) stated, "One cannot freely follow the medical process. Family pressure and social judgment increase mental load. Because of this, people often neglect their health priorities and follow these practices."

While discussing the topic of Stigma, Family Constraints, and Social Pressure as a challenge, Respondent (HP 10) had following to say, Respondent mentioned, *"Stigma and social pressure are significant challenges. Many families don't want the patient to openly attend rehab, so they take them to hakeems or babas to hide this fact. Many patients say, 'Ma'am, if relatives or villagers find out, it will be shameful."*

Respondent (HP 2) explained, *"Social pressure and stigma sometimes become barriers for patients. They do not want others to know they have an addiction. Indigenous practices without family and community support increase isolation and guilt. Therefore, cultural and social awareness is equally important for the recovery process."*

Respondent (IH 3) shared their insight while talking about Stigma, Family Constraints, and Social Pressure, they stated, *"People say, 'Brother, keep this issue secret; it will be shameful.' Families sometimes do not allow treatment. Social pressure and relatives' comments make the patient hesitant. As a result, many people never start treatment and rely on home remedies or go to their local hakeems."*

Patients do not have freedom in seeking treatment because family pressures usually limit them. The family might demand confidentiality, discourage treatment, or compel certain remedies (e.g. totkay or spiritual practices) to prevent being socially exposed. The outcome of this control is to restrict the freedom of choice of patients regarding medical or therapeutic plans and bolster emotional burden, guilt, and indecisiveness in making recovery choices. The participants mentioned that the restrictions posed by the family postponed the access to professional care, motivated, and caused conflict within oneself and the family. This deprivation of autonomy also

compromises the process of building self efficacy, which is vital in long term recovery.

These quotes always bring out the point that addiction is highly stigmatized and considered a moral or character defect. Patients are afraid of being gossiped about, shame and social judgment, which will not encourage them to openly admit their addiction nor participate in the treatment process. This makes patients conceal their plight, evade rehab, skip sessions, or attend half-heartedly, all of which are major hindrances to recovery and undermine adherence. The information shows that stigma is both external and internal because patients internalize judgment by society and self-blame. This secrecy and avoidance not only interfere with the therapeutic engagement but also diminishes the usefulness of the family or community support systems.

In addition to the issue of stigma, wider social norms push patients into silence and denial. The fear of labeling, judging, or suspecting the peers and relatives leads to a postponement of treatment start and an emotional expression. Patients develop defenses or seclude themselves, hindering therapeutic development and strengthening the isolation in the recovery process. The respondents underlined that social pressures establish a vicious circle where shame and secrecy contribute to the continuation of the addiction process, as well as hinder help-seeking efforts. Isolation makes anxiety, depression, and the risk of relapses more severe, which restricts the effect of even well-designed interventions. Treatment with interventions including family education and community sensitization and disclosure safe space could decrease the social barriers and enhance earlier and more consistent treatment.

5.3.3 Over-Reliance on Cultural Remedies Delaying Medical Care

Most families and patients give more preference to cultural or spiritual healing like totkay, herbal therapy, or prayer instead of medical procedures. This excessive dependence often postpones access to professional care, making the conditions worse and the process of recovery more complex. Respondents from healthcare highlighted that even though indigenous practice may be helpful in healing, it is hardly adequate on its own as a treatment. It is a tendency that is supported by social and familial pressures and is mandatory to determine such remedies to cultural issues as a first

resort before referring to professional help. In retrospect the patients later on opine that medical intervention early on could have helped reduce the amount of suffering, which makes it imperative to educate patients on complementary but not substitutive application of indigenous practices.

When I was waiting in the waiting room of the rehabilitation centre, I spotted an old woman who was the maternal grandmother of one of the patients. She started talking to me in a low, slow voice and gave her viewpoint of how the patient was being treated. “I don’t like all this Hospital and medicinal stuff,” she said, shaking her head slightly. “I wanted him to first go to our local hakeem; that’s how we always treated such problems.” She hesitated, and redid her shawl, and then said that the elder brother of the patient had objected to her proposal, and had instead sent him to the rehab centre. Her tone mixed frustration and concern, reflecting both her adherence to cultural healing practices and her uncertainty about formal medical approach. This encounter brings to the front the role of strong family commitment to traditional healing in making decisions on treatment, in some cases delaying engagement with formal rehabilitation. It should be mentioned though, that the grandmother was not considered as a part of the research sample frame and her opinions were not officially recorded in the data of the research.

Respondent (IH 1) explained, *“Yes, many times people depend solely on spiritual healing and do not consider modern medical care until something serious happens. People think, ‘Only totka, herbal remedies, and prayers are enough.’ This over-reliance delays recovery, and sometimes the health condition becomes more complicated. We always emphasize that medicine and indigenous practices should go together, but social and cultural pressure causes people to delay medical care.”*

Respondent (HP 2) mentioned, *“Many patients and families rely heavily on indigenous or cultural remedies. Herbal treatments, religious rituals, and traditional practices are often their first preference. like, many patients say, ‘I will first try Quranic recitation and herbal remedies, and if nothing works, then I will get treatment.’*

Respondent (HP 11) mentioned*, “We all know people from rural areas and their families prioritize cultural remedies. They try herbal remedies or totkay first,*

and when the effect is minimal, they start therapy. Even after trying those practices and them not working, they are still hesitant to try the medical system."

Respondent (IH 4) mentioned, *"Some patients depend solely on totkay and spiritual practices and avoid modern medical help. I explain to them that a complementary approach is best, but often they insist that only cultural remedies are sufficient."*

While talking about the challenges faced by patients, Respondent (IH 3) mentioned*, "People say, 'We will just do dam and totka; why go to a doctor?' This over-reliance is very common. Patients do not seek proper medical help until the condition becomes serious."*

Respondent (RP 7) mentioned, *"I also initially relied on these methods and delayed proper medical treatment. I didn't go to a doctor or psychiatrist until I was tired of trying many different things. Personally, I realized that cultural remedies can only support recovery, but sustainable recovery is not possible without proper treatment."*

While discussing the topic of Over-Reliance as a challenge, Respondent (RP 11) had following to say, *"I feel I relied too much on cultural remedies. When addiction first started, I kept trying molvi sahbs advice and herbal totkay and only later went to the doctor. Proper medical intervention from the start might have made controlling addiction easier."*

Respondent (RP 4) explained, *"I also feel people try totkay and spiritual practices first. I initially relied on peer totkay and home remedies, and by the time medical rehab started, my addiction was already deep."*

All these verbatim clearly demonstrate that totkay, herbal remedies, and spiritual rituals are the first line interventions that patients and families tend to seek before consulting a medical or psychological practitioner. This overreliance leads to late referral to professionals, whereby the addiction or health problems would have deteriorated, and hence recovery would be more complicated and time-consuming. Delays in formal care were reported by the participants to complicate both physical and psychological symptoms, thus requiring more vigorous interventions in the future.

The initial preference of culturally known remedies highlights the importance of comfort, familiarity, and perceived safety in the determination of health-seeking behavior. These trends point to the necessity to educate the indigenous community in terms of viewing indigenous practices as something that does not replace professional treatment, but rather, complements it. Combining cultural remedies and early professional interaction may reduce the period of suffering and may be more effective.

In addition to the individual conviction, social and family pressures also support the notion of cultural or religious remedies being attempted initially. This group mentality makes it standard practice to delay professional medical care and provide opposition when medical care is recommended, despite the numerous practitioners pointing out that indigenous practices are meant to be complementary, not to replace them. The patients said they felt conflicted between family demands and clinical orders, which caused internal conflict and stress. The collective beliefs are supported by social approval of the traditional remedies and therefore an individual has a challenge in making a professional choice on his own.

Other patients look back and criticize how they have overused cultural remedies in the past and realize that early medical care might have minimized the suffering and lacked success. These stories emphasize learning by doing, where native practices are eventually interpreted as auxiliary means as opposed to being treatment by themselves.These meditations demonstrate that there is a reconsideration of beliefs over time, with experience bringing health-seeking behavior. Patients tend to combine the lessons of both positive and negative experiences and eventually learn to appreciate the importance of professional care but still use the cultural practices as the supportive resources. This cyclic learning approach underscores the role of patient education, reflective counselling and culturally sensitive counselling in supporting balanced recovery pathways. It shows that empathy and fitting in to patient experiences can improve adherence and treatment outcomes.

5.4 Analysis

The challenges at the personal, institutional, and cultural levels shows that the problems of working with indigenous healing practices are not only logistical and

informational but are deeply rooted in the belief, emotional state, social pressures, and institutional settings of individuals. These difficulties show the process of recovery as being defined by arrangements between belief, trust, fear, access, and meaning, as opposed to being the sign of resistance to the healing itself. The discussion shows that the challenges occur where the methods of healing do not match the inner logic, realities, and socio-cultural environment of the person.

Skeptical attitude at the individual level comes out as a major psychological obstacle, especially to those who were educated and urban respondents like RP13. Her example demonstrates the need to note that recovery engagement is a process laid down by a high degree of epistemological trust, in other words, what is valued by an individual as legitimate knowledge. Although the indigenous practices were something the society could understand culturally, she felt that they lacked scientific qualities, and this caused emotional resistance and not assurance. The literature about patient-centered care underlines that in case treatment methods and beliefs of a patient are in opposition, they can diminish therapeutic alliance instead of improving the recovery. The experience of RP13 demonstrates that autonomy can be sacrificed through forced cultural integration, and the ethical significance of respect for skepticism, which is an important aspect of individualized care, is very high.

The misunderstanding of religion and the culturally instilled totkay or hikmat is an even greater internal conflict. The case of RP11 shows how an obscure line of demarcation between religious duty and cultural solution leads to guilt, anxiety, and indecision. Rather than empowering the process of recovery, this misunderstanding procrastinated the process of seeking help and increased self-blame. Religious coping literature has implicated the idea that in case religion-based practices are presented as tests as opposed to support mechanisms, the relapse that occurs may be construed as a spiritual defeat. The experience of RP11 is indicative of how lack of any explicit instructions is changing religion into the comforting into the psychologically burdensome.

The other critical individual problem is extreme religious dependence where the practices in spirituality are viewed as alternatives and not complements to therapy. The respondents had detailed how excessive reliance on prayer, wazifa or purity in rituals resulted in shunning of therapy, feeling guilty of missing practices and false

control. Practitioners always stressed the fact that these extremes redirected the responsibility towards active self-work. This is congruent with recovery literature that emphasizes the importance of balance: spirituality may boost motivation and meaning although when it is used as a way to avoid taking responsibility of their behavior, spirituality is a barrier to long-term recovery.

Recovery is also increased by involvement and continuity. The case of RP2 demonstrates the disruptive effect of motivation swings, emotional exhaustion, and structural resistance. Native and spiritual practices such as therapy are only effective when practiced on a regular basis. Yet, it is difficult to be consistent with attention deficits related to addiction, boredom, and disrupted routines. This is the reflection of the addiction literature which states that routine is necessary but difficult.

Fear and anxiety, unease also hinder engagement. Other patients reported feeling more anxious during her spiritual practices or intrusive thoughts or physical aches due to herbal treatment. Native practices may, ironically enough, be the causes of traumatic experiences or guilt that cannot be resolved so far, as we are left with no universal solutions, and a wrong intervention may only make the problem worse.

Economic limitations have a strong impact on the choice of healing. Totkay, or hakeem remedies, were not used by the many respondents due to their belief but because they were compelled to use them. When there is no affordable medical care, low-cost practices default and provide short-term relief but indicate their restrictions. It highlights the fact that structural inequality disguises itself as cultural preference. Reliance on Indigenous solutions is used not as an informed choice but as an economic rejection.

At the institutional level, the tight policies and protocols severely limit improvement in assimilating the indigenous practices. The scheduling, licensing, and documentation are inflexible issues, which are not always helpful in situations where patients are emotionally distressed or demand culturally relevant support. Practitioners were frustrated by the fact that the indigenous or spiritual approach to things, often responsive and situational, does not lend itself to bureaucratic frameworks. In their turn, patients felt that institutions were not attentive to their cultural and emotional needs.

One of the key institutional issues is a conflict between medical and spiritual solutions. The main difference between medical staff and spiritual facilitator lies in the priorities of evidence-based treatment and risk management versus the moral repair, meaning, and emotional grounding. Lack of coordination between these approaches causes patients to get mixed messages, which create confusion and lack of trust. A number of respondents reported that they had been conflicted between religion and medicine, and they were not sure what route was the right way to recovery. The literature on the topic of integrated care emphasizes that the risk to recovery is the most dangerous when it comes to fragmentation as opposed to either of the approaches.

Institutional integration is also complicated by the fact that the indigenous practices are not standard. The inconsistency in practices, doses, rituals, and instructions compromises faithfulness and predictability. The lack of coherence in the instructions given to both the practitioners and patients by different healers and contexts was also noted. Institutions cannot measure safety, efficacy, or ethical implications without standardized frameworks in place. To a patient, the lack of consistency decreases the confidence and adherence, which exacerbates the doubt and disappointment.

All other barriers are set against the background of cultural challenges. Long held belief systems influence the perception of addiction as a disease, moral weakness, spiritual failure, or social shame. These meanings have a direct impact on therapy decisions and interaction. Respondents mentioned a conflict between individual ideologies and beliefs, family demands, and institutional attitudes, which generated emotional stress and confusion.

One of the strongest cultural barriers identified is the stigma attached to visiting rehab centers. Many patients feared being judged, gossiped about, and losing their social status, which influenced the decision to conceal their addiction and/or postpone treatment or attend it with a hakeem or baba to avoid getting attention. The families did not try to seek help or rehab since they tended to keep a secret rather than providing care. This is consistent with the literature that presents stigma as an institutional obstacle that secludes persons and a lack of recovery motivation.

Excessive dependence on cultural solutions also postpones medical treatment on the cultural front. Families and communities tend to accept the attempts of totkay, herbal treatment, or spiritual rites first, which contributes to delaying the process of professional help. A large number of the participants retrospectively identified that such delay aggravated their situation. These stories demonstrate how a learning process works, where indigenous practices are finally redefined as supplementary as opposed to adequate, though in many instances only after many years of pain.

Across all three levels, challenges in healing engagement reflect misalignment between belief and practice, flexibility and structure, and culture and institution. Indigenous practices themselves are not inherently obstructive; rather, their effectiveness depends on clarity, balance, consistency, and integration. When skepticism is ignored, confusion remains unaddressed, or cultural pressure overrides personal agency, healing becomes fragmented. Conversely, recovery is strengthened when individuals are supported to navigate belief systems critically, institutions allow cultural sensitivity within ethical boundaries, and communities reduce stigma and delay. Together, these findings underscore that effective recovery requires not choosing between indigenous and biomedical approaches but creating pathways where meaning, access, and care are aligned.

5.4.1 Discussion of Findings

A significant issue identified is the incorporation of indigenous healing practices into the formal rehabilitation environment. All these challenges work individually, institutionally, and culturally, and express contradictions between historical, symbolic, and contemporary clinical paradigms.

On a personal level, the participants were skeptical; there was a conflation of religious practices and traditional healing (totkay/hikmat), and sometimes they over-relied on spiritual interventions. The Geertzian perspective sees these issues arise when there is an overlap or conflict between symbolic systems, which creates the uncertainty of legitimacy and effectiveness (Mansoor et al., 2025; Bano et al., 2019).

According to Rashid and others (2018), spiritual healing may cause psychological reassurance, although when the meaning becomes vague, it may also

lead to dependency or shirking of the whole care. Economic constraints also affected the need to employ local ways, and this highlights how ideology alone does not always determine the choices of healing.

In the past, there have been various systems of healing that people used pragmatically. The historical ecological approach connotes that individual decision-making is an adaptive strategy that has been developed over a long period of time and more so where biomedical care has been disproportionately distributed (Balée, 2006).

Some institutional obstacles were the absence of standardization, insufficient appreciation of the indigenous practices, and contradiction with biomedical procedures. These issues have a historical basis, as the legitimization of indigenous knowledge systems was historically delegitimized, especially in colonial and postcolonial health policies (Anderson, 2006; Nichter, 2008). Rehabilitation institutions are contemporary buildings that usually exist without being linked to local cultural ecologies. This distance puts boundaries on integration, even as indigenous healing remains relevant in the community. In the absence of formal structures, the interaction between clinicians and indigenous healers is uncoordinated and informal (Campbell-Hall et al., 2010).

Stigma, family pressure, and excessive dependence on traditional remedies, sometimes postponing institutional care, were some of the cultural issues. These obstacles represent more general cultural expectations in which addiction is a morally condemnable condition and the choice of healing is affected by family authority and community norms (Afaq et al., 2023).

The interpretive approach provided by Geertz is useful in understanding the construction of stigma culturally by the use of common moral stories. Addiction destroys not only the health of the individuals but also the social and moral order, and the process of recovery is culturally sensitive (Grim & Grim, 2019). Traditionally, societies have been using traditional systems of healing in restoring order even in situations where biomedical treatment is available (Janzen, 1978; Langford, 2002).

Although indigenous healing has a lot of advantages, personal confusion, institutional constraints, and cultural pressure present a challenge to its integration in

a formalized rehabilitation process. These issues indicate the clashes between symbolic belief systems and contemporary clinical systems and the historic marginalization of indigenous knowledge. To overcome these barriers, it is necessary to incorporate them in a culturally sensitive way without substituting current systems of healing (Afaq et al., 2023; Corso et al., 2022).

CHAPTER 6
CONCLUSION, RECOMMENDATION, AND LIMITATION OF THE STUDY

6.1 Summary

The current chapter concludes the main points, conclusions, and recommendations in this study and provides future research and practice directions. The research was a qualitative study designed to examine the role, effects, and issues of indigenous healing practices in Islamabad's rehabilitation institutions. In particular, the research aimed to learn how indigenous healing is perceived and experienced by indigenous people within rehabilitation, the health professionals, as well as the indigenous healers and the interaction of indigenous healing practices with the formal biomedical rehabilitation systems. Another direction, which the research took was to place these practices in their historical, cultural, spiritual, and ecological contexts.

Various stakeholder groups were involved in the study, and these included the rehabilitation patients and healthcare professionals, as well as indigenous healers, who included Islamic scholars and hakeems. Based on the detailed qualitative data, the study reviewed three thematic areas, including the identification of indigenous healing practices, the effect of these practices on the rehabilitation process, and the issues connected to integrating indigenous healing into the professional healthcare systems. These goals were discussed within the scope of the thematic analysis and discussion chapters, which provided the opportunity to interpret the results of the analysis empirically and also theoretically.

The results showed that the indigenous healing practice is entrenched in the religious belief systems, intergenerational knowledge, and culture-linked perceptions of health and illness. Quranic recitation, dua, group prayers, herbal remedies, and holistic practices, among others, were not seen as just additional means but rather as effective systems of healing. These practices serve as symbols, which, through the interpretation of Clifford Geertz, can be interpreted through his interpretive anthropology to make people understand suffering, addiction, and recovery. Historically and ecologically, this dependence on such practices indicates the long-term adaptations that were influenced by the religious traditions, the local knowledge system, and the lack of immediate access to formal healthcare means.

To study how the indigenous healing practices influence the rehabilitation process. The results show that such practices help in promoting emotional stability, spiritual reassurance, moral motivation, and a renewed sense of purpose in patients. Short-term effects saw a decrease in anxiety, hopefulness, and emotional support levels, whereas long-term effects saw a long-term level of commitment to the recovery process and moral systems to be followed during behavior. These effects are interpreted theoretically to outline the fact that healing is a biological process, yet it is pictorial and ecological in nature, defined by culturally significant narratives and practices that have their basis in the past.

Findings also touched on the issues that surrounded the implementation of indigenous healing in rehabilitation environments. The research found misunderstandings between the religious and non-religious spiritual methods, institutional resistance, and regulatory carelessness. These issues are indicative of overall strain between culturally supported systems of healing and biomedical models. In the interpretive and historical ecological perspective, these tensions can be explained by the marginalization of the indigenous knowledge and predominance of the biomedical ideas, which tend to ignore the symbolic meaning and cultural background.

6.2 Analysis with Theoretical Framework

The results are consistent with the two theoretical perspectives, which were applied in this research. The theory of historical ecology is used to understand the context in which indigenous healing practices are based on intergenerational knowledge, ecological consciousness, and continuity of people over time despite historical disturbances and disorientation. The interpretive anthropology by Geertz throws light on the symbolic and cultural sense of such practices, as rituals, prayers, and traditional therapies offer participants systematic and meaningful channels of healing.

Collectively, these models illustrate that indigenous healing is both feasible and that it meets emotional, spiritual, social, and ecological aspects of healing. They show the significance of holistic and culture-aware approaches to rehabilitation

programs and that recovery is not limited to the individual but includes community, culture, and the environment.

The historical ecological approach places these practices in the context of the history of human-environment interaction and history (Balée, 2006; Crumley, 1994). Plant-based remedies, ritual cleansing, and sacred ceremonies are practices that are based on generational ecological knowledge and spiritual ties with the environment and interpret the interdependence of people, land, and culture (Hatala et al., 2020).

These practices have not remained unchanged, as they have changed due to suppression by colonialists, modernization, and changing rehabilitation structures (Anderson, 2006; Comaroff and Comaroff, 1992). In this sense, addiction may be described as a detachment of cultural, social, and ecological systems, and indigenous healing will serve to provide a sense of balance and continuity, returning the individual to ancestral knowledge, community, and environmental background (Kirmayer et al., 2003; Grim & Grim, 2019).

In this study, the analysis of the case of addiction rehabilitation in Pakistan has been performed in terms of the incorporation of the historical ecology approach, and the evidence demonstrates that indigenous practices do not lose their connection to the ecological, ancestral, and cultural knowledge (Afaq et al., 2023). Geertzian interpretive methods are supported that show the symbolic relevance of rituals and culturally based practices to meaning, strength, and inspiration.

In practice, the rehabilitation programs are to be based on using both indigenous healing and biomedical approaches, using rituals, prayers, and holistic interventions to facilitate the motivation, emotional, and social reintegration (Danish Iqbal et al., 2025). There should be training of professionals on cultural competence, and any program should provide room for the intergenerational and ecologically competent practices to allow the development of hybrid solutions, which are mindful of both tradition and clinical demands (Dein et al., 2012).

The historical ecological approach contextualizes these issues in the processes of social change over a long period and underlines that the overcoming of isolation is impossible without adherence to cultural continuity and without losing the indigenous systems. It also pushes the emphasis on the fact that recovery is not an individual

process but is related to the social equilibrium and overall welfare (Balée and Erickson, 2006).

In conclusion, the application of Historical Ecology and Greetz's Interpretive Anthropology reveals that indigenous healing practices in addiction rehabilitation are not peripheral alternatives but culturally embedded systems of resilience. They offer holistic pathways to mental well-being by reintegrating individuals into networks of meaning, memory, and community. The findings underscore the importance of culturally grounded, ethically informed, and theoretically sensitive approaches to rehabilitation in Pakistan and similar contexts.

6.3 Limitations of the Study

Critical reflection of the limitations of the current study is important, as it does not only enhances the quality of transparency of the current research but also offers viable guidance on future research. Although the present research provides quite interesting information regarding the relevance of indigenous healing activity in the context of rehabilitation in Pakistan, some limitations have to be identified.

Among the major restrictions that were experienced in this study is the issue of access and scope. It was difficult to have regular access to rehabilitation centers and interviewees, especially because of the institutional gatekeeping and ethical concerns of addiction and rehabilitation. Consequently, the sample size, though adequate in qualitative inquiry is limited, which in turn might be a problem in terms of the transferability of the findings with regard to rehabilitation in all contexts in Pakistan.

Second, the research was concentrated on a particular group of stakeholders, i.e., on rehabilitation patients and healthcare workers, as well as on the chosen indigenous healers (Islamic scholars and hakeems). Although these views were at the center stage of the research objectives, other significant voices, like those of policymakers, rehabilitation administrators, and regulatory authorities, could not be accommodated.

The other weakness is the context-based nature of the indigenous healing practices. The practices are greatly influenced by regional, religious, and ecological factors. As a result, the results might be incomplete in terms of the differences that are

present in various provinces, sectarian traditions, or rural-urban settings in Pakistan. The wider geographic perspective would have shown more stratification of diversity in the knowledge and practice of indigenous healing.

Lastly, like most qualitative studies, the research is based on participants' interpretation and narration, which is influenced by individual belief systems, cultural definitions, and experience. Although this is consistent with the interpretive anthropological approach in the framework of which the study is done, it also implies that the results are interpretive but not generalizable in a statistical sense. However, such limitations do not minimize the usefulness of the study; it is only that future research can build and enrich insights in those areas.

6.4 Recommendations for Future Research and Practice

Based on the results of the current research, it is possible to provide a number of recommendations to the researchers, healthcare institutions, policymakers, and practitioners who can be considered to be even more engaged with the indigenous healing practices in the context of rehabilitation.

The next research should focus on broadening the scope and size of the investigation by covering a larger number of rehabilitation centers in various areas in Pakistan. It would be more informative to conduct comparative studies that would compare rural and urban environments or various contexts associated with different cultures and sects, and how indigenous healing practices are influenced by historical, ecological, and social factors.

The researchers are also encouraged to include institutional and policy-level perspectives like the rehabilitation administrators, policymakers, and healthcare regulators. This inclusion would assist in bridging the gap between culturally based practices of healing and the formal healthcare systems and provide information on how integration can be done at a structural level without excluding indigenous knowledge.

Rehab centers, being a practice-based model can take advantage of developing culturally sensitive systems that do not undermine the clinical quality by disregarding the spiritual and traditional healing beliefs of the patients. To mitigate the tensions

between biomedical and Indigenous healing, healthcare professionals should be culturally competent and have an interpretive understanding of health. In line with the World Health Organization's recognition of traditional and indigenous healing practices as legitimate and complementary forms of healthcare, it is recommended that healthcare professionals and rehabilitation institutions systematically integrate indigenous healing approaches into substance use rehabilitation programs (WHO, 2013). Such integration can enhance cultural sensitivity, improve patient engagement, and strengthen holistic recovery outcomes, particularly in contexts where cultural beliefs and spiritual practices play a central role in healing.

The policymakers are encouraged to introduce dialogue between the biomedical practitioners and the Indigenous healers, particularly Islamic scholars and hakeems to negotiate ethical boundaries, referrals, and what is understood by both. Rather than making Indigenous healing appear to be contrary to modern medicine, the collaboration will be able to develop complementary care models based on local realities.

Lastly, further research can be carried out on longitudinal effects of indigenous healing practices on rehabilitation outcomes, such as preventing relapse, emotional resilience, and reintegrating the community. The future study can enhance the inclusive, holistic, and contextually sensitive rehabilitation system in Pakistan by using interdisciplinary and culturally based methods.

6.5 Conclusion

Altogether, this research confirms that native healing methods still remain important and influential in the process of rehabilitation in Pakistan. Instead of being in contrast to modern medicine, the practices are embedded in a culturally determined system, which defines the way people perceive illness, recovery, and well-being. The results imply that strategies involving the culturally competent incorporation of indigenous healing practices (instead of marginalization) can result in better patient engagement and rehabilitation.

To sum up, the study has an anthropological and health-related contribution to literature, as it shows the significance of culturally based healing models in the rehabilitation process. Due to the implementation of the historical ecological approach

and the interpretive anthropology developed by Geertz, the study highlights the necessity to perceive healing as a process that is socially constructed, has meaning represented symbolically, and is situated historically.

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