ORIGINAL ARTICLE

# Role of culture and religious beliefs on non-medical help-seeking behavior among patients with chronic mental illnesses (CMIs) in Türkiye

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## ABSTRACT

**Background:** Cultural beliefs significantly shape societal attitudes toward mental illness, and these social attitudes profoundly impact help-seeking behaviors. Therefore, it is important to focus on understanding and addressing these social behaviors.
**Aim:** This study aimed to evaluate the effect of chronic mental illness interpretations based on culture and religious beliefs on non-medical help-seeking behaviors among patients in Türkiye.
**Methods:** The study was conducted from September to October 2023 using an inductive qualitative approach. In-depth face-to-face interviews were carried out with individuals diagnosed with chronic mental illness and their relatives, registered in a state-owned Community Mental Health Center (CMHC) in Türkiye. Using purposive sampling, 13 individuals who met the criteria were interviewed. Thematic analysis was used to identify themes.
**Results:** Three main themes and eight sub-themes were identified, including the reasons for seeking non-medical help (psychological challenges, subjective norms, physical requirements), factors contributing to seeking non-medical help (predisposing factors, enabling factors, and myths), and reflections on the benefits of non-medical practices (perceived physical benefits, perceived psychological benefits).
**Conclusions:** It was concluded that individuals with chronic mental illness and their relatives living in the Eastern Anatolia Region of Türkiye engaged in non-medical help-seeking behaviors and mostly turned to traditional religious practices. Culture and religious beliefs emerged as primary factors leading patients to seek non-medical treatment approaches. Consequently, there is a perceived need to explore non-medical alternative methods across various mental health settings and with diverse samples in future research endeavors.

**Key words:** Chronic mental illness, cultural belief, non-medical help-seeking behavior, religious belief, Türkiye

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**Submitted:** 15-Jan-2024, **Revised:** 01-Jul-2024,
**Accepted:** 18-Jul-2024, **Published:** 19-Aug-2024

| Access this article online | |
|---|---|
| **Website:** https://journals.lww.com/indianjpsychiatry | Quick Response Code |
| **DOI:** 10.4103/indianjpsychiatry.indianjpsychiatry_57_24 | |

## INTRODUCTION

Chronic mental illnesses (CMIs) are defined as mental conditions that affect individuals' cognition and emotions



How to cite this article: Ediz Ç, Uzun S, Mohammadnezhad M, Erdaş MB. Role of culture and religious beliefs on non-medical help-seeking behavior among patients with chronic mental illnesses (CMIs) in Türkiye. Indian J Psychiatry 2024;66:695-703.

for more than three months. They include depression, mood disorders, and other psychotic disorders that lead to impaired functioning in self-care, social relationships, work life, and leisure activities.[1] CMIs are a combination of abnormal thoughts, feelings, behaviors, perceptions, and relationships with others.[2] CMIs pervade all societies, irrespective of socioeconomic levels, cultures, and geographical regions. According to the World Health Organization's (WHO) 2019 data, approximately 264 million people worldwide are affected by depression, 45 million by bipolar disorder, and 20 million by schizophrenia and other psychotic disorders.[2] There is no recent statistical study on this subject in Türkiye. In this context, the Türkiye Mental Health Profile Survey (TMHPS), conducted in 1998 and regarded as the most comprehensive study in this field, revealed that 18% of the population had experienced mental health-related issues at least once in their lifetime. Similar findings were found in the Türkiye Burden of Disease Study (TDBS), conducted by the Ministry of Health in 2004.[3] The adverse effect of mental illnesses on individuals' emotions, thoughts, and behaviors, coupled with their tendency to become chronic and the elusive nature of their causes, often leads patients and their families to seek non-medical interventions.[4] The patterns of seeking and receiving help play a pivotal role in the treatment and psychosocial outcomes of CMIs. Various factors, including the duration and severity of the illness, age, gender, educational background, prior healthcare experiences, marital status, cultural norms, and religious beliefs, influence help-seeking behaviors.[4,5]

Cultural and religious beliefs play a significant role in shaping societal attitudes toward mental illness. Additionally, these beliefs and social attitudes have a profound influence on individuals' behaviors when seeking help for mental health issues.[5,6] The prevalence of non-medical practices deeply rooted in social cultures, often perceived as natural and free of side effects, contributes to the adoption of such practices.[6] Sarıkoç *et al*.'s[5] (2015) study revealed that 81.2% of relatives of individuals with mental illness expressed a belief that non-medical treatments posed no harm to patients.

Those who are suffering from CMIs may have different non-medical-seeking behaviors. In Türkiye and various cultures, non-medical treatments are frequently employed by patients with CMIs. Relevant studies in Türkiye revealed that common help-seeking behaviors among chronic psychiatric patients include consulting religious officials and shrine visits,[7] engaging with traditional healers (hodja, shrine, hospital, amulet, special prayer, herbal medicine, lead pouring, leech, and meditation) at a lower rate.[5] Another study in Türkiye indicated that 89.3% of caregivers preferred religious approaches for their patients.[6] A study examining the non-medical help-seeking behaviors of Turkish psychiatric patients in Türkiye and Germany found that the most common non-medical treatment-seeking behavior was seeking guidance from religious leaders (74.4% in Türkiye and 87.9% in Germany).[4] In a US study on individuals with CMI, alternative healthcare practices include meditation, massage, yoga, and catathymia practices, often followed by religious or spiritual practices.[8] Patients' relatives in African culture rely on herbal medicine, priests, and traditional healers for patients.[9] In India, more than half of the patients' relatives of patients with schizophrenia and other psychotic disorders resort to faith healers.[10]

In Türkiye and different societies, relatives use non-medical practices to treat CMI. Understanding the help-seeking behaviors of individuals with CMI and the methods used by patients and their families other than medical treatment is crucial for guiding and raising awareness about receiving correct and effective treatment. In this context, this study aimed to explore the role of culture and religious beliefs on the non-medical help-seeking behaviors of individuals with CMIs in Türkiye.

## MATERIALS AND METHODS

### Study design and setting

This qualitative study was conducted between September 2023 and October 2023 using an inductive qualitative approach. The authors adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines, ensuring the comprehensive reporting of their research process.[11] A qualitative study helps researchers explore the knowledge, perceptions, and experiences of participants.[12] In-depth face-to-face interviews were carried out with those diagnosed with CMIs and their relatives, all registered in a state-owned CMHC in Van (a city in the eastern Anatolia region), Türkiye. Although modern medical methods are accessible even in the remotest areas of Türkiye, non-medical treatment methods are still widely used, particularly in the eastern regions.[4]

### Study sample

The inclusion criteria include: (a) being diagnosed with at least one of the CMIs; (b) having sought non-medical help at least once during their illness; (c) being able to communicate appropriately; (d) being registered in a state-owned CMHC; and (e) agreeing to participate. The exclusion criteria were: (a) having language, speech, or hearing impairments hindering communication; and (b) refusing to participate.

In the region where the study was conducted, most non-medical practices are through family referrals. Given this situation, patients' relatives were included in specific interviews to ensure the accuracy of patients' information regarding the symptoms of non-medical practices. Within our sample, the information provided by the relatives of six patients who agreed to participate was verified against the information provided by the patients, increasing the

depth of understanding. Similarly, within our sample, data were gathered from the relatives of six patients to enhance the depth of understanding. The inclusion criteria for the relatives are (a) being able to communicate appropriately; and (b) agreeing to participate. The exclusion criteria for the relatives are (a) having language, speech, or hearing impairments hindering communication and (b) refusing to participate.

### Sampling and sample size

The study participants were chosen using a purposive sampling method. Participants were registered in a state-owned CMHC in Van, a city in Türkiye. Accordingly, 23 patients registered in the CMHC were included in the study. Thirteen participants were interviewed until data saturation was achieved.[12]

### Data collection tool

A semi-structured, open-ended questionnaire was used for the interviews [Table 1]. The questionnaire was developed based on a literature review and research questions. It consisted of two parts: the first covered demographic information (age, gender, marital status, occupation, socioeconomic status, and whether the individual has engaged in non-medical help-seeking behavior, etc.), and the second contained five open-ended questions. Probe questions were asked following the main questions. The Turkish version of the questionnaire was tested in a pilot study with a few patients to ensure the questions were understandable and to identify potential challenges in conducting interviews, allowing for solutions to be implemented during the data collection stage.

### Study procedure

To inform patients and their families, flyers were installed in the CMHC two weeks before recruiting them. An information sheet was provided to those who met the criteria. Those willing to participate were asked to sign a written consent form. Face-to-face, in-depth interviews were conducted by the main researcher, who had previous experience conducting interviews with each participant to explore their thoughts on non-medical help-seeking behavior. Interviews were conducted in a private room at the CMHC. During the interviews, participants were prompted to elaborate on their responses with questions like “Can you explain your answer a little more?” and “What do you mean by this?” All interviews were recorded with a Sony voice recorder.

### Data analysis

Following the interviews, the recorded interviews were transcribed verbatim by the main researcher and checked by the second researcher. Data analysis employed the 7-stage method developed by Colaizzi (1978) for phenomenological studies.[12] The interview texts were independently and repeatedly read by two researchers to comprehend the conveyed information. Key statements were selected, reorganized, and expressed in general terms. The data within the statements were identified and analyzed. Researchers formulated and confirmed meanings through discussions until a consensus was reached. Themes and sub-themes were then identified and organized. The study’s themes and sub-themes were developed through a clear statement narrative, and participant statements were included for reader verification of data interpretation and analysis.[13,14]

### Study rigor

Study rigor refers to the quality, authenticity, and truthfulness of the findings of qualitative research, relating to the degree of trust or confidence readers have in the results. Key components of study rigor include credibility, transferability, dependability, and confirmability.[15] These criteria and the associated strategies used in this study are discussed in Table 2.

**Table 1: The semi-structured interview questions**

| |
|---|
| 1. When did you realize your illness, and how did you interpret it? |
| 2. How long after realizing your illness did you take action to seek help? What actions did you take, and where and to whom did you apply? What influenced your choice of non-medical help? |
| 3. How did the non-medical center(s) you received help from interpret your illness? What treatment was offered, and were you charged a fee? |
| 4. Did you follow the recommended treatment method? How long did you follow the treatment, and do you believe you benefited from it? |
| 5. Are you planning to use non-medical practices again? Why? |

**Table 2: Summary of criteria and strategies applied for the study rigor**

| Criteria | Strategies |
|---|---|
| Accountability | To inform patients and their families, flyers were installed in the CMHC two weeks before recruiting them. Those willing to participate were asked to sign a written consent form. In-depth interviews were conducted for one week, and each one lasted 35–45 min. Following the interviews, the recorded interviews were transcribed verbatim by the main researcher and checked by the second researcher. Every step of the study and its results were discussed with the researchers. |
| Dependability | Data analysis employed the 7-stage method developed by Colaizzi (1978) for phenomenological studies.[12] The interview texts were independently and repeatedly read by two researchers to comprehend the conveyed information. Key statements were selected, reorganized, and expressed in general terms. Researchers formulated and confirmed meanings through discussions until a consensus was reached. Themes and sub-themes were then identified and organized. All data was coded manually, and all coding was checked and re-checked thoroughly. |
| Confirmability | The study utilized a semi-structured, open-ended questionnaire to conduct interviews. The data was checked by the co-authors. |
| Transferability | Purposive sampling techniques were used in the research, and in-depth interviews were carried out until data saturation was achieved. |

### Ethical considerations

Ethical approval was obtained from the Hakkari University Scientific Research and Publication Ethics Committee (dated August 24, 2023, numbered 2023/97-01). In addition, official permission was obtained from the relevant institution where the study was conducted. Verbal and written informed consent were obtained from all participants before initiating the interviews. Recordings and transcripts were stored on a password-protected device, ensuring confidentiality and data integrity. The study adhered to the principles of the Declaration of Helsinki and followed ethical standards.

## RESULTS

The study included individuals with a mean age of 40.46 ± 9.60 and an average illness duration of 14.30 ± 6.99 years. Among the participants, ten were single, and seven were male. Seven participants had a primary school degree. The detailed demographic characteristics of the participants are provided in Table 3.

### Themes identified

Three main themes were identified, including the reasons for seeking non-medical help, factors contributing to seeking non-medical help, and reflections on the benefits of non-medical practices. Each theme includes different sub-themes that are summarized in Table 4. In this section, the participant's quotations are presented with the number allocated to each participant, such as P1, P2, P3...

### Theme 1. Reasons for seeking non-medical help

This theme includes three sub-themes that explore the reasons for seeking non-medical help, mostly from the religious shrine, as explained below.

#### *Psychological challenges*

Based on the information from the interviews, individuals displayed non-medical help-seeking behaviors due to a range of emotional and psychological challenges like fear, nervousness, pessimism, hopelessness, considering oneself as a prophet, experiencing visual hallucinations, believing in the casting of spells, fearing the evil eye, a sense of helplessness, mental collapse, and having suspicious thoughts.

**Table 3: Characteristics of the study participants**

| Participant number | Age | Gender | Marital status | Education level | Occupation | Socioeconomic state | Duration of the illness | Type of the illness | Place of residence |
|---|---|---|---|---|---|---|---|---|---|
| P1 | 49 | Female | Married | Primary school | Housewife | Middle | 15 years | Schizophrenia | City |
| P2 | 28 | Female | Single | University | Unemployed | Lower middle | 5 years | Bipolar disorder | City |
| P3 | 37 | Male | Single | Primary school | Self-employed | Lower middle | 12 years | Schizophrenia | City |
| P4 | 25 | Male | Single | Primary school | Unemployed | Lower middle | 3 years | Psychosis | City |
| P5 | 38 | Male | Single | Primary school | Self-employed | Lower middle | 15 years | Schizophrenia | City |
| P6 | 55 | Female | Single | High school | Housewife | Lower middle | 30 years | Schizophrenia | Village |
| P7 | 45 | Female | Single | Primary school | Housewife | Lower middle | 15 years | Schizophrenia | District |
| P8 | 42 | Male | Single | High school | Self-employed | Upper middle | 15 years | Schizophrenia | City |
| P9 | 34 | Male | Married | High school | Civil servant | Lower middle | 10 years | Bipolar disorder | City |
| P10 | 42 | Female | Single | High school | Self-employed | Lower middle | 15 years | Schizophrenia | City |
| P11 | 31 | Male | Single | High school | Unemployed | Middle | 10 years | Bipolar disorder | City |
| P12 | 44 | Female | Single | Primary school | Housewife | Lower middle | 22 years | Schizophrenia | Village |
| P13 | 56 | Male | Married | Primary school | Self-employed | Lower middle | 19 years | Bipolar disorder | District |

**Table 4: Summary of themes, sub-themes, and codes**

| Themes | Sub-themes | Codes |
|---|---|---|
| Reasons for seeking non-medical help | Psychological challenges | Fear, Irritability, Pessimism, Hopelessness, Considering oneself as a prophet, Visual hallucinations, Believing that a spell has been cast, Thinking of the evil eye, Despair, Mental depression, Skeptical thoughts |
| | Subjective norms | Family wishes, Relative/neighbor recommendations, Finding non-medical conditions useful, Avoiding social stigma |
| | Physical requirements | Sleep problems, Not finding medical treatment useful, Fatigue, Weakness, Loss of appetite |
| Factors contributing to seeking non-medical help | Predisposing factors | Consulting a religious leader, Wearing an amulet, Visiting religious turbes/shrines, Carrying a sheik's cloth on the body, praying, Being hypnotized by the religious leader |
| | Enabling factors | Self-acceptance, Praying, Return to spirituality, Dreaming, Yoga, Meditation, Receiving social support. |
| | Myths | Drinking blessed water, Long stay in a dark room, Talking to and believing in non-human beings, Divorcing, Exercising, Massage, Drinking chamomile tea, Yoga, The religious leader hit the head with a stick. |
| Reflections on the benefits of non-medical practices | Perceived physical benefits | Reduced sleep problems, Reduced fatigue, Reduced appetite |
| | Perceived psychological benefits | Reduction of anxiety, Reduction of fear, Spiritual healing, Reduction of anger, Reduction of tension, Reduction of delusions |

One of the participants stated that due to some psychological symptoms that consistently affected his daily life, he preferred to follow various non-medical supports advised by religious shrines.

> *"I was a university student at the time and feeling a deep sense of pessimism and hopelessness. It was like I couldn't catch my breath, and it felt as if the world was coming to an end for me. I thought it might be a psychological issue. After a few months of experiencing these symptoms, I went to a doctor. I underwent a month of treatment in a psychiatric facility. After being discharged, I went with my mom to a religious shrine. I didn't feel completely healed through conventional treatments, so we decided to search for non-medical alternatives, and we tried six different religious sources." (P2, a 28-year-old female).*

It is commonly believed that religious officials are the most effective healers for mental illnesses.

> *"I was experiencing constant fatigue and having a psychological breakdown. My relatives said I had a demon inside me. In our region, it was common for everyone to take their patients to a religious official in such cases. My family also believed that their religious official could cure my illness." (P8, a 42-year-old male).*

### *Subjective norms*

The interviews also revealed that individuals turned to non-medical practices due to family requests, suggestions from relatives or neighbors, the belief that these approaches would be beneficial, and a desire to avoid social stigma.

One of the participants explained that they sought non-medical help due to the lack of progress with medical treatment.

> *"I underwent a month of treatment in a psychiatric facility. After being discharged, my mom consistently took me to religious leaders because I didn't see any improvement with medical treatment. Additionally, people around us recommended these non-medical approaches, claiming that others with similar conditions had been healed by religious leaders. One religious leader made an amulet for me to wear, another hit me on the head with a stick, and a sheik recited prayers over me in a dark room in a shrine until I fell asleep. Some of them also advised me to stop taking the medications prescribed by the doctor, which I did for a while as they suggested." (P6, a 55-year-old female).*

Participants perceive that seeking non-medical support helps them remain anonymous and avoid being stigmatized as mental health patients in society.

> *"I chose non-medical help because psychiatrists are often stigmatized as 'mad doctors' in our society, and I wanted to avoid being labeled as mentally ill in my environment." (P9, a 34-year-old male)*

### *Physical requirements*

Participants preferred non-medical behaviors due to issues such as sleep problems, perceived ineffectiveness of medical treatment, fatigue, weakness, and loss of appetite.

Some cited physical reasons, including the belief that non-medical approaches would be beneficial, as well as fatigue and weakness.

> *"I constantly felt fatigued and experienced a mental collapse. Believing it might be a psychological issue, I sought help from religious leaders. I chose non-medical help because psychiatrists are often stigmatized as 'doctors for the mad' in society, and I wanted to avoid that label." (P3, a 37-year-old male)*

They believe that non-medical approaches would be beneficial for sleep problems.

> *"My wife had sleep problems. One of our relatives advised us to go to a religious teacher. We heard that he was good for others with such diseases before, so we did." (P2, a 28-year-old female)*

## Theme 2. Factors contributing to seeking non-medical help

This theme comprises three sub-themes that delve into the factors contributing to seeking non-medical help, outlined as follows.

### *Predisposing factors*

Participants described their engagement in various religious practices as part of their non-medical efforts, such as seeking guidance from religious leaders, wearing amulets, visiting religious shrines, carrying a sheik's cloth, praying, and undergoing hypnosis by a hodja.

It is commonly accepted that various religious practices use non-medical help as an option to cure mental illnesses.

> *"I was told that someone had cast a spell on me and that I was affected by the evil eye. The religious leaders I visited made talismans for me or gave me blessed water to drink. They also emphasized the importance of not neglecting my religious duties and encouraged regular prayer. One religious leader at his center hypnotized me, suggesting that I was communicating with Jinni. I drank blessed water for six months. Unfortunately, my condition worsened, and I developed paranoid thoughts, suspecting that my spouse was being unfaithful." (P13, a 56-year-old male)*

A series of actions were taken by religious officials to treat patients with mental illnesses.

> *"A religious leader told me not to worry. He gave me an amulet to keep with me. He said I would get better. Another one we visited gave me water with prayers to drink. Some other religious leader took blood from my ear, but I don't remember why he did that." (P5, a 38-year-old male)*

### *Enabling factors*

Participants reported that self-acceptance, yoga, prayer, dealing with spirituality, and dreaming were non-medical practices they engaged in.

One participant reported that she felt good enough to accept his illness.

*"I've accepted my illness, and I've got used to living like this. Accepting it feels good to me." (P6, a 55-year-old female).*

One participant reported that engaging in spirituality had helped him with his mental illness.

*"I am a religious person, and seeking spirituality to overcome my illness makes me feel good. However, I understand that medication is crucial in treating this kind of psychiatric condition." (P9, a 34-year-old male)*

*Myths*

Participants reported engaging in various practices such as drinking blessed water, staying in a dark room for an extended period, communicating with and believing in Jinni, getting a divorce, exercising, getting married, receiving massages, drinking chamomile tea, practicing yoga, and having a religious leader hit them on the head with a stick.

Most participants believe that the evil eye is linked to mental illness and that wearing amulets can help protect against it.

*"My relatives told me I was scared and affected by the evil eye. One imam made an amulet for me and told me to keep it. The other one asked us to hang the amulet he made on the doorstep of our house, saying it would ward off the evil eye." (P10, a 42-year-old female)*

One of the participants reported that a religious leader had advised that drinking blessed water and getting married would heal him.

*"A religious leader advised me to get married, saying it would help me recover. During another visit, I was given blessed water to drink, and prayers were said for my recovery. I was also seeing a doctor while trying these non-medical methods. Another religious leader told me to stop taking all the medications prescribed by the doctor, but I didn't follow that advice. We paid fees to everyone we visited, and honestly, we spent a lot." (P7, a 45-year-old female).*

**Theme 3. Reflections on the benefits of non-medical practices**

This theme includes two sub-themes that explore reflections on the benefits of non-medical practices.

*Perceived physical benefits*

Most of the participants expressed that religious practices were beneficial for reducing fear and sleep problems.

*"After wearing the amulet for a few months, I noticed a decrease in my fears and an improvement in my sleep. I believe I benefited from wearing it." (P4, a 25-year-old male)*

It was also expressed that religious practices were beneficial for reducing fatigue and weakness.

*"I constantly felt tired and weak. The religious teacher gave me an amulet to carry, and after doing so, my fatigue and weakness disappeared." (P11, a 31-year-old male).*

*Perceived psychological benefits*

The majority of participants stated that non-medical practices help reduce anxiety, fear, anger, tension, and delusions.

One of the participants reported that religious practices were beneficial for reducing fear and outbursts.

*"I wore the amulet given to me and drank the blessed water as instructed. I wore the amulet for about two years, and during that time, it had a positive effect on me. My sleep improved, my fears decreased, and my emotional outbursts stopped." (P1, a 49-year-old female)*

One participant stated that religious practices made her feel psychologically good.

*"Following the advice of the religious teacher, I felt psychologically better for a while." (P10, a 42-year-old female)*

## DISCUSSION

This study aimed to evaluate how cultural and religious beliefs influence non-medical help-seeking behaviors among patients with CMIs in Türkiye, using a phenomenological approach. It explores the perspectives of individuals living in the Eastern Anatolia Region and their interpretations of mental illness within cultural and religious contexts. This research contributes to the national and international literature by highlighting the impact of cultural and religious perspectives on medical help-seeking behaviors among individuals with CMIs. Additionally, it aims to identify gaps for future research in this area.

Three main themes emerged and were discussed in the study: the reasons for seeking non-medical help, factors contributing to seeking non-medical help, and reflections on the benefits of non-medical practices.

### Reasons for seeking non-medical help

In the study, mental, social, and physical reasons were found to be among the non-medical help-seeking behaviors of individuals. In particular, factors such as fear, nervousness, pessimism, hopelessness, religious delusions, visual hallucinations, referrals to non-medical help-seeking behaviors by family, suggestions from relatives or neighbors, belief in the effectiveness of non-medical treatments, avoidance of social stigma, doubts about the efficacy of medical treatment, fatigue, weakness, and loss of appetite were identified. Chadda *et al*.[16] (2001) reported that non-medical help-seeking behaviors were influenced by beliefs that the illness was caused by supernatural forces, perceived reliability and easy access to non-medical help, and recommendations from friends or relatives. In a study conducted by Yaşan and Gürgen (2004) in our country, it was reported that factors such as a lack of information about the disease, the long duration of the illness, the inability to benefit from medical treatment, a

low education level, being born in a village, and the belief that mental illnesses are caused by supernatural powers were effective in non-medical help-seeking behaviors.[17] Similarly, Bahar *et al*.[18] (2010) determined that individuals sought non-medical help for reasons such as not wanting to use medication, not benefiting from physician treatment, seeking support for physician treatment, and feeling that there were no other options. These results highlight the critical role of health professionals in educating patients about their treatment options and the progression of their disease.

Understanding how communities perceive and respond to mental illnesses is crucial due to their high prevalence. Attitudes and beliefs about the causes and treatments of mental illnesses vary across regions and over time, influenced by societal perceptions, cultural norms, stigma, and interpersonal dynamics.[4,5] These factors significantly shape how individuals seek help for mental health issues and their willingness to explore different forms of support.[5] Individuals facing mental health challenges, influenced by these factors, often resort to diverse help-seeking behaviors. Help-seeking behavior refers to seeking external resources to address problems when internal resources are insufficient to manage distress or disruptions to normal life functions."[19,20] Our study found that individuals sought non-medical alternatives because they perceived pharmacological methods as ineffective in achieving desired outcomes.

Several factors influence individuals' decisions to seek help from psychiatrists, including the perceived severity of symptoms, the impact on social activities, stress levels, cultural values, societal awareness of mental illness, the availability of social support, and beliefs about the effectiveness of psychiatric specialists in addressing the issue. Negative societal attitudes toward mental illness can significantly impact patients' and their families' help-seeking behaviors, as they may avoid seeking treatment to evade stigma, potentially leading to untreated conditions and a worsening illness trajectory.[21] Moreover, suppose relatives believe psychiatrists are ineffective or that conventional treatments cannot cure the illness. In that case, they may turn to alternative methods, like non-medical healers, during the help-seeking.[4-22] These situations collectively underscore the challenges of treating mental illnesses.

The literature indicates that several factors influence the preference for traditional healers, including beliefs in supernatural causes, perceived reliability, ease of access, and recommendations from friends or relatives.[23] Similarly, a study conducted in our country identified reasons such as lack of information about the illness, long duration of illness, dissatisfaction with medical treatment, lower educational levels, rural upbringing, and belief in the supernatural origins of mental illnesses as influential in traditional help-seeking behaviors.[6] Teshager *et al*.[24] (2020) also noted that patients often delayed seeking modern psychiatric treatment, choosing religious healers because they attributed mental disorders to supernatural causes. The study further revealed that the chronic and debilitating nature of mental illness led patients and their families to explore multiple help-seeking methods, aligning with findings in the literature.

### Factors contributing to seeking non-medical help

**O**ur study demonstrated that predisposing factors, enabling factors, and myths contributed to individuals seeking non-medical help. Specific behaviors included consulting a religious teacher, wearing amulets, visiting religious shrines, carrying a sheik's cloth, praying, being hypnotized by a sheik, self-acceptance, practicing yoga, taking refuge in spirituality, daydreaming, drinking recited water, staying in a dark room for extended periods, talking to and believing in non-human beings, divorcing one's spouse, exercising, getting massages, drinking chamomile tea, and being hit on the head with a stick by a religious official. A study conducted in Malaysia revealed that 69% of patients visited traditional healers before consulting a psychiatrist.[25] Likewise, a study in India reported that 29.5% of patients consulted religious healers.[26] Likewise, Odinka *et al*.[27] (2014) conducted a study with schizophrenia patients in Nigeria and found that patients resorted to traditional and religious healers as help-seeking behavior. Adeosun *et al*.[28] (2013) indicated that most patients (69%) primarily sought help from traditional and religious healers. These findings suggest that religious beliefs and social and cultural characteristics significantly influence individuals' help-seeking behaviors.

Individuals experiencing mental illness often seek causal explanations for their condition, leading to various help-seeking behaviors categorized broadly as medical or non-medical.[29] Age, gender, socioeconomic status, educational background, health insurance, symptoms, and illness severity can influence these behaviors. Additionally, societal factors, including social status, acceptance, stigma, and cultural perspectives on illness, also shape help-seeking decisions.[29] Understanding these determinants is crucial for directing individuals to appropriate treatment centers promptly.[6] Societal attitudes toward illnesses profoundly impact help-seeking behaviors. This study uniquely contributes to the literature by exploring how cultural and religious beliefs influence medical help-seeking behaviors among individuals with chronic mental illness in Turkish society.

A study conducted in China highlighted alternative help-seeking behaviors as a significant barrier to accessing mental health services.[30] Iversen *et al*. (2010) found that more than three-quarters of patients diagnosed with mental illness preferred informal sources of help, such

as priests, over medical assistance.[31] Similarly, in a study by Basumatary *et al.* (2020) involving relatives caring for schizophrenia patients, 72.9% of participants sought help from faith healers who used magical rituals and religious beliefs.[32] These findings resonate with our study, indicating that the challenging and enduring nature of CMIs often leads patients and their families to explore various avenues of assistance.

### Reflections on the benefits of non-medical practices

In our study, individuals reported experiencing both physical and psychological benefits from non-medical help-seeking behaviors. Specifically, they noted improvements in sleep problems, fatigue, and loss of appetite, as well as reductions in anxiety, fear, anger, tension, and delusions. Tanrıverdi (2023) found that progressive relaxation practices significantly reduced psychiatric symptoms and enhanced mental well-being in individuals diagnosed with schizophrenia.[33] Similarly, Seki Öz and Taktak (2023) reported that 72.7% of schizophrenia patients preferred writing amulets, and 69.7% sought help from a religious teacher or exorcised a jinni after diagnosis, believing these practices were beneficial[34] These findings suggest that individuals view non-medical help-seeking behaviors as important for their physical and psychological well-being.

According to WHO data encompassing all psychiatric illnesses, individuals commonly explore natural methods and utilize traditional and complementary medicine at least once in their lifetime. Herbal mixtures and homeopathy were reported as the most frequently used therapies, respectively.[29] Patients often turn to healers, herbal medicine, folk remedies, meditation, and local treatments in various cultures, including Türkiye.[17,23] Recently, practices such as yoga, reflexology, music therapy, cinema therapy, and animal therapy have emerged in psychiatry, showing promising results in improving symptoms and functionality in patients.[35] Non-pharmacological methods have shown effectiveness in individuals, leading to positive outcomes when applied appropriately.

Studies suggest potential benefits from non-medical treatments yet concerns persist regarding their safety and possible negative effects on individual treatment outcomes. Uncertainties include interactions between non-medical practices and conventional drugs, as well as risks such as organ function deterioration or adverse effects on the illness process from inadvertent use.[23]

Our study comprehensively explores the motivations behind non-medical help-seeking behaviors among individuals with mental illness, emphasizing the influence of cultural and religious beliefs. Qualitative interviews enable deep exploration, yielding comprehensive and insightful findings. Given these insights, non-medical practices must be performed by qualified people under controlled conditions, guided by appropriate regulations.

### Limitations

One limitation of our study is that all participants were selected from a single province in the eastern region of Türkiye. Therefore, the findings are specific to this group and setting, and may not fully represent the diversity of individuals with mental illness across the broader population.

## CONCLUSION AND RECOMMENDATIONS

Our study showed that individuals resorted to non-medical help-seeking behaviors because they did not believe in medical treatment, did not want to use medication, followed advice from relatives and friends, and thought that supernatural powers caused the disease. Understanding these reasons is crucial for guiding patients toward medical treatment effectively.

The chronic and debilitating nature of chronic mental illness often prompts patients and their families to seek multiple avenues of help. Individuals may feel powerless and turn to traditional treatments as an alternative, especially during the onset, exacerbation, or recovery phases of the illness, when responses to single help-seeking attempts are insufficient or unexpected. Understanding why patients opt for non-medical treatments is crucial for guiding them toward pharmacological interventions. In this regard, health professionals, particularly psychiatrists and psychiatric nurses, play a vital role. It is recommended that they raise awareness by educating individuals, families, and society about mental illnesses. Changing negative beliefs and prejudices about pharmacological treatments is essential.

### Financial support and sponsorship

Nil.

### Conflicts of interest

There are no conflicts of interest.

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## COMBINED CRITERIA FOR REPORTING QUALITATIVE RESEARCH (COREQ)[11]

**Alan 1: Research team and reflexivity**

**Personal Characteristics**

| Number | Characteristics | Guiding questions | Explanations |
|---|---|---|---|
| **1** | Interviewer/facilitator | Which author(s) conducted the interview or focus group? | The first author conducted the interview**.** |
| **2** | Credentials | What were the credentials of the researchers? e.g., Ph.D., MD | First author: Ph.D.<br>Second author: Ph.D.<br>Third author: Ph.D.<br>Fourth author: Doctor of Psychiatry |
| **3** | Occupation | What was their occupation during the study? | First author: Dr. Faculty Member, Psychiatric Nursing<br>Second author: Dr. Lecturer, Psychiatric Nursing<br>Third author: Ph.D. Faculty Member, Public Health<br>Fourth author: Doctor |
| **4** | Gender | What was the sex of the researcher? | Two researchers Female<br>Two researcher: Male |
| **5** | Experience and education | What are the experiences and education levels of the researchers? | The first author has taken qualitative courses, has experience in qualitative research, and has published qualitative studies in international journals.<br>The second author has taken qualitative courses, has experience in qualitative research, and has published qualitative studies in international journals.<br>The third author: has taken qualitative courses, has experience in qualitative research, and has published qualitative studies in international journals.<br>The fourth author has taken qualitative courses. |

**Relationship with participants**

| | | | |
|---|---|---|---|
| 6 | Relationship status | Was there a relationship between the researcher and the participants before the training? | No relationship was established before starting the study. |
| 7 | Interviewee's information about the interviewer | What did the participants know about the researcher, e.g., personal goals and reasons for doing the research? | Participants knew that the researcher had a doctorate in the field of mental health and diseases. |

| | | | |
|---|---|---|---|
| 8 | Interviewee characteristics | What characteristics of the interviewer/facilitator were reported? e.g., bias, assumptions, reasons, and interests in research | At the beginning of each interview, participants were informed about the purpose and objectives of the study. |

**Domain 2: Study Design**

**Theoretical framework**

| | | | |
|---|---|---|---|
| 9 | Methodological orientation and theory | What methodological orientation was identified to support the study, e.g., discourse analysis, ethnography, phenomenology, and content analysis? | This was a qualitative study. |

**Sampling**

| | | | |
|---|---|---|---|
| 10 | Sampling | How were the participants selected? e.g., purposeful, convenience, consecutive, snowball. | The criterion sampling method, one of the purposive sampling methods, was used. |
| 11 | Approach method | How were the participants reached? e.g., face-to-face, telephone, mail. | The timing of the interviews was determined by the individuals who agreed to participate in the study. |
| 12 | Sample size | How many participants were there in the study? | A total of 13 individuals were included in the study. |
| 13 | Exclusion | How many people refused to participate or dropped out? Reasons? | No adolescents refused to participate in the study. |

**Setting**

| | | | |
|---|---|---|---|
| 14 | The setting of data collection | Where were the data collected? e.g., home, clinic, or workplace | Detailed information is given in the data collection section of the study. |
| 15 | Presence of non-participants | Was there anyone else other than the participants and the researchers? | No, there was not. |
| 16 | Description of the sample | What are the important characteristics of the sample? e.g., demographic data, date | Individuals who agreed to participate in the study were included in the study. |

**Data collection**

| | | | |
|---|---|---|---|
| 17 | Interview guide | Were questions, prompts, and guidelines provided by the authors? Were they tested in a pilot study? | Detailed information is given in the methods section. |
| 18 | Repeat interviews | Were repeated interviews conducted? If yes, how | No, they were not. |

| | | | |
|---|---|---|---|
| | | many? | |
| 19 | Audio/visual recording | Was audio recording or visual recording used to collect data in the research? | Detailed information is given in the methods section. |
| 20 | Field notes | Were field notes taken during and/or after the interview or focus group? | No, they were not. |
| 21 | Duration | How long were the interviews or focus groups? | Each interview lasted between 35 and 45 minutes. |
| 22 | Data saturation | Was data saturation discussed? | Yes, it was. |
| 23 | Transcripts returned | Were transcripts returned to participants for comment and/or correction? | No, they were not. |

**Domain 3: Analysis and results**

| | | | |
|---|---|---|---|
| 24 | Number of data coders | How many data coders coded the data? | Two researchers and a third individual coded the data. |
| 25 | Description of the coding tree | Did the authors describe the coding tree? | The titles and subtitles in the results section represent the final coding tree. |
| 26 | Derivation of themes | Were the themes predetermined or derived from the data? | Themes were derived from the data. |
| 27 | Software | If any, what software was used to manage the data? | The data were analyzed manually. |
| 28 | Participant control | Did participants provide feedback on the findings? | No, they did not. |

**Reporting**

| | | | |
|---|---|---|---|
| 29 | Quotations provided | Are participant quotes cited to illustrate themes/findings? Is each quote identified, e.g., by participant number? | Yes, they are. Participant quotes are provided to illustrate themes/findings. e.g., participant number |
| 30 | Data and findings consistent | Was there consistency between the data presented and the findings? | Yes, there was. |
| 31 | Clarity of main themes | Are the main themes presented in the findings? | Yes, they are. |
| 32 | Clarity of subthemes | Is there a description of the different cases or a discussion of minor issues? | Yes, there is. |