Sosyal Bilimler
EKEVAKADEMİ
dergisi

eISSN:2148-0710 - pISSN:1301-6229

Makalenin geliş tarihi: 17.08.2023
1.Hakem Rapor Tarihi: 04.09.2023
2.Hakem Rapor Tarihi: 04.09.2023
3.Hakem Rapor Tarihi: 05.09.2023
Yayına Kabul Tarihi: 20.09.2023

TRADITIONAL PRACTICES IN ANATOLIA FOR PATIENTS WITH MENTAL DISORDERS IN THE CONTEXT OF FUNCTIONAL HEALING: A QUALITATIVE STUDY

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Abstract

Traditional methods have been used for the treatment of mental disorders throughout history. Although these traditional methods have changed in form, the underlying purpose and application methods have remained the same. The effect of these traditional methods on healing is as controversial as their long history. In the study, it was aimed to analyze the effect of the traditional methods used for treating patients with mental disorders on individuals in the context of functional healing. Phenomenological and qualitative research design was used in the study. 11-item semi-structured questionnaire form was used in order to collect the data. The questionnaire form was prepared by consulting with two experts who were specialists on the study subject. The questions in the questionnaire form were prepared in line with the culture of the region where the study was conducted. As for the type of questions, the participants were asked open-ended questions. The research was carried out by one researcher. In the analysis of the data, content analysis method was employed. While caregivers generally provided positive feedback for social functional healing and the roles and responsibilities in daily life as a result of traditional practices, they gave negative feedback for particularly drug compliance and work/school life. In the study, mostly social inclusion, involving in home routine, and spiritual methods were mostly used as traditional methods. Although individuals displayed partial healing in in social and daily life, the traditional methods preventing drug use kept individuals from their occupational/school lives.

Keywords: *Functional, Improvement, Anatolia, Nursing.*

İşlevsel İyileşme Bağlamında Mental Bozukluğa Sahip Hastalara Yönelik Anadolu'daki Geleneksel Uygulamalar: Nitel Çalışma

Öz

Tarihten bu yana mental bozuklukların tedavisinde geleneksel yöntemler kullanılmıştır. Geleneksel yöntemler şekil değiştirse de temelindeki amaç ve uygulama şekli değişmemektedir. İyileşmeye olan etkisi de yine yöntemlerin tarihi kadar eski tartışma temeline sahiptir. Bu çalışmanın amacı; işlevsel iyileşme bağlamında mental bozukluğa sahip hastalara yönelik anadolu'daki geleneksel uygulamaların bireyler üzerindeki etkisini incelemektir. Çalışmada fenomolojik ve kalitatif araştırma yöntemi kullanılmıştır. Verilerin toplanması için 11 soruluk yarı yapılandırılmış soru formu kullanılmıştır. Soru formu, çalışma konusu ile ilgili uzman olan iki bilirkişiye danışılarak hazırlanmıştır. Soru formundaki sorular çalışmanın yapıldığı bölgeye ait kültüre uygun hazırlanmıştır. Katılımcılara açık uçlu sorular sorulmuştur. Çalışmayı tek araştırmacı yürütmüştür. Verilerin içeriğinin değerlendirilmesinde İçerik Analizi yöntemi kullanılmıştır. Bakım verenler genellikle geleneksel uygulamaların sonucu olarak; sosyal işlevsel iyileşme ve günlük hayattaki rol ve sorumluluklar için olumlu geri bildirimler verirken, özellikle ilaç uyumu ve iş/okul hayatı için olumsuz geri bildirimlerde bulunmaktadırlar. Çalışmada geleneksel yöntem olarak daha çok topluma katma, ev rutinine dahil etme, spiritüel içerikli yöntemler kullanılmıştır. Bireyler sosyal ve günlük hayatta kısmen iyileşme göstermiş olsalar da, geleneksel yöntemlerin ilaç kullanmanın önüne geçmesi bireyleri mesleki/okul yaşantılarından uzakta tutmuştur.

Anahtar Kelimeler: *İşlevsel, İyileşme, Anadolu, Hemşirelik.*

1. Introduction

In today's world, it is observed that functional healing (FH) in mental disorders cannot be ensured adequately by the pharmacological agents used for this group of disorders (Eaton et al.,2008;

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Pham et al., 2021; Wittchen et al., 2011). It has been reported that especially antipsychotic agents fall short of eliminating the burden of the symptoms of disorders, that they may also create additional burden due to their side effects, and that they somehow cannot develop the compliance that is required for social adaptation. In order to provide FH, various treatment methos are applied to individuals with mental disorders in addition to pharmacological agents (Nortje et al., 2016). Besides standardized psychotherapy/psychoeducation, traditional/complementary interventions, which are influenced by the society's spirituality, religion, beliefs, and experiences, are also applied all over the world (Burns &Tomita, 2015; Greje et al., 2015; Hickie et al., 2013; Pham et al., 2021).

The low financial share allocated for the treatment of mental disorders in low/medium income countries is an effective factor in the use of traditional methods in such countries, and this situation is reinforced by low levels of education and awareness. In reality, this situation faces us as a human care and rights problems in low/medium income countries where individuals do not have access to services such as psychoeducation and psychotherapy (Burns &Tomita, 2015; Greje et al., 2015; Hickie et al., 2013; Pham et al., 2021).

Unique individuals also have unique mental health and mental health problems. Even when individuals enter a diagnosis process with the same symptoms, and they are exposed to the same treatment process, they follow a different course, as it is known. At this point, individuals' mental health processes and their reactions related to FH that develops depending on their mental health processes are also affected by the culture in which they live. Other than their individual characteristics, individuals are in interaction with the cultural characteristics of the society in which they live and especially with the society's attitude towards mental disorders. It seems that it is inevitable for an individual to be affected by social attitudes in a general sense (Fernando, 2010; Pham et al., 2021).

It has been reported that Anatolia is an important region where the first records of mental disorders were discovered. The fact that the power of believing-unbelieving in angels, the devil, sacrifice, and the God first emerged in this geography also sheds light on today's traditional mental health/disorder practices (Black & Green ,1992; Ünal 1998). It is known that there have been belief and practices in Anatolia since ancient times such as believing that an individual was sick as s/he did not believe in God, or forcing individuals with mental disorders to stay at home through physical detention methods so that they would not hurt others (Black & Green,1992; Ünal, 1998; Siddiq, 2018;). However, no study has been encountered in the literature that examined the traditional methods applied to individuals with mental disorders. In the literature review made, only one study conducted in Southeast Anatolia on 29 samples stood out (Fylon, 2005; Siddiq, 2018).

This qualitative study was conducted in order to reveal the current status of traditional mental health practices in Anatolia, to examine whether these practices are applied in combination with the medical therapy that should be continued, and to evaluate how current traditional practices affect FH of individuals.

2. Material and Method

2.1. Study Design and Participants

The study was conducted in Malatya province located in the east of Turkey between 15/10/2020-15/02/2021 Phenomenological and qualitative research design was used in the study. Phenomenological design is a qualitative research design that is used to determine individuals' understanding, emotions, perspectives and perceptions related to a specific phenomenon or concept and to understand how they define the phenomenon (Rose et al., 1995). The data were collected from the primary relatives of individuals with 8 psychotic symptoms. The data were collected through face-to-face interviews. An 11-item semi-structured questionnaire form was used to collect the data. In preparing the questionnaire

form, expert opinion was taken from two specialists. The questions included in the questionnaire form were prepared considering the culture of the region where the study was conducted. In order to ensure objectivity of the study, the study sample was chosen among individuals with psychotic symptoms who had at least high school or university education level. The primary caregivers who were interviewed within the scope of the study were chosen among the caregivers who had provided care for the individual with psychotic symptoms starting from childhood period. The participants of the study 1) were the primary caregivers who had provided care for the individual with a mental disorder as of childhood period, 2) were individuals with mental disorders who had high school or university education, 3) were diagnosed with a psychotic disorder in a period in their lives, 4) the primary caregivers from whom the data were collected did not have any neurological or mental disorders, 5) the primary caregivers did not have any communication problems. While 4 individuals studied had high school education, 2 were medical doctors, one of them was a teacher, and one of them was an accountant with university degree. The individuals who were examined were not currently receiving any medical therapy, although they had used drugs in the past. In the light of the information obtained from the caregivers within the scope of the study, it was analyzed how the traditional practices affected their functional healing.

2.2. Data Collection

In the collection of the data, semi-structured in-depth interview form was used. The participants were asked open-ended questions. The study was conducted by one researcher. The data of the research were made by voice recording over the phone. The questions of the semi-structured interview form were asked to the participants after obtaining permission from the participants to register. A researcher interviewed all participants. Interviews were continued with each participant until data saturation was reached. Each interview lasted approximately 20-40 minutes. The interviews were obtained by talking in an environment where both the researcher and the participant would not have connection problems and would not experience noise problems.

2.3. Data Analysis

In data analysis, content analysis method was employed. Content analysis is a method that is developed for reproduced and valid results (Graneheim & Lundman, 2004). Focus group discussions were recorded on video. The discussions were watched by two independent experts, and similarities and differences were determined, as a result which codes were created. Main themes and subthemes were determined for similar codes determined (Corbin & Strauss, 1990; Graneheim & Lundman, 2004).

The following steps were followed for the analysis;

1) Transcription of audio files for transcoding with MAXQDA. Having the opportunity to read at this stage also made it easier for all experts to return to texts again and again.

2) The texts deciphered in MAXQDA were read repeatedly by all researchers.

The resulting expressions

3) in step 3 are formulated.

4) In step 4; sub and main categories were classified. (This is done by clustering, as MAXQDA allows.)

5) Last but not least; The relationship between alt codes and themes (with MAXQDA) was analyzed (Gizzi &Radiker, 2021; Kuckartz & Radiker, 2019; Radiker, 2020;).

2.4. Ethical Considerations

Informed consent was taken both from the individuals with psychotic symptoms and the primary caregivers. In addition, ethical approval was obtained from Cankırı Karatekin University Ethics

Committee. It has been reported that it is ethically appropriate as a result of the 05.10.2020 /20 date and meeting.

3. Results

3.1. Field Data Collection Interview (Primary Caregiver Interview Questions)

With the interview questions, it was aimed to explain the traditional practices of the caregivers, and to evaluate the functionality areas (social, psychological, occupational, family, health, treatment) of the individuals with psychotic symptoms and diagnosis using/not using medication for whom they provided care, and traditional practices.

Table 1. *Open-ended interview questions in the questionnaire form asked to primary caregivers*

Questions	Question Text
1	What is your relationship with the individual diagnosed with a mental disorder?
2	How old is the individual diagnosed with a mental disorder?
3	At what age did the individual diagnosed with a mental disorder start to experience symptoms related to the diagnosis??
4	What are your observations related to the social relations of the individual diagnosed with a mental disorder?
5	With what is the individual diagnosed with a mental disorder occupied in his/her work life or social life?
6	How are the attitudes of other people towards the individual you provide care for?
7	What reaction is shown by other family members to the decisions, thoughts, and emotions of the individual diagnosed with a mental disorder?
8	What difficulties do you experience with the individual diagnosed with a mental disorder?
9	How did the treatment of the individual diagnosed with a mental disorder proceed after s/he was first hospitalized?
10	What practices are applied among the general public in your region as regards the treatment of individuals diagnosed with a mental disorder?
11	What traditional practices did you apply to the individual diagnosed with a mental disorder as caregiver/other family member?

Some characteristics of individuals diagnosed with mental disorders mentioned by the caregiver are given in Table 2.

Table 2. *Descriptive Features*

Caregiver No	Kinship of the Caregiver/Gender of the Individual	Symptom Onset / Current Age of the Individual with Mental Disorder	Symptom Onset / Current Occupation of the Individual with Mental Disorder
1	Mother/Male	20/56	University student/Retired doctor
2	Mother/Female	19/59	High school graduate/High school graduate (Unemployed)
3	Mother/Female	21/60	High school graduate/High school graduate (Unemployed)
4	Mother/Male	21/61	University student /Retired teacher
5	Sister/Female	22/59	Civil servant /Retired
6	Mother/Female	20/58	Civil servant Retired
7	Mother/Male	24/61	Teacher/Retired teacher

8	Mother/Male	26/62	Doctor/Retired doctor

The main theme and sub-themes of the study were determined as follows.

Table 3. *Sub-themes created two independent experts within the scope of the study*

Main theme	Sub-themes
Effect of traditional mental health practices on functionality	Effect on social functional healing
	Effect on work/school life
	Effect on starting and maintaining treatment
	Effect on healing in daily life

3.2. The Effect of Traditional Mental Health Practices on Social Functional Healing

The individuals with mental health problem examined and the primary caregivers from whom the data were collected had received support from their social environment when the symptoms emerged and afterwards, and they had not withheld any information. They had not detached the individual from responsibilities along with their environments; for example, the individual had continued to take care of the animals or gone to work in the field with friends. Family members and caregivers had continuously checked the individuals especially in the acute period when positive symptoms (hallucinations, illusions, etc.,) started to emerge, while ensuring that they continued to do the routine chores with their friends and relatives.

"When symptoms started, it was the spring. They were going to plant chickpeas. My son was studying medicine in another city. He used to come and help his father in the spring time for about 10 days. That year when he came, I sometimes would find him sitting in the couch in the courtyard talking to himself and getting frustrated. But, as I thought that his courses were difficult, I would not interfere. Early in the morning, he would go to the field on the tractor with his father and our relatives. They would go to the village coffee house in the evening. Our relatives and villagers would continuously tell us that we were exhausting the boy too much. They insisted that we should have lead cast over his head, and we did, but he got more frightened. He could not return to his school that year. He stayed and helped us." (Caregiver No.1)

"Everyone in the village was saying that my daughter was trying to draw attention in order to get married. In those times, we would carry drinking water from the village fountain to our homes. My daughter started to pour water on the street while carrying it home. She would also throw away the buckets to the street while coming come. I started to accompany her. Sometimes, her friends would go with her. When she was accompanied by someone, she would not get frightened. Therefore, I would send both her brother and cousin with her when she went to graze the sheep in the morning. I would pray for them when they were leaving the house." (Caregiver No.2)

3.3. The Effect of Traditional Mental Health Practices on Work/School Life

It was understood from the data obtained that individuals were generally separated from work or school life or could not continue their work/school lives for a certain period. Primary caregivers usually display "overprotective" behaviors. In addition to applying traditional mental health practices in line with the culture of the region where they lived (keeping the individual that shows primary symptoms in a dark room, using incense to exorcise, visiting the graves of people who are believed to be close to the God spiritually and getting the individual to lie on the grave alone, etc.), the caregivers of the individuals from whom the data were collected also preferred to "have the individual continue to live his/her social life in a secure area within the society" similar to today's "society mental health practices."

However, occupational functionality, which is important for the individual, was procrastinated on the grounds of "safety."

''We saw that it was impossible to continue like this. We told him to drop the school. He would not do the profession anyway when he became a teacher. What would his friends do with someone who spoke to himself and was afraid of them? We did not find our son on the street. Everyone in our village liked us and him a lot. What would I do if someone hurt him? Just to make sure that our son was okay, I told his father to get him to drop the school. He was in fact very smart; we could not understand how he turned out to be so. We did not know about the disorder, either. His father did not even take him to the doctor so that he would not go out. We put him to all kinds of work in the village. Vineyard, garden, … . His friends were very helpful, too… From time to time, I would invite his friends over and prepare food for them so that he would not get bored. We had never taken him to any entombed saint to heal him. I do not believe in such nonsense. Family and friends are the best remedy. This is what we learned from our elderly." (Caregiver No.4).

"She wanted to go to work. And, she went… She used to work in a government office. She got restless, she sometimes cried a lot at work, and she sometimes had fights with everyone. She had already started to smoke excessively. In those times, telephone was a rare thing, we could not talk often, and we were very worried at the same time. (The caregiver started to cry. There was a moment of silence.) … Her father died when she was too young. I sent word to her brother to take her from the city and bring to the village. We also had a house in the city, but what would she do there on her own? Everyone would call her "lunatic" … She would lose all her mind there. We got her to quit her job. I told her brother to 'take her to the doctor', but he did not. I was not so clever at that time; he said 'the government would fire her anyway claiming she went mad'. There is a shrine around our village. They say the man lying there was an important dervish. We frequently took her there. And there was a black stone at the entrance; we would touch it with our faces. The God must have heard our prayers; her sister in Istanbul came home. She said there was a doctor there, and she took her to that doctor. I said the "healing pray" that my grandfather taught me 101 times the day before she went to the doctor. Thank God, the medications worked well at that time. She even went to work 6-7 months later." (Caregiver No. 6).

3.4. The Effect of Traditional Mental Health Practices on Starting and Maintaining the Treatment

As the caregivers were usually mothers (7 caregivers were mothers in the study), they did not want to leave their villages in order to protect their children. They expressed the safe area as their villages where they lived with their relatives and others. They also stated that they believed that under the influence of the medication prescribed if they took their children to the doctor, their children would not deal with the work in the village and their condition would exacerbate. They even thought that the individuals who received treatment would never go to school or work again. Nevertheless, since the children of two caregiver mothers (one was studying medicine in the third year, and one was a medical doctor) were doctors, it was not difficult for these mothers to have access to a specialist and start treatment for their children. These two individuals, who were reported to be taking no medication treatment, were interviewed separately. These two individuals both had insight and their occupational functionality discontinued as they were retired.

"I said so many times that we should take her to the doctor, but my husband would tell my daughter studying at high school and sitting idly before us every day at night what works she would do the next morning. He would repeatedly say that no one would marry her if she took medication. My daughter would not speak much, but sometimes she would get so frustrated that she almost beat me a few times at home. I must tell the truth that I sometimes would get very angry; then, she would become

totally quite, and I would say prayers for her in certain numbers. In fact, whenever she started to go crazy, there was a set of prayers for her in an order; whoever was with her would say those prayers." (Caregiver No.3)

"My son quit his job and came. We thought he would know his condition better as he was a doctor. He said he would stop taking medication. In fact, he was getting even worse when he took the medicine. But, when he stopped taking his drugs, he started to walk back and forth in the house, talking to himself. He would not go out much. Whenever a villager felt ill, they would come to him. He would not turn down anyone. He did not occupy himself with anything for 2-3 years; he just helped the villagers. He would never take any medicine. Sometimes, children and women were afraid to sit close to him (as he was incessantly talking); then he would say that he would not hurt anyone and that his mind was working that way; there was nothing to do about it. Actually, everyone got accustomed to him. I would visit Khidr and light candles every Thursday. I fasted 24 months. My son went to visit one of his teachers. He also prescribed medicine, but I never saw him taking it. He went back to his job and retired later. But, he is still talking to himself, and we got used to him…" (Caregiver No. 8)

3.5. The Effect of Traditional Mental Health Practices on Healing in Daily Life

Among the traditional practices applied regarding healing of functionality in daily life, being involved in work and social routine in the area where one lived and visiting the graves of figures that are thought to be close to the God stood out. For instance, as the importance of being "clean" was emphasized (the importance of cleanliness in religious rituals is clearly indicated), it was understood from the data obtained from the primary caregivers that the individuals with mental disorders followed daily hygienic rules every morning, that they fulfilled the responsibilities assigned to them in the family, and that they felt secure while doing their daily routines, but it was also inferred that family members ignored the fact that individuals might not fulfill the roles and responsibilities, that they might be afraid of the animals in the open areas where they are sent alone, and that they run the risk of being hurt by other people living in the village. Nevertheless, the daily routine followed ensures that what the individual will do in a given day becomes definite.

"*My son would come to the village in the summer as he was a teacher. He has a nervous character. His students used to be frightened by him to a certain extent, but he really loves children. He raised vey successful children. He even tutored them in his own house. When he arrives in the village, what he will do is already defined. He always comes with his family. Firstly, he and his children do some repair work in the house, Then, the field work comes. His father left all work to him. We are too old for such work. In the daytime, they go to the field in the morning, and when they return home, their meal is ready. Sometimes, he works on the tractor. We go to bed early at night. My son prays five times a day, and he regularly performs ablution. In fact, as it is too hot in the summer, everyone takes a shower at least once a day in daytime." (Caregiver No. 7)*

"Every morning, my sister would go to her job. As we lived in the same house, our daily routines were defined. We even shared our salaries. We would not spend excessively at home. Sometimes, I would wake her up so she would not be late for work. There was a certain time when we came back home. No one would return home after 8 in the evening. She always followed the rules. She would buy things needed at home while she was returning. Her room was tidy. She was preparing for a promotion exam at her office, but as she did not want to take medicines, she was a bit restless. She was afraid of people, and people were afraid of her. I and my mother would take her to the hearth that we were members of. The old man (priest, religious leader) there would say prayers for us. He would tell us that my sister should not stay away from daily routines, that our family would heal her, and that she should take her medicine regularly to get better. My sister would heed him. She would say medicine made her feel better,

but she took the medicine for 2 years and then stopped. Maybe because of this, she would cry and ask why she was acting like that. The next day, we would return to our daily routine." (Caregiver No. 5)

4. Conclusion, Discussion and Recommendations

The caregivers from whom the study data were collected mentioned pictures in which positive symptoms were intense, and negative symptoms were rare. It was mentioned that the social functionality of individuals who experienced the first symptoms without being subjected to discrimination in their own environment as a traditional intervention was not affected. From the perspective of the literature, it is understood that the positive symptoms experienced by individuals were useless without medication, ant that it was necessary for them to be treated with medicine in this acute period in order to gain insight (Bornheimer, 2019; Lyne et al., 2018; Londgen et al., 2020). However, the sustainability of social functionality" of individuals who were not separated from their environment and followed their routines was ensured in line with "social mental health" interventions applied today (Fisher, 2021; Kohrt et al., 2018; Turner et al., 2018). It is believed that this situation resulted from the "healing" approach adopted in Anatolia throughout history regarding mental disorders and mentally ill individuals (Gençel 2006; Yücel, 2016).

Increased social dysfunction, lack of insight, and intense stigmatization bring along problems that result in occupational and academic dysfunction in individuals with psychotic symptoms (Bartholomeusz et al., 2013; Driessens, 2007). Today, it is known that medical treatment yields effective and positive outcomes in terms of gaining insight, increasing functionality, and functional healing along with interventions such as psychotherapy and psychoeducation (Kern, 2009; Santesteban et al., 2017; Valencia et al., 2012). It was observed from the data obtained from the primary caregivers that they did not apply traditional practices commonly applied by the society such as physical detention and keeping the individual in a dark room. Although they applied the practice of "involving in the community", which is a more advanced way considering the period and the society they were in, they seemed to have adopted an approach that ignored medical treatment. While this situation maintains social functionality, it yields negative inadequate results in terms of occupational and academic functionality.

In a study conducted in Uganda, it was reported that traditional healing methods proved effective in the healing of psychosis when applied along with modern methods (medical treatment) (Abbo et al., 2012). In another study conducted in Sudan, it was stated that traditional healing methods had positive effects on negative and positive symptoms in psychosis (Sorketti et al., 2013). In the present study, the individuals who did not take medication did not show sufficient improvement as a result of traditional practices that only involve socialization and religious rituals. There is considerable information in the literature regarding positive results obtained in terms of functionality as a result of drug compliance along with spiritual approaches (Borras et al., 2007; Huguelet et al., 2010; Mohr et al., 2010). Although the individual who was provided with care by Caregiver No. 7 had considerable insight, positive symptoms prevented him from doing his job for a long period. And, this situation continued due to lack of drug compliance. Besides, another point to consider is that it is thought that drug compliance might hamper the tasks to be assigned to the individual by family members.

Ina study conducted, the "understanding" of culture regarding mental disorders was emphasized. It was concluded in the study that cultural perspective should be broadened in order to understand the nature of mental disorders and contribute to healing (Slade et al., 2014). In the present study, it was determined that compliance with daily routines was ensured in individuals, but assigning individuals more tasks than they could accomplish by the caregivers and other family members might affect daily healing. Saying prayers, performing the salaat, and getting advice from a religious leader used as traditional practices are both a result of culture and beliefs. While these traditional methods contribute

to daily healing, it is seen that keeping the positive symptoms of individuals who do not use medication under control seems to be difficult. Still, individuals being successful in occupational terms, having targets, and developing good relations with the people they are in contact show "the awareness of having a mental disorder and experiencing related symptoms." For example, it has been reported that both in the Chinese society and the Chinese literature, "natural healing with natural elements" routines positively affect healing that also covers daily life (Thing et al., 2020).

In the study, it was determined that traditional methods that were mostly used were spiritual methods such as involving in the community, including in home routines, guiding towards establishing relations with people who love the individual in order to prevent stigmatization, saying prayers, visiting a shrine, getting advice from a religious leader, and compliance with the dynamics of religious rituals. Although the individuals exhibited partial healing in social and daily life, prioritizing traditional methods over medical therapy kept the individuals away from their work/school lives. The individuals gained insight over time, they used medication from time to time, and 2 of them returned to school, while 4 of them went back to work. In conclusion, individuals can "heal functionally" in their own culture, but together with drug compliance in today's conditions, faster occupational and academic healing can be achieved, and individuals will not only display healing in their cultural environment, but they will also heal in a social sense.

Limitations

The group included in the study consisted of people who were educated and "had the privilege to study in quality schools", and their family members were people who abstained from enforcing methods. This situation may not represent all traditional practices and cultural structures in the region.

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