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The Survivors of Political Violence in Khyber Pakhtunkhwa and Mental Health Care System through Alternative Treatment Interventions

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Abstract: *The Khyber Pakhtunkhwa province of Pakistan is the contemporary case study for political violence, with survivors full of trauma, stress, and anxieties who had no adequate mental healthcare system, but showed resilience and growth. The interventions they had were no less than those offered through any world mental healthcare system, but so limited that only a few hundred mental healthcare practitioners were available for 240 million population. The alternative cultural practices are usually not termed as mental healthcare but instead referred to as supplementary support system. The argument here is that what if the primary system, i.e. Mental Healthcare System, is not functional or adequate? What else the family support does if it is not performing the primary role as an alternative mental healthcare intervention? The people of Khyber Pakhtunkhwa survived and absorbed all the shocks of terror in the most resilient manner. Yet the world gets no visuals of (abnormal) intellectually disabled people on the streets, which could be expected with presence of such violence, inadequate healthcare, and high population indicators in any world society in the global north. Though there are reports that tolerance in Pakistan is reduced, and the community is radicalized but there are many other reasons for this kind of behavioral patterns. The efficient role played by family and kinship, peers, and spirituality is a case study for global testing and generalization, placed for critics to analyze. The study reveals that identification of illness, referrals, initial care and support, counselling in the isolation phase, enhancing self-confidence, supporting the world view transformation, and emotional healing are all provided through family, kinship, and peers, adequately forcing the mental healthcare system to serve as supplementary consideration of the victims of violence.*

Key Words: Mental Healthcare System, Political Violence, Alternative Treatment Interventions, Stress, Trauma, Post-traumatic Growth

Introduction

The people of Khyber Pakhtunkhwa province in Pakistan have survived the deadly wave of political violence, with specific reference to terrorism, in the last two decades. Earlier work mainly focused on age, gender, religion, personality traits, psychological therapies, and chronic illnesses concerning post-traumatic stress and growth, or psychological impacts of violence and terrorism. However, family support has not yet beenstudied as a coping mechanism for trauma. This research unfolds the different dimensions of family support as a treatment intervention. It is assumed that the trauma survivors look up to their 'family support network' rather than the state institutions, because family is liable to provide identity and protection to its members and is considered a prime source of support in life adversities. People rely on their family members due to different factors, including but not limited to trust, cultural values, respectfor elders, social and economic dependency, conservative approach, and religious beliefs. Since it has been established that family support has significance for the growth and recovery process, still family support in comparison to the healthcare system has not yet been studied in our society. It is anticipated that post-

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trauma family intervention not only assists the survivors in resolving trauma symptomatology but also enhances safety, growth, and recovery. However, it is still unclear as to which processes, aspects, and variables of a family predict post-traumatic growth and recovery. The concepts used in the study are defined as:

Political Violence

Political violence is the intentional use of force and power to attain political goals. It includes both psychological and physical acts intended to intimidate or injure the population. Some instances of political violence include aerial bombardments or shootings; arrests and torture; detentions; terrorism and home demolitions (Sousa, 2013).

Trauma

'Trauma' is derived from the Greek word, meaning 'to harm or to damage'. In this research 'trauma' is considered a 'psychological trauma' which refers to "a distressing impact of a stimulus on a person's ability to deal with it". Furthermore, "one or more incidents which can alter an individual's mental system, threatening to split their mental cohesion." (Perrotta, 2019).

Stress

In this research, 'stress' refers to 'post-traumatic stress disorder (PTSD)'. PTSD is a psychological condition caused due to experiencing a traumatic incident that threatens a person's physical or psychological integrity. The common symptoms of PTSD include re-experiencing the sensations, memories, and emotions caused by the traumatic event through nightmares, flashbacks, avoidance of situations, irritability, hyper-vigilance, difficulty sleeping, emotional withdrawal, poor concentration, and suicidal ideation (Schein et al., 2013).

Growth

Growth, in this research, refers to 'Posttraumatic growth (PTG)' which is defined as "the positive psychological changes occurring as a result of an individual's encounter with trauma and its adverse effects". It is believed that traumatic events affect a person's core belief about the world, others and themselves; while, posttraumatic growth is a process which helps the individual's to reinstate their belief systems (Cárdenas-Castro et al., 2021).

Pakistan, a South Asian country, is the sixth most populated nation exceeding 241 million people as reported by the national population and housing census in 2023 (*Gallup Pakistan*, 2023). The World Bank classified Pakistan as a lower-middle-income economy, as the country's Gross National Income per capita was USD 1,500 in 2016. Pakistan ranks in the 'low' category of 164 out of 192 countries in the Global Ranking on the Human Development Index (HDI) ("Human Development Report," 2024). The government's expenditure on health was 0.7% in 2015, of the total Gross Domestic Product (GDP), which was lesser as compared to the average of lower-middle income countries. The country is comprised of four provinces including Khyber Pakhtunkhwa (KP), Punjab, Sindh, and Baluchistan. The population of KP has reached 40.85 million according to the 2023 Census. 81 % of the population is rural while 19 % is urban. 9.5% of the Annual Development Budget has been allocated to the health department by the KP province (Data Collection Survey on Health Facilities & Equipment in the Islamic Republic of Pakistan, Final Report, 2018). The country has underprivileged mental health indicators, having fewer than 500 psychiatrists for a huge population, whereas around 24 million people need some form of psychological assistance (WHO, 2023). The country has brought many reforms to the healthcare system; however, it is still struggling with numerous challenges like lack of access to healthcare services, unequal resources, poor governance, corruption, inadequate health information management system, shortage of trained staff, and lack of monitoring in health policy and planning (Kurji et al., 2016). The same is the case with the mental health system, as it is also functioning ineffectively and results in compromised health outcomes (WHO, 2009). More than 90% of individuals with common mental disorders remain untreated due to a dearth of mental health professionals and stigma about mental health (Sikander, 2020).

Theoretical Framework

The shattered assumptions theory depicts the trauma and discusses how traumatic incident results in disrupting the assumptions and core beliefs of the victims; the social support theory postulates that social support can promote health and well-being of the victims and lessen the negative outcomes of stress; the family resilience theory focuses on the relational perspective of resilience highlighting that supportive relationships are key to positive adaptation of life adversities; the resilience theory proposes that protective factors on individual, family, and societal levels serve an individual to build their resilience and enable them to adapt the trauma in a better way; the religious coping theory states that religious and spiritual beliefs serve as coping mechanisms for dealing with adversities of life; and the posttraumatic growth theory asserts that after encountering a life crisis an individual struggles for survival, and that struggle gives birth to positive change and transformation.

The combination of these theories builds a comprehensive framework that is associated with all the domains of this research i.e. trauma, stress, growth, and treatment interventions, in a meaningful way. Together, all these theories give a glimpse of how victims possibly cope with their major life adversities, specifically in the absence of a formal mental healthcare system.

Research Question

This study derives its crux through the question of why family support supersedes the healthcare system for trauma survivors in Pakistan? What is the magnitude of the gap (if exist) in formal healthcare service provision? and how the alternative (cultural) mechanism bridges the gap as an alternative treatment intervention?

The research discusses the role of family support as an alternative treatment intervention for trauma survivors, due to lack of a formal mental healthcare system. The research also explores, identifies, and documents the informal coping mechanisms that are widely used as a substitute in the absence of a formal mental healthcare system. This study is an attempt to explore and describe the informal mental health model, which is assumed to be employed for post-traumatic growth and recovery of trauma survivors.

Research Objectives

1. To explore the gaps in mental healthcare for trauma survivors (with PTS) in the research area.
2. To examine the vulnerabilities of trauma survivors through adopting alternative coping mechanisms in the absence of a (formal) mental healthcare system.

Methodology

The prolonged exposure to violence in Khyber Pakhtunkhwa challenges the mental health of its population more than any other provinces in the country. Khan et al., (2018) found that 75% of children suffered from PTSD after Army Public School Massacre, while 23% people of KP sufferedfrom PTSD due to terrorism in 2013. The estimated population that suffered from war on terror from 2005 till 2022, including death toll and injuries, are reported as 46,028 civilians and security forces personnel from KPand newly merged tribal districts, while total number of terrorism related incidents arereported as 13,035 (South Asia Terrorism Portal, 2023). On the other hand, Pakistan has less than 500 psychiatrists for 249 million people, leaving behind more than 90% population untreated (Sehat Kahani, 2022).

Population and Coverage of the Study

The research identifies and accesses trauma survivors and bereaved families affected by political violence from different segments of Khyber Pakhtunkhwa. For data collection, the research relied primarily on four leading mental healthcare centers (private and public) carefully chosen from Khyber Pakhtunkhwa to gain access to the survivors and families having a history of post-traumatic stress. Prior permission was obtained from the mental healthcare unit, informed consent was taken from the respondents, and interviews were conducted keeping in view the ethical considerations, issue sensitivity, and testing protocols. The study is based on in-depth interviews, as case studies, with persons experiencing Posttraumatic Growth. The sample is divided into three broad categories i.e. (i) traumatized civilians; (ii) traumatized non-civilians; and (iii) bereaved families, with equal representation to draw necessary

conclusions. The civilian population comprises all adult (above 18) individuals, both male and female, who are not in any government service, including both civil and military. Whereas the non-civilian populationincludes police officers, military personnel, and government employees (e.g., doctors, teachers, bureaucrats) who are considered responsible for public safety and order. Lastly, the bereaved families refer to 'those families who have lost their loved ones due toa traumatic event'.

Findings

According to the DHIS Annual Report (2017), there are 1,349 Primary healthcare centers, 125 Secondary healthcare hospitals, and 08 tertiary healthcare hospitals in KP. Psychiatry Units and Psychiatrists could only be found in the Tertiary care or the DHQ hospitals in KP, and that too in a very small number. In the Punjab province, there are Mental health preventive services and Psychological and Psychiatric rehabilitative services available in the primary and secondary healthcare facilities (i.e. BHU, RHC, THQ, and DHQ hospitals).

Mental healthcare in Pakistan is primarily split between two models, which are hospital-based and community (primary care) based models (Sohail et al., 2017). According to the WHO-AIMS report on Mental Health System in Pakistan (2009), mental health facilities are provided in four capacities including, (i) Out-patient facilities (RHCs, BHUs, THQs, DHQs), (ii) Community-based Psychiatric In-patient facilities (RHCs, THQs, DHQs) (iii) Mental hospitals (Tertiary care) and (4) Forensic units.

i. **Out-patient Facilities**: Pakistan has approximately 3729 out-patient mental health facilities, which treat 343.34 patients per 100,000 population. These users are mainly treated for neurotic, somatoform, and stress-related disorders (33%), and (30%) for mood disorders. Follow-up care facilities are provided by 46% of these facilities in the community and only 1% use mental health mobile teams. One or more psycho-social interventions have been used by 1-20% in the previous year. At least one psychotropic medication of each category (anxiolytic, mood stabilizer, anti-psychotic, anti-depressant, and antiepileptic) is available at 33% of mental health outpatient facilities or a pharmacy throughout the year. However, there are no day treatment facilities in the country.
ii. **Community-based Psychiatric In-patient Facilities**: The country has 624 community-based psychiatric in-patient units, which consist of 1.9 beds per 100,000 population. Patients admitted are diagnosed mainly with mood disorders (46%) and neurotic, somatoform, and stress-related disorders (32%). One or more psycho-social interventions were used by 1-20% of patients in the in-patient units last year. At least one psychotropic medication of each category (anxiolytic, mood stabilizer, anti-psychotic, anti-depressant, and antiepileptic) is available in 34% of psychiatric in-patient units. However, there is no availability of community residential facilities in the country. 1% of all admissions in mental hospitals are involuntarily done.
iii. **Mental Hospitals**: Five mental hospitals run in the country, comprising 1.9 beds for a population of 100,000. These facilities are integrated with mental health outpatient facilities. The admitted patients are primarily diagnosed with mood disorders (31%), and neurotic, somatoform, and stress-related disorders (24%). In the last year, 20% of patients obtained one or more psycho-social interventions. At least one psychotropic medicine belonging to each therapeutic class (anxiolytic, mood stabilizer, anti-psychotic, anti-depressant, and antiepileptic) is available at all mental hospitals. 30% of all admissions to mental hospitals are involuntarily done. Inequitable access to mental health facilities for minorities is another issue in the country.

Due to a shortage of mental health practitioners in the primary health centers, medical doctors, nurses, and healthcare workers are given training in mental health. 27% of the training for medical doctors is devoted to mental health, in comparison to 3% of nurses and 11% of non-doctor/non-nurse primary health care workers. The assessment and treatment protocols of major mental disorders are available in a few (21-50%) doctors-based primary healthcare centers. Only 21-50% of primary healthcare doctors refer one patient per month on average to a mental health expert. While centers that lack medical doctors do not refer mental health patients to experts. 1-20% of doctors-based primary health centers interact with alternative or traditional practitioners instead of mental health facilities. There are no restrictions on doctors in primary health centers to prescribe psychotropic medications (WHO-AIMS Report, 2009).

The government (Ministry of Health) and international agencies, private trusts, foundations, NGOs, and professional associations have been engaged in promoting public education and awareness on mental health. The target of these campaigns was both the general population and professional healthcare groups, including women, children, adolescents, ethnic groups, trauma survivors, and other minority or vulnerable groups, as well as the conventional/ allopathic/ modern service providers, or alternative/ complementary/ traditional healers, social services staff, teachers, and other relevant health-related groups (WHO-AIMS Report, 2009).

Pakistan lacks psychiatric training at both the undergraduate and postgraduate levels. If the medical curriculum adds psychiatry as a subject, it can assist future doctors in identifying and treating mental health issues to some extent. Capacity building of the general practitioners and family physicians via training on mental health will also assist in diagnosing and dealing with mental health disorders. There is a lack of training consultants in the country, hence no training could be conducted in specialized fields like forensic psychiatry, geriatric psychiatry, child psychiatry, learning disability, psychotherapy, and drug and alcohol abuse. Emphasis is required on training in psychotherapy, as psychological therapies are not easily available in Pakistan. Counseling along with an eclectic approach is mostly used by psychologists due to a lack of training in psychotherapies. Trained clinical psychologists could be utilized in the improvement of counseling and psychotherapies. Due to the dearth of specialists, the family, in Pakistan, is an important resource for looking after the patients. To improve patient care, families could be utilized and considered an important resource (WHO-AIMS Report, 2009).

Shedding light upon the community-based model (i.e. primary health care), Irfan (2013) states that mental health is declared by WHO as a significant component of health and that primary healthcare should be incorporated into the health system. In Pakistan, primary health care disregards mental health by mainly focusing on physical health.

Table 1

Province-wise Total Number of Health Facilities

	Tertiary Hosp.	DHQ Hosp.	THQ Hosp.	RHC	BHU	Dispensary	MCH Centre	Sub-h. Centre
Punjab	23	34	88	293	2461	499	289	443
Sindh	7	11	56	130	774	643	90	15
Khyber Pakhtunkhwa	9	21	77	90	822	307	49	30
Balochistan	4	27	10	82	549	575	90	24
ICT	2	8		3	5	-	-	-
FATA	0	4	14	9	174	11	22	211
Other	0	11	39	36	223	277	235	484
Total	46	108	280	638	5002	2318	775	1207

**Source:* Punjab Health Department Web/Technical Resource Facility (2012) Health Facility Assessment-Pakistan National Report.

The table shows that Khyber Pakhtunkhwa (KP) had 30 Sub-Health Centers, 49 Mother and Child Healthcare Centers, 307 Dispensaries, 822 BHUs, 90 RHCs, 77 THQ Hospitals, 21 DHQ Hospitals, and 09 Tertiary Hospitals in 2012, as reported by the Punjab Health Department Web (2012).

Barriers to Primary Mental Healthcare in Pakistan

Primary mental health care in Pakistan has some shortfalls. It is not user-oriented, i.e. the users of mental health do not have a say in service planning or service delivery; the service mainly focuses on the identification and treatment of mental disorders having minimal focus on the preventive mechanism and rehabilitation processes; general practitioners working in the community settings are not trained in mental health while the focus is on the tertiary care settings. According to WHO, mental health should be incorporated into primary care to share the burden of mental disorders, reduce the treatment gap for mental disorders, address the fact that physical health problems result in mental health issues, enhance access to the identification and treatment of mental disorders, promote human rights to the mental health patients by reducing the stigma and discrimination, enhance cost-effective and affordable mental health

services, and ensure good health outcomes by identifying and managing common mental health problems at the doorstep. All these reasons are relevant and significant for Pakistan to integrate mental health into primary care or community-based healthcare. The infrastructure and capacity of the primary health care system must be improved to ensure appropriate care of the local communities in appropriate settings, enabling individuals to be responsible for their health, reducing inequities and inequalities in health service delivery, and improving evaluation and research. There are mostly no specialists or facilities to deliver mental health services at the grass root level, and mental health is associated with stigma and discrimination (Irfan, 2013).

Irfan (2013) found that mental health in Pakistan should be integrated with primary health care to deal with the burden of psychiatric disorders and the impact they cause on the economy of the developing nation. To attain this objective, the primary care workers should be trained and supervised, psychotropic medications should be made available at the primary care centers, collaboration is required between the non-government and government organizations, outreach services should be introduced, a conviction is needed that primary care would improve the patients access and hence would result in better well-being of people, a political commitment of devising mental health policies and strategies is required, and that mental health integration should start from the higher levels (national) to the lower levels (local).

A study by Munawar et al. (2020) focused on mental health literacy as a barrier among the people of Pakistan. The term means the beliefs and knowledge that people carry about mental disorders. It is believed that such literacy can help in the identification, management, and prevention of mental disorders; however, in Pakistan, mental health literacy is overlooked, while, comparatively, physical health literacy is widely studied. The study utilized different databases, including Cochrane, PubMed, and PsycINFO, to gather relevant literature. Mental health education, mental health literacy, and mental health were the terms used to find literature. The review gauged the knowledge of mental health among the public and professionals, and it was found that there is a dearth of awareness of mental illness and its treatment among both samples. To accomplish the goal of increased psychiatric care and public health, the gap in mental health literacy needs to be filled among the public and professionals. The study also finds that due to limited mental health literacy, people do not accept evidence-based mental health treatments, which further results in a lack of mental health services for the needy.

Non-Conventional (Alternative) Mental Healthcare System in Pakistan

The non-conventional mental healthcare can also be referred to as 'alternative coping mechanisms.' To have positive attitudes and behaviors toward mental health, the first step is to recognize the mental health issue. Physical illness comes with less or no stigma in comparison with a mental health issue, which comes with a great deal of stigma. In regions where mental health literacy is less, associate stigmas with mental health issues, and hence people having mental health issues only manage to report somatic (bodily) complaints of mental disorders. The empirical evidence suggests a high prevalence of depressive disorder in Pakistan; however, people's information about and attitude toward the disease and its symptoms are very limited (Munawar et al., 2020).

Faith Healers, Spiritual Healers, and/or Traditional Healers

Munawar et al. (2020) assert that among the different informal mechanisms for treatment, faith healers, spiritual healers, and/or traditional healers are either preferred or are the only mental health care providers in Pakistan. Since faith healers are the first line of consultation for the people in Pakistan, there is a need to build the capacity of these faith healers on the different means and modes of mental health treatments. This will enhance literacy and adherence to mental health treatment. The faith healer's treatment practices are according to the cultural value system of the country. A study was conducted by Saeed et al. (2000) in a rural area of Pakistan called Gujar Khan, in which the work of faith healers was observed in the treatment of mental disorders among 139 attendees. Five faith healers out of nine accepted to participate in the study, who had a large following and who were thoroughly available at their facilities. Most of these healers are descendants of the famous saints of that area, who claim to have received special powers from their elders. These faith healers are treated as spiritual guides and mentors by the people who feel honored by following their wishes. These healers undertake religious education and thorough training

under their mentors and guides to enhance their natural gifts. The researcher was a psychiatrist who initially observed and recorded the faith healers' work and then applied a screening test i.e. General Health Questionnaire (GHQ), and a diagnostic interview i.e. Psychiatric Assessment Schedule (PAS), on the attendees in a side room. The results of the study revealed that the faith healers classified the mental disorders based on mystic causes and identified 11 types of mental disorders i.e. Saya (shadow); Jinn (ghost) possession; Churail (demon) possession; Tawiz (Amulet); Medical problems; Spirit infestation; Evil eye; Amal (Act); Jhalla/Jhally (insane/simple ton); Jadoo (Witchcraft/ Black magic); and Dar (Fear). The study found that the most common problems identified were saya (27%), jinn possession (16%), and churail possession (14%). Twenty-five individuals (08%) were diagnosed with medical problems and were referred to a health facility by the faith healer. On the other hand, 61% of the same attendees were diagnosed with mental disorders using the above-mentioned scales i.e. 24% with major depression, 15% with generalized anxiety disorder, and 09% with epilepsy. This shows some agreement between the two classification systems i.e. one used by the faith healers and the other by using Diagnostic and Statistical Manual (DSM)-III-R diagnosis. The study concluded that faith healers are a significant source of support for mental health patients in Pakistan, mainly for the illiterate population and women clients.

These faith healers use cultural psychotherapeutic methods and powerful suggestive techniques for the treatment of mental health issues as well. It is important to find ways to collaborate with such faith healers in future research so that efficient and culturally appropriate mental health treatment can be accessed. The study shows that there is a similarity between the diagnosis of faith healers with the classification of mental disorders in DSM-III-R. Saya seems to correlate with anxiety disorders and major depressive episodes, jhalla (madness) or possession is commonly identified with psychosis, while epilepsy corresponds with saya, possession, or a medical problem. As far as the treatment given by faith healers is concerned, they do not relate to the western medical treatments in any respect, i.e. they do not target the symptoms of a problem; rather, the cause of the problem is removed or reduced. Their treatment involves a ritual procedure comprising a spiritual or mystical component. The treatment takes place in a shrine in a group setting with the support and participation of the people available at the shrine. The faith healers use the component of respect bestowed upon them to expect improvement and recovery in the attendees and other people who are available at the shrine.

The indigenous healers from India and Ghana also use similar healing methods. Whereas, in the western model the diagnosis is based on the duration of the illness, presence of a group of symptoms, and exclusion criteria. The Western classification of disorders has a reliable scientific background. The treatment strategies used by faith healers sync with the cultural and traditional values of the attendees, they use influential suggestive techniques which are supported by their groups, the family of the attender is informed that the person (patient) is not responsible for their illness rather their condition is caused by the possession of jinn, spirit or churail, so the attender does not have to face blame for their illness, the attender, family and the healer all share same belief patterns which makes it easy for the attender to express their feelings without any barrier or stigma (Saeed et al., 2000).

Different Alternate Treatment Mechanisms

Different alternate treatment mechanisms for mental disorders are identified as:

i. **De-possession:** It is a procedure used to free a possessed person who is possessed by a spirit. "The healer puts the attendee into a trans-like position and the jinn or churail is made to speak through the attender's voice. The healer orders the jinn or churail to leave until it agrees to go" (Saeed et al., 2000, pp. 480-485).
ii. **Instructions and Advice:** It is a procedure to prevent the effects of Tawiz and Jadoo (magic) and to make the person get rid of Amal, Dar, and Saya. "Instructions to give regular prayers, recitation of Wazifas, and Holy verses a specified number of times at certain times of the day" (Saeed et al., 2000, pp. 480-485).
iii. **Tawiz:** It is a procedure used to counteract the effects of Tawiz or to protect the wearer or Tawiz from the evil eye or jadoo (black magic). "Treatment includes symbolic lines or verses written onto a piece of paper, which the attendee either wears in a locket or it is dissolved in water to be drunk for a specified number of days" (Saeed et al., 2000, pp. 480-485).
iv. **Dam:** It is used to counteract the effects of Jadoo, Tawiz, and Amal. "The healer recites the Holy

verses for the treatment, then blows them onto the attendee's body. Alternatively, the verses are blown onto sugar or water that must be taken on specified days of the month." (Saeed et al., 2000, pp. 480-485).

v. **Duaa:** It is a common component for most of the treatments. "It is a practical assistance for the welfare of the attendee." (Saeed et al., 2000, pp. 480-485).
vi. **Religious Ceremony:** It is used to counteract the effects of the evil eye, Tawiz, Amal, and Saya. "Special arrangements are made in advance. An assistant recites Holy verses loudly, and the healer, attendant, and all people present go into a trance-like state. The healer instructs that the difficulties presented by the attendee and their family are reduced immediately. This continues until the attendee agrees." (Saeed et al., 2000, pp. 480-485).
vii. **De-infestation from spirits (exorcism):** It is used for infestation or possession by spirits. "It is a religious ceremony to remove spirits from the home." (Saeed et al., 2000, pp. 480-485).
viii. **Advice for follow-up:** It is a common component of all treatments. "Almost all attendees were invited for follow-up (e.g. to come on the next three or five Thursdays). Some treatments would be repeated, and some attendees were required to attend until there was a complete cure for the problem" (Saeed et al., 2000, pp. 480-485).
ix. **Physical treatment:** It is used for Saya, Tawiz, and Dar. "A stick was rolled over the body of a mute attender along with the recitation of verses until the attender began to speak (a case of hysterical aphonia)" (Saeed et al., 2000, pp. 480-485).
x. **Medical Treatment:** It is used in Epilepsy. "In two cases phenobarbitone, 30mg daily, was given by the healer (both for the cases of epilepsy)" (Saeed et al., 2000, pp. 480-485).

Collaboration with faith healers is pertinent so that efficient and culturally appropriate mental health treatments can be accessed because the mental health condition of the country has not much improved since its inception. The perception of mental health is still negative and stigmatized. People call mental health hospitals 'Mad Houses' in their local languages, where patients are still chained. There are few qualified psychiatrists and fewer trained doctors for the patients. People still opt for unregulated traditional practices, mainly in the rural segment of society. People with mental illness usually approach religious healers as their first healthcare contact. They believe that evil eyes, magic, or bad wishes from others cause ill mental health conditions, and recitation of holy verses and religious amulets are the most common treatments. Privately run small psychiatric hospitals are established throughout the nation, which are playing a huge role in service delivery. These hospitals are run by psychiatrists and affiliated mental health experts. Recently, self-help techniques have significantly increased through the source of television and by introducing soft psychotherapeutic techniques like yoga, inspirational speakers, and sleep management (Sohail et al., 2017).

According to Sohail et al. (2017) mental healthcare in Pakistan is a mixture of multiple mechanisms. Two models prevailing in the country include the community-based model (primary care) and the collaborative care model (partnership with traditional healers). Due to the failure of the urban hospital-based models to reach out to the masses, the community-based model served the purpose of integrating mental health services in the primary care units in collaboration with mental health experts. One of the focuses of this approach was on the preventive aspects of mental health by raising awareness and involving the community in mental health efforts with the help of trained health workers. On the other hand, the second model focused on collaboration between the traditional healers and the specialist centers. The focus of this approach was to train the traditional and religious healers in the community on diagnosing and referring severe mental disorders (psychosis, major depression, and epilepsy) to specialist centers while dealing with the common mental disorders on their own. These models are, unfortunately, in their initial phases and need to be scaled up.

Discussion

Since there is a lack of mental health specialists in Pakistan, it is pertinent to uplift the community-based models, and effective interventions could be carried out with assistance taken from non-specialist health care providers and community agents. There is a need to augment these favorable interventions. According to Karim et al. (2004), mental illness is a state of mind that is not completely developed and leads to

impaired social functioning, decreased intelligence, and seriously irresponsible or aggressive conduct. Likewise, personality disorder is a permanent disability of the mind that leads to 'abnormally aggressive or seriously irresponsible conduct.' In Pakistan, religion plays a huge role in dictating mental health. Religion demands ideal or good conduct on the part of a man, which is only possible in the presence of good mental health, as mentally healthy people can promote the best version of a man on earth. There are certain myths and misperceptions about the origin of mental illness. Some people believe that mental illness occurs due to supernatural forces like jin (ghost), spirit possession, exaltation (extreme happiness), black magic, or God's punishment for sins one has committed. Some believe that excessive intake of Western drugs could also be a cause of mental illness. Others believe that bodily dysfunctions like hepatobiliary or gastrointestinal upset can also cause mental illness. Modern education is playing its role in changing the perceptions and attitudes of the people, mainly in urban areas.

In Pakistan, it is the responsibility of the family and community to support the mentally ill by providing moral, financial, and manpower support, or taking assistance from the zakat-based social welfare system. Generally, the male family members are responsible for arranging the finances for medicine, while the women feed and nurse them. During hospitalization, the family members are always available with them at the hospital. Similarly, the family, most commonly the eldest son, is responsible for looking after their old parents and grandparents who are suffering from mental illness or dementia. Clients from poor economic backgrounds cannot afford their mental healthcare expenses. The responsibility is on the family members to pay or borrow money for the treatment. Charity and zakat funds are also utilized for treatment purposes, though it is not enough to be universally accessible (Karim et al., 2004).

A deeper understanding of the collective repercussions of political violence is pertinent for mental health professionals operating in conflict zones to ensure secondary or tertiary prevention, or the recovery from and management of the impacts of political violence. Equally crucial is individuals' capacity to contribute to the reconstruction of the social and political spheres of their societies post-political violence through active engagement, a process reliant on trust and the ability to collaborate effectively (Hernández, 2002). Recovery from the impacts of political violence extends beyond the individual world, by encompassing their social and political worlds as well. This enhanced understanding has the potential to inform the development and execution of treatment, intervention, and prevention initiatives and policies that address the impact of political violence on health across various levels of operation (Almedom & Summerfield, 2004).

Riggs (1994), as cited in Eubank & Weinberg, (2001) argued that democratic principles serve as a framework for resolving political conflicts without resorting to violence. This happens because, in theory, all pertinent racial, ethnic, religious, and socioeconomic groups could engage in the process and achieve some of their objectives through peaceful methods, hence they are less inclined to resort to violence. The research findings of Rummel (1995), as cited in Eubank & Weinberg, (2001) suggest that autocratic (dictatorship) regimes are significantly more prone to civil wars and other forms of political violence since they limit alternative avenues for political expression.

In light of the preceding discussion, there are ways to find a middle ground. This pertains to the magnitude and timing of political violence. It is argued that democracies witness high levels of unrest, characterized by relatively unexpected mass protests with some associated violence, whereas autocracies tend to face more severe forms of violence, such as civil wars. While democracies may encounter protests, autocracies often experience rebellions. Additionally, regarding concern for the timing, some contend that democracies are prone to experiencing significant episodes of political violence during their initial transitional phases of development (Gurr, 1980, as cited in Eubank & Weinberg, 2001).

Conclusion

Apart from traditional healers, some alternative healers also work in Pakistan, including homeopaths, acupuncturists, and Chinese medicine practitioners. The most famous among these are the homeopaths, who are accessed by the lower-middle class majority, because of the belief that homeopathic medicine provides natural healing with no side effects. There are even reputed homeopaths who provide cancer treatment in the country. There are also associations for homeopaths, with teaching colleges and registered authorities. Madrassas are religious schools for the training of religious healers. Likewise, for Ayurvedic

and homeopathic healers, there are schools for their training. However, no formal training program exists for traditional healers (Karim et al., 2004).

There is a cultural perception of formal health care in Pakistan. People only undertake specialist mental health services, while ignoring and bypassing the primary health care services due to the perception that the primary care is not competent enough to provide proper care. This results in a lack of treatment for minor illnesses, which could be treated at the primary care units. Traditional healers are an important source of help for dealing with illness in Pakistan. According to Pakistan's National Mental Health Survey, 3-5% of all health consultations were with traditional healers. Different traditional healers are local practitioners of a community. These may include imams, hakims (who use ayurvedic medicine), khalifs, gadinashins (who inherit the healing craft from earlier generations and sit on the teacher's or master's seat), and people who practice magic and sorcery (enchantment). There are associations of the Hakims that are officially registered with Pakistan's Medical and Dental Council. There is no formal earning system for traditional healers. Their disciples usually give them cash gifts, and the wealthy followers even donate to their properties, becoming a source of their permanent income (Karim et al., 2004).

The analysis of study demonstrated that vicims and survivors of political violence did not access the formal mental healthcare services due to gaps in mental healthcare system including, misperceptions regarding the mental health treatment and medications, viewing treatment a sign of weakness, shortage of psychological and psychiatric services, lack of counseling and psychotherapeutic services, lack of satisfaction from the psychiatry unit in tertiary care hospitals, costly and unaffordable psychotherapeutic services, non-serious attitude towards mental health treatment, side effects of psychotropic medications, female victims not permitted seek treatment by the male households, accessibility issues, lack of trained professionals in the field, misdiagnosis, excessive use of medications, malfunctioning of psychiatric practice, stigma attached to mental health, masculinity norms and barriers to mental health acknowledgment, and lack of trust in professionals due to breach of confidentiality. As a result of these gaps, the victims were approached by alternative or non-professional healers who offered them care and support. The first responders who provided them with emotional support and healing were the close family members including spouse, parents, siblings, children, uncle, aunt, and even cousins, friends; and social network including peers and colleagues; spiritual and religious healers including imams and mullahs; and reliance on religious practices such as offering prayers, recitation of the Holy Book (Quran) and versus from the Quran, or in very limited cases the victims relied on amulets for their protection and safety. Hence, the study revealed that mental health care interventions are rooted in the community and culture of Khyber Pakhtunkhwa, which supported the recovery and healing of victims of political violence.

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