



**A retrospective review of lifetime prevalence of traditional
healer consultation by an outpatient sample of Xhosa
schizophrenia sufferers**

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A retrospective review of lifetime prevalence of traditional healer consultation by an outpatient sample
of Xhosa schizophrenia sufferers

This research report is submitted to the Faculty of Health Sciences, University of the Witwatersrand,
Johannesburg, in partial fulfillment of the requirements for the degree of Master of Medicine in the
branch of Psychiatry.

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DECLARATION

I, Taryn Sutherland, declare that this research report is my own work. It is being submitted in partial fulfillment of the requirements for the degree of Master of Medicine in the branch of Psychiatry. It has not been submitted before for any degree or examination at this or any other University

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Nov 2015

DEDICATION

This work is dedicated to all those suffering from severe mental illness especially those who unselfishly gave up their time to participate in this project.

ABSTRACT

AIM: To describe the demographic and clinical characteristics of a group of patients of Xhosa ethnicity diagnosed with schizophrenia. To also determine the prevalence of their consultations with a traditional healer as well as the factors associated with an increased likelihood of such consultations.

METHOD: The study was a review of a database originally compiled as part of an ongoing genetic study. Patients on the database were all of Xhosa ethnicity, with a diagnosis of schizophrenia and had all been recruited from community clinics and psychiatric hospitals in the Cape Town Metropole region.

RESULTS: Data was extracted and analysed for 92 patients, who met the criteria for inclusion in this study. The majority of the patients were male (77.2%), single (88%) and unemployed (96%). The mean duration of illness was 20.5 years and the mean number of hospital admissions for their mental illness was 2.4. Close to half (43.5%) of the patients reported being non-compliant on their medication. Ten percent admitted to making one or more suicide attempts in their lifetime. Nicotine was the most commonly used substance (69.6%) followed by alcohol (55.4%), cannabis (37%) and methamphetamines (9.8%).

Thirty eight percent of the patients reported having a traditional healer in their family. Twenty two percent had consulted with a traditional healer. In the bivariate analysis the following factors were significantly associated with consulting a traditional healer: having two or less psychiatric admissions ($p=0.014$); compliance on medication ($p=0,012$); and having a traditional healer in the family

($p=0.005$). When controlling for age, sex and marital status only having a traditional healer in the family was significantly associated with consulting traditional healer ($p=0.011$).

CONCLUSIONS: This study found that a high proportion of the participants had consulted a traditional healer. This was significantly associated with having a traditional healer as a family member. It is recommended that programmes, to improve the mutual understanding and co-operation between Western practitioners and traditional healers and consequently mental health outcomes, need to be developed and implemented.

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1.0 INTRODUCTION

Schizophrenia is a chronic, debilitating illness with a peak onset in early adulthood (1). International birth cohort studies conducted in Northern Finland and Britain found the age of onset to be 23 years and 22 years respectively (2, 3). These findings correspond with a South African study which found the mean age of onset to be 22.86 years of age (4).

Systematic reviews have estimated the incidence of schizophrenia to be between 11.1 per 100 000 to 15.2 per 100,000 with lifetime prevalence rates of between 4 and 5,5 per 1000 (5, 6). While schizophrenia was initially believed to occur at equal rates in all populations more recent evidence suggests higher rates in certain subgroups of the population. There is limited evidence of a higher prevalence in males, in people living in urban environments (7) and in immigrants (8). Despite a relatively low incidence and prevalence, due to its profound effect on functioning and chronic nature schizophrenia is the eighth leading cause of disability adjusted life years in the age group 15-44 years globally (9).

Early, effective treatment may reduce disability by allowing individuals to complete the formative processes which occur in late adolescence and early adulthood. Additionally early treatment may be more effective in reducing symptoms and improving long term prognosis (10).

The culture of individuals with schizophrenia and their families is important as it influences their understanding of illness causation and treatment. Individuals holding more traditional beliefs of causation are more likely to seek help from a traditional healer (11). This is significant as it delays antipsychotic treatment (11) which can adversely affect the short and long term prognosis of the illness.

The literature review will discuss this interplay between culture and traditional and western medicine with regards to schizophrenia.

For the purposes of this study, the following definitions apply:

Schizophrenia: “a clinical syndrome of variable but profoundly disruptive psychopathology that involves cognition, emotion, perception, and other aspects of behaviour.” (12)

Xhosa: the second largest cultural group in South Africa. The Xhosa language is part of the Nguni language group (13)

Traditional healer: “a person recognised by the community in which he lives as competent to provide health care using plants, animals or mineral products, or using any religious or social methods acceptable by the population in the community where he lives.” (14)

Traditional medicine: “the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses.” (15)

Western Medicine: Treatment and care provided by medical doctors including psychiatrists or other health professionals such as nurses

2.0 LITERATURE REVIEW

2.1 Culture and mental illness

Culture can be defined as “learned systems of meaning, communicated by means of natural language and other symbol systems” and “capable of creating cultural entities and particular senses of reality” (16). Culture is integral to our understanding and experiences as human beings. Although culture changed as primitive humans evolved physically and cognitively so too did culture influence that evolution with the neocortex evolving “in great part in interaction with culture” (17). As humans evolved unique civilisations emerged each with their own cultural identity, beliefs and practices. Although science searches for the biological mechanisms which are hypothesised to be a common cause of illness in individuals regardless of their culture Fabrega (18) hypothesised that “even if such a mechanism was found for each psychiatric illness, the social and symbolic importance of psychiatric illness would not diminish because realizations of psychiatric illness have far different meanings and consequences” than for example diabetes because they affect the core of the self. Thus culture can be

seen as both integral to our experience as human beings and holding a special relevance for our interpretations of mental illness.

The strong influence of culture on the understanding of lay people's beliefs about the cause of schizophrenia has been demonstrated in a South African study by Mbanga et al (19). This study examined the attitudes and beliefs of the relatives of schizophrenia patients (n=100). Their findings indicated that the majority (67%) of respondents believed that witchcraft or possession by evil spirits played a role in the development of schizophrenia. Similarly a study of Indian first episode psychosis patients found that 70% believed the cause of their illness to be spiritual or mystical (20)

Studies have also suggested differences in beliefs about schizophrenia between developed and developing nations. Furnham and Pereira (21) compared beliefs about the causation between Sri Lankan and British students finding the Sri Lankan students to favour superstitious and sociological causes to explain the development of schizophrenia and the British students to favour more biological explanations. A similar study examining beliefs of Chinese and British university undergraduates found

Chinese participants to have more religious and superstitious beliefs towards the causation and treatment of schizophrenia and to prefer the use of alternative medicine (22).

One explanation for this may be increased access to medical care in wealthier nations which exposes individuals to more allopathic and scientific beliefs about illness causation. Another explanation is western culture itself which may discourage the belief in non-biological causes of schizophrenia or promote a more medical model of disease causation. In order to try and understand the effect that westernisation has on help seeking behaviour for mental illness Chen and Mak (23) examined four different groups of undergraduate students (n=747) each with different levels of western influences, namely : European Americans, Chinese Americans, Hong Kong Chinese and Mainland Chinese. The findings support a relationship between increased exposure to western culture and willingness to seek help from mental health professionals with European and Chinese Americans having more favourable views of consulting allopathic practitioners for mental illness than the other two groups. Since beliefs about causation are associated with help seeking behaviour (11) it is likely that the more westernised groups supported more medical or biological explanations of causation.

These studies demonstrate the ongoing and dynamic influence of culture on the understanding that individuals have of schizophrenia and underline the relevance of considering individuals cultural beliefs in the management of the illness.

2.2 Traditional healers

Individuals who hold a more traditional belief of the causation of mental illness are more likely to first seek help from a traditional healer rather than from Western medical practitioners. Anecdotal evidence also indicates that there are many more traditional healers than there are psychiatrists in developing countries and they are cheaper and more accessible.

There are very few published studies reporting on the impact of care provided by traditional healers and of the influence of the different types of traditional healers on the outcomes of mental illness. First contact with traditional healers impacts on the duration of untreated psychosis. In a study of 54 patients in Kwa Zulu Natal, Burns et al (11) looked at associations between causal attributions and

pathway to care and the duration of untreated psychosis. They reported that in 39% of the patients consultation with a traditional healer was associated with a longer duration of psychosis. The authors concluded that first contact with traditional healers was associated with longer duration of untreated psychosis and higher number of provider contacts. Other studies also reported a long duration of untreated psychosis; decreased likelihood of responding to anti-psychotic treatment (24); increase in negative symptoms (25); and poor functional outcomes (26).

In summary, the delay in psychiatric treatment can adversely affect both short term outcomes and long term prognosis (11). The general consensus is that a combination of traditional healing and the biomedical treatment would have superior outcomes.

In South Africa there are the following kinds of traditional healers:

a) Traditional doctors- inyanga (Zulu) or ixhwele (Xhosa) – these are specialists in the use of medicinal herbs (27, 28) and remedies of animal origin (28). They produce both curative and prophylactic treatments (28). They may specialize in the treatment of a single disease or disease of an

organ and/or system (28). They also produce mixtures to combat witchcraft and for luck, happiness and success (27, 28). Approximately 90% of these traditional healers are male and unlike some other healers they do not receive a “calling” to become inyanga but rather choose to do so (28). Their training generally takes the form of an apprenticeship of a few years (28). Unlike sangomas they do not claim to have divine powers and thus the patient must be present at the time of the treatment (28).

b) Diviners- isangomas (Zulu) or amgqiras (Xhosa) – they act as mediums and interpreters for messages from ancestral spirits (27, 28). They define or diagnose illnesses and describe it in terms of sociocultural context (27, 28). One needs to be summoned by the ancestors in order to become a diviner (27, 28) and the training consists of an apprenticeship of a few months to several years duration (28). During this time the diviner will learn to use objects for divination such as throwing the bones and master the trance states in which communication with the ancestors occurs (27, 28). About 90 per cent of sangomas are female (28).

c) Faith healers- umprofethi (Sotho) or umthandazi (Nguni) – they integrate traditional practices and Christian beliefs and their power is attained from God and/or ancestral spirits (28). They generally belong to one of the independent African churches and heal by prayer, by touch or by using holy

water or ash but also make use of herbal remedies and trance like states (27, 28). There is no pre-determined training period and trainees often live with a faith healer during their training (28).

There are three basic principles which underlie the approach of traditional healers (29, 30) namely:

- a) Clients should be given enough time to discuss their symptoms and concerns in order to feel that the healer has understood their problems and the impact they are having;
- b) The healer approaches the diagnosis and treatment of the patient as that of a whole being for whom the mind and body are intimately connected and
- c) The patient is considered in a wider social context as part of a family and a community

Thus the traditional healers adopt a holistic approach to the diagnostic process (27). The healer's diagnosis is made by combining various sources of information including personal observation, the patient's own reports of their symptoms and divination. Observations of other family members regarding the patient's illness may also be obtained (28).

2.3 Legislation defining the role of traditional healers in health services

2.3.1 International Legislation

Worldwide, national recognition and regulation of traditional and complementary/alternative medicines and practitioners varies considerably. In a 2001 WHO survey 44 African nations were surveyed and 61% of these had legal statutes regarding traditional medicine, however not all national policies had been implemented (31).

Countries such as Benin and Cameroon both have official legislature to govern the practice of traditional medicine as well as training programs for traditional healers. In both there is a licensing process and a registry of traditional medicine practitioners and traditional healers have been integrated into primary health care programmes (31).

Lesotho has two statutes that regulate the practice of traditional medicine and limit it to registered practitioners. Lesotho's laws also act to limit the scope of practice that traditional healers may be

involved in, for example: prohibiting practices such as giving injections, performing surgery or treating cancer. Traditional healers are also prohibited from influencing someone to abstain from Western health care. Lesotho has a training programme for health workers regarding traditional health practices (31).

Mozambique does not have official legislation governing the practice of traditional medicine. There is no licensing process for traditional health practitioners or procedures for the official approval of traditional medicines (31).

Some developed nations also have legislature pertaining to traditional healers. In Canada the Yukon territories passed a bill in 1990 (revised in 2003) to secure aboriginal control over traditional aboriginal practices and to protect these healing practices as a viable alternative to Western health care (32).

In North America Traditional Native North American medicine in the United States is regulated under the Indian Self-Determination Act which aims to include Native Americans in decision making

regarding the implementation of health care services affecting them and allows for the use of traditional medicine men (33).

In summary the laws governing the practice of traditional medicine differ between countries. There are varying requirements with regards to registration and training for traditional healers and with regards to the integration of traditional healers into the health system. The presence of official legislature promoting integration does not always correlate with official programmes to accomplish this.

2.3.2 South African Legislation

In South Africa, the apartheid government discouraged the practice of traditional medicine. Legislation such as the Witchcraft Suppression Act of 1957 and the Witchcraft Suppression Amendment Act of 1970 prohibited traditional healers from practicing (34).

In 1994 the South African government accepted the National Health Plan which included a commitment to involve traditional healers in the official health care services and give consumers the freedom to choose their preferred mode of health care (35).

Following this, there has been a move to regulate traditional healers as well as provide recognition as health care professionals. The Traditional Health Practitioners Act, 2004 aims, amongst other things: to ensure the quality of health services within the traditional health practice; protect those using or affected by these services; encourage research in this field; set and maintain standards for training of traditional health practitioners; compile and maintain a professional code of conduct for traditional health practice and ensure that traditional health practice complies with universally accepted norms and values (36). The Act requires that every traditional health practitioner, including herbalists, diviners and traditional surgeons be officially registered.

2.4 Collaboration between traditional healers and Western health care practitioners

Collaborations between traditional healers and Western practitioners face many challenges. There is little consensus between the two regarding diagnoses of various mental illnesses since the healers diagnoses are often based in spiritual and supernatural beliefs and Western medical beliefs are based on theories of biological dysfunction (37). Combined with this is the promotion of vastly different modes of treatments by each sector and an element of distrust and skepticism from both sides. A study conducted by Sorsdahl, Stein and Flisher (38) analysed the data collected from focus groups held with 24 traditional healers and concluded that traditional healers reported regularly treating patients with mental illness and that they often identified such patients by their abnormal behaviour and aggression. They were found to have limited trust in Western health care techniques and although they did consider referral for Western care they often viewed this as a short term solution or last resort. Kahn and Kelly (39) explored psychiatric nurses' views regarding the use of traditional healers. Although they felt that psychiatry and traditional healers could co-operate they felt psychiatry would be superior in any collaboration between the two.

Despite these challenges previous studies have shown that collaboration between allopathic and traditional practitioners can yield positive outcomes. A South African study found that with a brief training period (2 days) traditional healers were able to significantly improve outcomes when integrated into the programme of directly observed treatment for tuberculosis. Patients supervised by healers had the same rates of treatment completion as those supervised by other categories of supervisors and expressed high levels of satisfaction with the care they received from healers (40) A pilot project in Cameroon describes the involvement of healers in a diabetes control programme. Promisingly healers continued to apply practices learnt in workshops given up to eight months after training such as referring suspected diabetes cases to medical facilities for blood glucose testing and refraining from scarifying diabetics. In addition they reported they had begun educating their patients, peers and people in their communities about diabetes (41)

In Canada, the Canadian Native Aboriginal Health Organization has developed a comprehensive model to formalize the integration of traditional and Western health services (42). The central elements in their programme are community engagement and autonomy over health care decisions with no hindrances in accessing the preferred means of care. The programme outlines various steps it will take

to achieve a culturally appropriate health service such as giving community elders seats on hospital boards, giving traditional healers the same status as a pastor or other religious leaders and allowing traditional healing ceremonies to take place in hospital as well as providing facilities for the production of traditional medicines and the creation of laws to regulate these medicines and ensure their safety.

In South Africa although legislation promotes co-operation between healers and the formal health sector little has been done to create a culturally responsive and integrated programme to provide quality holistic care for psychiatric patients.

People with mental illness often integrate divergent traditional and Western viewpoints when making sense of their illness and commonly engage in both modalities of care (43). Although there are challenges to developing collaborations there is also evidence that optimising the partnership between traditional healers and Western practitioners may result in improved health outcomes. Such collaborations may be especially relevant in a resource constrained setting like South Africa.

2.5 Prevalence of traditional healer usage

2.5.1 International Literature

There is a great diversity in the pattern of traditional healer usage. It is determined by the region where the person resides, the age and income of the person, the access to mental health care and the persons' perceptions of traditional medicine. Rates of complementary medicine use and consultation of non-allopathic practitioners are increasing worldwide, even in many developed nations (31). According to the WHO the most commonly reported reasons for using traditional and alternative medicine are that it is more affordable, corresponds more closely to the patient's ideology, and is less paternalistic than Western medicine (31).

In the United States many ethnic minority groups use both Western doctors as well as traditional healers. A study of 150 Native American patients found that 38% of patients see a traditional healer and of those who do not, 86% would consider seeing one in future (44). The patients rated their healer's advice higher than that of their physician's advice in 61.4% of cases. Further, the study

reported that only 14.8% of the patients, who were also seeing traditional healers, informed their physician about this.

In Japan the number of Kampo practitioners (practitioners of medicine techniques derived from traditional Chinese practices) has shown a marked increase and Kampo medicines are now also dispensed by Western doctors (45). These medicines have dedicated pharmacies and some are covered by public health insurance.

Studies from African countries have given discrepant results. A survey conducted in Nigeria found that only 2% of patients with a severe mental illness had received care from a traditional practitioner (46). However a second study from the same country found that 26 % of patients suffering from a mental illness visited a traditional healer before consulting mental health services (47).

A Ghanaian study conducted found that only 6% of patients consulted a traditional healer prior to presenting themselves to mental health care services whereas 14% had consulted a pastor. Having

consulted either a traditional healer or pastor was associated with a delayed presentation to mental health services (48).

In contrast a first episode psychosis study in Zambia found that approximately one third of patients had seen a traditional healer prior to admission (49).

2.5.2 South African Literature

A systematic review by Peltzer (50) found that use of a traditional and/or faith healing amongst the general population in South Africa appears to have markedly decreased over the past 13 years (from between 3.6–12.7% to 0.1%). In support of this a 2011 survey conducted by Statistics South Africa found that 70,7% of households would first consult a public clinic for health care needs with only 0,1% reporting that they would first consult a traditional healer (51). However this is discrepant with findings in the mentally ill.

Peltzer, Mngqundaniso, and Petros (52) found that mental health problems were 14th on a list of the most common conditions seen by traditional practitioners, affecting 9% of their clients. This figure may be even higher given that other categories of conditions such as “ancestral problems” and “spirit illness” affected over 40 percent of patients and it is probable that some of these would be diagnosed as mental illness under Western diagnostic systems.

A study conducted in the Western Cape found that 61% of patients admitted for psychiatric care had consulted a traditional healer during the preceding 12 months (54). Similarly in Kwa-Zulu Natal, Burns et al (23) found that 40% of participants with first onset psychosis had consulted a traditional healer prior to admission for mental illness. These studies contrast with a study by Temmingh and Oosthuizen (55) in the Western Cape, where only 14,3% of patients with first episode psychosis consulted a traditional healer before admission. There are numerous possible explanations for the discrepant findings in these studies. The studies examined diagnostically heterogeneous samples: the one study included all admissions regardless of diagnosis (54) whilst the other two examined schizophrenia spectrum disorders, which includes schizophreniform disorder, schizophrenia and schizoaffective disorder (23,55). The study samples were culturally heterogeneous: one study used a sample of black

African individuals of mainly unspecified descent (54) whilst the other two included individuals of different ethnicities but with a majority being of Zulu ethnicity (23) or of mixed ethnicity (55). There may also be interprovincial variations in traditional healer usage: a national survey of 4762 South African households reported a higher percent (1.5%) of household members in Kwa Zulu Natal visiting a traditional healer compared to those in the Western Cape (0.2%), which had the lowest percentage of all provinces. Lastly, the year during which the studies were conducted may add to the discrepancy in the findings: namely: 1999 (54); 2008 (55) and 2011 (23). It is difficult to prove whether the differences reflect changes in the health-seeking behaviour over time due to the very small number of studies, differing methodologies and culturally heterogeneous samples.

Therefore, it appears that a significant number of individuals with mental illness consult traditional healers and that there is a notable difference in rates of traditional healer consultation between studies. It is possible that these discrepant findings are contributed to by diagnostic heterogeneity within and between the study samples, cultural heterogeneity, geographic variations in traditional healer use and the time period over which the studies were conducted.

2.6 Factors associated with having consulted a traditional healer or alternative health care practitioner

Decisions about health seeking are complex and influenced by numerous factors. Barker, Olukoya and Aggleton (56) proposed a model of health seeking behaviour in which structural and personal determinants interact. They suggest that individual factors such as beliefs about illness causation, the appropriateness of western/traditional treatment and perceived stigma interact with structural factors including accessibility and affordability of services, and social support to determine if an individual seeks care from traditional healers. The following literature examines help seeking behaviour in various countries and cultures.

2.6.1 International Literature

A survey conducted in the USA found alternative medicine use to be predicted by “philosophical congruence” i.e. congruence with individual’s personal and spiritual beliefs and beliefs about illness

causation (57). In addition they found that belonging to a cultural sub-group identified by their commitment to environmentalism and feminism and value for personal growth, psychology and spirituality predicted the use of alternative medicine. A high level of education and poorer health status also predicted seeking alternative treatments as did anxiety, back pain, chronic pain and urinary tract conditions. Dissatisfaction with Western Medicine and a desire for greater autonomy in their treatment were not significant predictors of having used alternative medicine. This study looked at a vast array of different treatments including acupuncture, homeopathy, megavitamins, spiritual healing, lifestyle, relaxation and folk medicine. The most commonly used treatment was chiropractic treatment which was used by 15.7% of respondents.

In a survey conducted in Great Britain 7.8 % of the 8889 respondents reported attending an alternative health practitioner in the previous 3 months. Predictors of alternative medicine use included being female, suffering from a chronic medical condition and having more frequent general practitioner consults. A diagnosis of anxiety (type unspecified) was predictive of consulting a herbalist while depression predicted consultation with a homeopath and/or spiritual and religious healer (58)

An Australian study (n=3027) found that users of alternative medicines were more likely to be single, female, employed and of a higher socioeconomic status. Alternative health practitioners were more likely to be consulted by middle aged individuals, females and those with a higher income and a higher level of education. Most reported using alternative medicines to prevent illness and some reported using them as curative agents (59).

A large survey (n=16038) in the USA reported that 9.8% of participants with a mental condition had consulted an alternative practitioner with those with transient stress or adjustment disorders most likely to use complementary therapies to treat their conditions and those with psychotic and affective disorders least likely to do so. In this study: females, younger individuals and those with a high school education were more likely to use complementary therapies (60)

A study of 150 Native American patients found that 38% reported to seeing a Native American Healer and of those who did not 86% would consider seeing one at some point in the future (61). More females sought help from traditional healers than males and older patients were more likely than

younger ones to have consulted a healer. Most patients reported seeing the healer for spiritual assistance with only five reporting they went purely for physical complaints.

Studies from developed nations therefore suggest that the decision to use complementary forms of health care is influenced by both demographic factors, personal belief systems and illness factors. In these studies females were consistently reported as being more likely to have consulted an alternative health care practitioner. A higher level of education and higher income, were also found to be significant in some studies. Certain conditions such as anxiety disorders, transient stress, adjustment disorders, chronic pain and chronic medical conditions were all found to have been associated with having seen an alternative health care practitioner. Complementary medicines were reported to be used as both preventative and curative agents.

There is limited data examining traditional healer use in African countries. A study conducted in Tanzania found that being better educated, older, widowed or separated, and being of Christian faith were independently associated with consulting a traditional healer (62). This contrasted somewhat with findings in a Zimbabwean study which found that patients of traditional healers were more likely to

have a lower level of education, be female and unemployed (63). A study conducted in Sudan also found that female gender and a lower level of education predicted traditional healer consultation (64).

It is difficult to draw comparisons between studies conducted in developed and developing countries.

The cultural and spiritual beliefs differ vastly between the two as do the economic and social pressures. Of the three studies identified which examined traditional healer use in other African countries two identified female gender and a lower level of education as predictors for consulting a traditional healer. None of these studies looked specifically at people suffering from schizophrenia.

2.6.2 South African Literature

There is a paucity of literature examining factors which are associated with traditional healer consultation in South Africa both within the general and psychiatric populations. Some of the available literature examines health seeking behaviour in the context of the HIV epidemic.

One such study which examines health seeking behaviour in the rural village of Tiko demonstrated the influence of numerous factors on health seeking behaviour. Traditional beliefs about HIV related symptoms and their causation and beliefs in the efficacy of various treatments were found to influence the decision whether to seek Western or traditional care (65). Personal experience, advice from others in the social network and financial circumstances also influenced health seeking behaviour. In this community Western medicine was often seen as a last resort once other treatments had failed.

Pelzer and Mngqundaniso (66) interviewed 222 individuals immediately following their consultation with a traditional healer. The patient demographics in this study showed that 80% were women, 97% were Zulu, 81.5% were between 18-45 years old and most had a Grade 9 education or higher. In twelve percent of the patients psychological problems were stated as the main reason for the consult.

A study conducted in Kwa-Zulu Natal examined health seeking behaviour in 1282 individuals prior to their death. Virtually all had consulted a Western Medical Practitioner and 50% had also consulted a traditional healer. Those with lower levels of education were more likely to have consulted a traditional

healer and those who were better educated and with greater financial resources were more likely to have consulted a range of different providers spending significantly more on their treatment (67)

A large population based study conducted in South Africa (n=3651) found that amongst those with a lifetime DSM IV disorder 8.9 percent had consulted a traditional healer (68). Significant predictors of traditional healer consultation were: older age, black race, lower education, unemployment, and having an anxiety or a substance use disorder. However, only mood disorders, anxiety disorders and substance use disorders were analysed in this study. In their study of individuals with schizophrenia spectrum disorders Temmingh and Oosthuizen (54) found that more individuals with first episode psychosis than multi-episode psychosis consulted traditional healers at some point in their pathway to care (14,28 % vs. 1,4%).

From the small number of South African and African studies found it is evident that beliefs around illness causation, financial factors and the social network may all play a role in help seeking behaviour. Studies which examined demographic factors associated with having consulted a healer

show contradictory findings. It is likely that these discrepancies are contributed to by the different methodologies used as well as the use of diagnostically and culturally heterogeneous samples.

Examining traditional healer consultation in culturally and diagnostically homogenous groups of schizophrenia sufferers would provide a clearer understanding of help seeking behaviour in this population.

3.0_DEFINING THE PROBLEM AND THE NEED FOR THIS STUDY

While traditional healers enjoy official recognition in South African legislature there are few programmes to formalize their involvement in South African health care services. Traditional healers are frequently consulted for health problems including psychiatric illnesses. They are often seen as being a more accessible and culturally acceptable means of treatment and thus for a substantial proportion of patients are the first contact with any form of health care worker. Consultation with a traditional healer may delay antipsychotic treatment worsening long term prognosis. There is evidence to show that traditional healers can contribute to illness management and there are a number of possible points where traditional healers could act to improve the outcomes for patients presenting to them with schizophrenia. Early referral for antipsychotics, working with families to optimize support and working in the communities to improve awareness and compliance are all areas where engagement of traditional healers may be beneficial. Engagement with traditional healers may increase the acceptability of treatment for patients and families.

Studies looking at the prevalence of traditional healer consultation have given conflicting results and few have examined this in a group of chronic schizophrenia sufferers especially in South Africa. However, examining health seeking behavior in individuals with schizophrenia is important as it can identify areas where educational programmes and awareness campaigns may be most beneficial. This is particularly important in the South African context where two separate health systems operate in parallel to one another. Identifying areas where Western health services and traditional health services overlap is important so that partnerships can be strengthened to optimise health service delivery as has been achieved in other countries.

4.0_HYPOTHESIS

It is hypothesized that Xhosa speaking patients with schizophrenia have a higher prevalence of traditional healer consultation and that this is associated with the following factors: older age, employment, poor compliance on medication, number of admissions for mental illness and being related to a traditional healer.

5.0 OBJECTIVES

The specific objectives of this study in a group of Xhosa patients with schizophrenia were to:

- a) Describe the socio-demographic and clinical characteristics
- b) Determine the prevalence of patients who consulted a traditional healer
- c) Compare the socio-demographic and clinical characteristics of the group of patients who consulted a traditional healer to the group of patients who did not consult a traditional healer
- d) Determine, if any, the factors associated with an increased likelihood of having consulted a traditional healer

6.0 METHODS

6.1 Subjects

This study utilised a database of patients of Xhosa ethnicity recruited as part of an ongoing genetic study at the University of Stellenbosch. The University of Stellenbosch granted permission for part of the data from this genetic study to be used by the author in her MMed research dissertation at the University of the Witwatersrand. The cohort of patients was initially recruited by means of referrals from community clinics and psychiatric hospitals in the Cape Town Metropole region. Patients were included if they:

- 1) Had a diagnosis of schizophrenia according to The DSM-IV TR criteria
- 2) Were of Xhosa ethnicity (four out of four grandparents reported to be of Xhosa origin)
- 3) Were older than 18 years of age
- 4) Were willing and able to sign informed consent

There were no other exclusion criteria.

6.2 Procedures

In the original study, mental health workers identified possible participants, and candidates were then screened for suitability after obtaining written informed consent. They were diagnosed on the basis of DSM-IV criteria using a structured clinical interview. One caregiver or close family member who voluntarily agreed to take part in the study was interviewed by a trained psychiatric nurse who visited the family at home and administered a structured questionnaire. It allowed for yes, no or unsure responses and focused on respondents' views of the causes, treatment, and course of schizophrenia. The role of traditional healing methods was assessed by means of the addition of two options to the treatment section, namely the use of traditional healers' services and traditional rituals.

This study was a retrospective review of the database of the abovementioned genetic study. The investigator studied the database and extracted data on self-reported traditional healer use as well as certain demographic and clinical variables. This information was captured on a data sheet compiled by the author (annexure 1) and included:

- **Demographic data:** Age; gender; marital status (which was classed as either married, single, divorced or cohabitating); employment status (past and current employment); number of cohabitants in the home.
- **Factors relating to physical illness;** number of hospital admissions for ill health; self-reported HIV status
- **Factors relating to the psychiatric illness;** duration of illness; number of psychiatric admissions; previous history of suicide attempts; medication compliance; side effects on medication
- **Traditional healer;** consultation with a traditional healer; was the participant related to a traditional healer.

6.3 Ethical considerations

The participant's personal details remained anonymous and confidential and were not recorded on the database or data sheets. Permission was granted by the University of the Witwatersrand Human Research Ethics Committee (M10211).

6.4 Data Analysis

Data records were captured on a spreadsheet (Microsoft Excel) and were analysed using STATA 11.0 (StataCorp, College Station, Texas). Associations between categorical variables were analysed using Pearson's Chi-squared test and prevalence ratios (PRs) with 95 per cent confidence intervals. The non-parametric Wilcoxon rank sum test and the t-test for independent samples were used for analysis of numerical variables. Variables that were considered as potential risk factors were included in the model for generalized linear regression analysis to estimate the prevalence ratio. For all analyses, a P-value of less than 0.05 and a 95% confidence interval that did not span unity were considered the thresholds of statistical significance.

7.0 RESULTS

Ninety two participants were included in this study. The data in this study was obtained from a database of patients of Xhosa ethnicity recruited as part of an ongoing genetic study at the University of Stellenbosch. In some instances there was no data for certain variables and these were recorded as unknown in this study. There was no opportunity to contact the participants as this was a retrospective record review of a database. This was recorded as one of the limitations of this study

7.1 Demographic characteristics of the study population

The mean age of the study population was 43.42 years (SD - 11.28) with an age range of between 23 and 71 years. The majority of the participants were between the ages of 23 and 50 years (71,74%; n=66); males (78.3%; n=72) and single (88.04%; n=81) (Table 7.1). Although 61.96% (n=57) of the sample had worked sometime in the past the vast majority (96.74%; n=89) were currently unemployed. Most of the patients (97.83%; n=90) were living with other people. The homes had between 1 and 6 cohabitants with a mean of 3 persons (Table 7.1).

Table 7.1: Demographic characteristics of the study population

Variables	Number	Percent
Age Groups		
18-30 years	10	10.87
31-40 years	26	28.26
41-50 years	30	32.61
51-60 years	15	16.3
61-70 years	6	6.53
>70 years	2	2.17
Unknown	3	3.26
Gender		
Female	20	21.74
Male	71	77.17
Unknown	1	1.08
Marital status		
Single/Divorced	82	89.13
Married/Cohabiting	10	10.87
Employment status		
Currently employed		
Yes	3	3.26
No	89	96.74
Previously employed		
Yes	57	61.96
No	30	32.61
Unknown	5	5.43
Number of cohabitants living with participant		
0	2	2.17
1-3	49	53.25
3-6	30	32.61
Unknown	11	11.96

7.2 Clinical characteristics of the study population

The mean duration of illness in the study population overall was 20,51 years. On stratification, approximately 27% (n=25) had an illness duration of 5–15 years and 26% (n=26) of 16–25 years (Table 7.2). Approximately forty two percent (n=39) had more than two previous hospital admissions and only in only 30.43% of cases was it for physical ill health (Table 7.2).

Just over half of patients (n=54, 58.70%) reported being fully compliant; 6.52% (n=6) were partially compliant and 16.3% (n=15) reported non-compliance to their medication (Table 7.2). Further, 54,53% (n=50) of the patients reported no side effects on their medication. Nearly half (45.6%; n=42) of the patients reported not having tested for HIV. Of those that had been tested, approximately 8% (n=8) reported that they were HIV positive (Table 7.2). The majority (n=60, 65.21%) of the patients reported a history of substance use and the most common substance of abuse was nicotine (69.57%) followed by alcohol (55.43%), cannabis (36.95%) and methamphetamines (9.78%). Thirty eight percent (n=35) reported having a traditional healer in their family. Almost a quarter of participants (22.8%; n=21) had consulted a traditional healer for their illness (Table 7.2).

Table 7.2 Clinical characteristics of the study population

Variables	Number	Percent
Duration of illness		
5-15 years	25	27.17
16-25 years	26	28.26
25-35 years	15	16.31
35-45 years	3	3.26
Unknown	23	25
Number of admissions for mental health		
0	6	6.52
1	20	21.74
2	19	20.65
>2	39	42.39
Unknown	8	8.70
Admissions for physical ill health		
Yes	28	30.43
No	61	66.30
Unknown	3	3.26
Self-reported side effects on medication		
Yes	8	8.70
No	50	54.35
Unknown	34	36.96
Compliance on medication		
Fully compliant	54	58.70
Not compliant	15	16.30
Partially compliant	6	6.52
Unknown	17	18.48
Self-reported HIV status		
Positive	8	8.70
Negative	26	28.26
Untested	42	45.65
Unknown	16	17.39
Previous suicide attempt/s		
Yes	10	10.87
No	82	89.13
History of traditional healer visit/s		
Yes	21	22.83
No	68	73.91
Unknown	3	3.26
Related to a traditional healer		
Yes	35	38.04
No	57	61.96

7.3. Characteristics associated with having consulted a traditional healer.

Twenty one patients had consulted a traditional healer for their illness. The demographic (Table 7.3) and clinical characteristics (Table 7.4) of those that consulted a traditional were compared to those that did not. There were no significant associations between demographic characteristics of the population group and having consulted a traditional healer (Table 7.3).

Table 7.3 Bivariate analysis of the demographic characteristics of patients who consulted a traditional healer versus those who did not

Variables	Consulted traditional healer		RR (95% CI)	P-value
	No N=68	Yes N=21		
Age Groups				
Mean ± SD	43.5 ± 12.0	44 ± 9.3		0.8722
Range	23 - 71	25 - 62		
Gender				
Female	17 (85%)	3 (15%)	1.7 (0.6 - 5.3)	0.304
Male	51 (73.9%)	18 (26.1%)		
Marital status				
Married/Cohabiting	7 (70%)	3 (30%)	1.3 (0.5 - 3.7)	0.6127
Single/Divorced	61 (77.2%)	18 (22.8%)		
Currently employed				
No	65 (75.6%)	21 (24.4%)	-	0.3275
Yes	3 (100%)	-		
Living alone				
No	67 (77%)	20 (23%)	2.2(0.5 - 9.2)	0.3737
Yes	1 (50%)	1 (50%)		

Table 7.4 Bivariate analysis of the clinical characteristics of patients who consulted a traditional healer versus those who did not

Variables	Consulted traditional healer		RR (95% CI)	P-value
	No N= 68	Yes N=21		
Length of illness				
Median	19	19		0.7972
Range	7-49	8-33		
Admissions for mental health				
> 2 admissions	33 (86.8%)	5 (13.2%)	2.8 (1.1 - 7.0)	0.0137
≤ 2 admissions	27 (62.8%)	16 (37.2%)		
Admissions for physical health				
Yes	20 (76.9%)	6 (23.1%)	1.1 (0.5 - 2.5)	0.8488
No	45 (75%)	15 (25%)		
Compliance				
No/partial	20 (95.2%)	1 (4.8%)	6.9 (1.0 - 48.4)	0.0122
Fully	35 (67.3%)	17 (32.7%)		
Suicide attempt				
No	61 (75.3%)	20 (24.7%)	0.5 (0.1 - 3.3)	0.4385
Yes	7 (87.5%)	1 (12.5%)		
Traditional healer in family				
No	49 (86%)	8 (14%)	2.9 (1.3 - 6.2)	0.0046
Yes	19 (59.4%)	3 (40.6%)		
Substance use				
No	20 (69%)	9 (31%)	0.6 (0.3-1.4)	0.2505
Yes	48 (80%)	12 (20%)		

Individuals who had had more than two admissions for mental health were 2.8 time more likely to have consulted a traditional healer as compared to patients with less than or equal to two admissions for mental health ($p=0.0137$; 95% UCL-LCL =1.1 - 7.0) (Table 7.4). Similarly, having a traditional healer in the family was also found to be significantly associated with having consulted a traditional

healer ($p=0,0046$; 95% UCL-LCL=1.3-6.2) (Table 7.4). Although full compliance to medication was found to be significant ($p=0,0122$; 95%UCL-LCL =1.0-48.4), 18% of this data was missing leading to wide confidence intervals and reducing the validity of this result (Table 7.4). Length of illness ($p=0.7972$), admissions for physical health ($p=0.8488$), suicides attempt/s ($p=0.4385$) and substance use ($p=0.2505$) were not significantly associated with having consulted a traditional healer (Table 7.4).

Significant bivariate associations were then computed in a multivariate analysis of the factors associated with having consulted a traditional healer when controlling for gender, age, and marital status (Table 7.5).

Table 7.5: Multivariate analysis of the factors significantly associated with having consulted a traditional healer when controlling for age, sex and marital status

Consulting traditional healer	PR	P-value	95% CI
Sex	2.1	0.271	0.6-7.5
Age	1.0	0.977	0.9-1.1
Marital status	0.8	0.779	0.2-4.0
Admissions for mental health	2.2	0.139	0.8-6.3
Compliance	5.2	0.113	0.7-39.8
Traditional healer in family	3.9	0.011	1.4-11.0

Number of hospital admissions ($p= 0.139$) and compliance to medication ($p=0.113$) were no longer significantly associated with having consulted a traditional healer whilst having a traditional healer in the family remained significantly associated ($p=0.011$; 95% UCL-LCL =1.4-11.0) (Table 7.5).

When compliance was removed from the multivariate analysis, having a traditional healer in the family remained significant ($p=0.007$; 95% UCL-LCL =1.4-9.1) (Table 7.6).

Table 7.6: Multivariate analysis of the factors significantly associated with having consulted a traditional healer with compliance excluded from the model

Consulting traditional healer	PR	P-value	95% CI
Sex	2.5	0.155	0.7-9.1
Age	1.0	0.586	0.9-1.1
Marital status	1.3	0.695	0.4-4.6
Traditional healer in family	3.6	0.007	1.4 - 9.1

8.0. DISCUSSION

8.1 Prevalence of traditional healer use

This study found that approximately 23% of the patients had consulted a traditional healer.

The prevalence rate was similar to a study conducted in Zambia (n=160), where about a third of patients with first episode psychosis sought help from a traditional healer before approaching a

Western health care practitioner (69); and a Nigerian study (n=219) which found that 28% of new out patients had previously visited a traditional healer (70).

The rate was lower when compared to two South African studies: a study by Burns et al (11) (n=54) conducted in Kwa-Zulu Natal where 38,5% of patients with first episode psychosis had consulted a traditional healer; and a study by Ensink et al (53) (n=62) conducted in the Western Cape in which 61% of individuals consulted a traditional healer in the year before their first psychiatric admission. It was also lower when compared to some international studies: a study from the United Arab Emirates

which found that 85.7% of those diagnosed with schizophrenia had attended faith healers prior to consulting psychiatric services (71); a study in India which found that 51% of new attendees had seen a traditional healer (72); and a Balinese study examining index presentations to psychiatry which found that 87% had consulted a traditional healer prior to being admitted (73). There are a few possible reasons for these discrepant findings.

It is possible that the culturally heterogeneous groups (different cultural beliefs and practices) in the study samples may have affected the reported prevalence of traditional healer consultation. Culturally heterogeneity is more likely to be expected in international studies; however it appears to be also evident in local studies. Our study examined only individuals of Xhosa ethnicity whilst other local studies made use of predominantly Zulu participants (11) or black South Africans of unspecified ethnicity (53).

There is interprovincial variation in traditional healer consultations. In South Africa it has been reported that the highest rates of healer consultation is in Kwa-Zulu Natal and lowest in the Western Cape (55). This may have contributed to discrepancy between our findings and that of Burns et al (11) but

not for the difference between our findings and those of Ensink et al (53). Economic differences between the different sample groups may also be a factor as traditional healer visits have been shown to decrease with increasing wealth (55).

Finally, the variations in the reported prevalence rates may also be influenced by diagnostic heterogeneity of the study samples and the differing research methodology. The study samples varied from patients with a first episode of a schizophrenia spectrum disorder (schizophreniform disorder, schizophrenia or schizoaffective disorder) (11), to patients with any psychiatric diagnosis (53), to only patients diagnosed with schizophrenia (71) and to all new attendees regardless of their diagnosis (72,73). This diagnostic heterogeneity may have affected rates of traditional healer consultation because of the cultural variation in the interpretation of the symptoms by the patients and their decision of the need to consult with a traditional healer. There are no reports of the influence of the different mental illnesses has on help seeking behaviour. These methodologies differences make direct comparisons of the findings of the various studies difficult to interpret.

Our prevalence rates findings were higher when compared with a study conducted in the Western Cape, where only 14,28% of patients with first episode psychosis and 1.4% of those with multiple episodes of psychosis consulted a traditional healer prior to admission (54). However, unlike our study, the majority of this sample were of mixed ethnicity and the minority were black (69% versus 12.6%). This is significant as black individuals have been shown to consult traditional healers twice as often as other race groups (55). Our rates were also higher when compared to a study in Nigeria, another lower middle income country. In this large face-to-face survey (n=4984) just 2% of individuals with a severe mental illness had received treatment from a traditional healer or alternative practitioner in the preceding year (74). However, this study did not examine prevalence or help seeking in patients with psychosis and this may have contributed to the lower rates. The authors also concluded that the low rates of healer consultation may have been a result of the limited number and types of syndromes examined (mood disorders, anxiety disorders and substance use disorders) in their study (74).

In summary, there is a large variability in the rates of traditional healer consultation, both within South Africa and internationally. As previously stated, this may be due to multiple factors including: cultural and diagnostic heterogeneity of samples and population specific economic factors. The studies do not

take into account any idiosyncratic factors which may be acting at the community level to affect help seeking behaviour. The discrepant findings of these studies highlight the lack of generalizability between communities and the need for ongoing studies in diverse population groups.

This study did not find the prevalence of traditional healer consultation to be affected by reported markers of clinical severity or disease chronicity e.g. hospital admissions, suicide attempts and duration of illness. This suggests that the primary motivating factor for seeing a traditional healer may be related to the individuals or family's belief system. It is possible that this study did not account for certain illness characteristics which may be salient to participants or their families consulting a traditional healer.

Finally, the prevalence rates for traditional healer use may have also been influenced by bias: the retrospective nature of this study and the element of recall bias; and response bias (if participants felt that they would be negatively viewed for consulting a traditional healer). A Zambian study found that 64% of pregnant women would not inform their health care provider of any traditional healer visits and

over 50% felt that admitting to seeing a traditional healer would negatively impact on their obstetric care (75).

8.2 Factors significantly associated with traditional healer use

8.2.1 Being related to a traditional healer

This study found that participants who were related to a traditional healer were 3.9 times more likely to consult one ($p=0.011$) as compared to those who were not related to a traditional healer. There are no published studies with similar findings.

Families of people with schizophrenia are often responsible for taking a person for care and often their own beliefs significantly influences the modality of care (Western vs. traditional) that person with the illness actually receives. Families with traditional healers within them may support a more traditional belief about disease causation and therefore be more likely to seek traditional healer assistance.

Reported studies in the Xhosa population group found that 67% of relatives believe that witchcraft or spirit possession play a causal role in schizophrenia (19). Symptoms of schizophrenia are sometimes interpreted as 'ukuthwasa' or a process of spirit possession by the family. The belief is that the individual is being called to become a traditional healer and must consult a traditional healer in order to be trained further (76). A Nigerian study found that 86% of initial healer consultations for mental illness were initiated by the individual's family members. The majority of patients who had consulted a traditional healer (71%) attributed the disease to supernatural forces (70). Patients and relatives' beliefs about illness causation were significantly associated with seeking traditional or spiritual healing.

Being related to a traditional healer may also make traditional form of treatment more accessible than other forms of care. The distance needed to travel to a health care centre has previously been shown to be a significant barrier in seeking care with a study in Papua New Guinea finding a distance of 3.5 km resulting in 50% less attendance (77). Therefore having a relative in close proximity or one who visits the patient's home may play a significant role in the individual consulting the traditional healer.

In addition to physical accessibility, seeking help from a traditional healer relative may be more financially accessible. Although previous research has found traditional health care to be more

expensive than western health care (53) it is possible that having a traditional healer as a relative may make such consultations more affordable.

This study also found that thirty eight percent of participants had a traditional healer in their family.

Considering that previous estimates regarding the number of traditional healers show there to be 185 000 traditional healers in South Africa and just 2600 in the Western Cape. The finding in our study was much higher than expected considering the limited number of traditional healers in the country (78).

It is well known in psychiatry that individuals who are genetically related to an individual with schizophrenia are more likely to suffer from a mental illness. Syndromal or sub-syndromal psychiatric symptoms are interpreted as a calling to be traditional healer or 'ukuthwasa' (76) with subsequent training as a traditional healer. This may have contributed to the higher than expected number of participants in this being related to a traditional healer. A South African study reported that 4.5% of Xhosa schizophrenia sufferers had previously been diagnosed with ukuthwasa (79) and a small

Ugandan study (n=29) also reported that 65% of traditional healers reported a history of unspecified emotional problems (80).

It is possible that the higher than expected number of traditional healers may represent an actual increase in number of healers in the communities studied or that previous figures have underestimated the number of traditional healers. Although an Interim Traditional Health Practitioners Council was appointed in February 2013 traditional practitioners are largely unregulated.

8.2.2 Number of admissions for mental health

Prior to controlling for age, sex and marital status patients with two or less admissions for mental health were 2.8 times more likely to have consulted a traditional healer as compared to patients with more than two admissions

No studies could be found which specifically examined number of admissions for mental illness in relation to a history of traditional healer consultation. However previous research has shown that the

use of traditional medicines is associated with non-compliance with nevirapine in pregnancy (75) and non-compliance on anti-hypertensive treatment (81). There is evidence that poor compliance on medication is associated with relapse and hospital re-admission in schizophrenia (82, 83). This makes our finding very surprising.

One possible explanation is that individuals and families who use traditional medicines may be less likely to seek hospital admissions for themselves or their relatives as this is not in keeping with their beliefs about the illnesses cause and treatment. This is supported by previous research which document delays in seeking treatment for first episode psychosis in individuals who consult traditional healers (11).

Another consideration is that individuals, earlier in the course of their illness, were more likely to consult traditional healers than Western hospitals. This hypothesis is supported by the findings of Temmingh and Oosthuizen (54). that first episode patients consulted more types of help providers than multi episode patients (2 vs 3) and ten times more first episode patients saw a traditional healer in their care pathway. The authors hypothesised that this may be due to previous psychoeducation and

better knowledge of pathways to care amongst multi-episode patients and their caregivers. However

we did not find an association between length of illness and traditional healer consultation.

This study found that the hospital readmission rate in this participants was low: only 42% had more

than two admissions and 6,5% had never been admitted. A large US study examined rates of re-

hospitalisation for schizophrenia over an eight year period between 1984 and 1991, and reported

marked variations in re-admission rates between the various states, with an average of 4,08

readmissions in Iowa and 1,95 readmissions in Utah (84). The lower readmission rate in our study

must be considered in terms of the current shortage of hospital beds available for in-patient treatment.

It is likely that not all the patients who required admission could have been admitted due to non-

availability of hospital beds. Other factors include: obstacles to accessing health services may have

prevented patients from attaining care even when they require admission; there may have been a

greater social support network in these patients than in the patients in the US which would allow them

to be managed at home; and it is possible that these patients have a better clinical course than

patients in the US and thus required fewer admissions.

8.2.3 Medication compliance

Prior to controlling for age, sex and marital status participants who were fully compliant on their medication were 6.9 times more likely to consult a traditional healer.

In general, compliance to medication amongst patients with schizophrenia is a problem. Large international studies such as Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) have shown high levels of medication non-compliance in schizophrenia (85). Another large United States study found that by the end of the first year most patients with schizophrenia had discontinued their antipsychotics (86). A South African study by Kazadi, Moosa and Jeenah (87) on 217 patients with schizophrenia found that two thirds were not completely compliant with their prescribed psychiatric medication.

Studies have reported an association between poor compliance with medication and the use of traditional healers. A South African study by Peltzer (81) found non-compliance on anti-hypertensive medications to be significantly associated with the use of non-Western healing practices and the belief

in the curability of hypertension by traditional healers. A study conducted in Zambia found that HIV positive pregnant women who had consulted a traditional healer were less likely to adhere to antenatal Nevirapine treatment (75).

It is therefore rather surprising to find that full compliance with medication associated with high rates of traditional healer usage. It is possible that the actual measurement of compliance in this study may have been inaccurate for the following reasons:

- i) The large amount of missing data led to wide confidence intervals reducing the validity of the result.
- ii) It is possible that there may have been an element of response bias as participants may be less likely to report behaviour which they believe the interviewer would deem undesirable i.e. poor medication compliance. Previous research has documented very poor correlation between adherence monitoring via electronic monitoring caps and patient and prescriber reports of adherence (88). Electronic monitoring detected non-adherence in 57% of cases whereas just 5% of patients reported being non-adherent. In addition interview based self-reports of compliance are less concordant with electronic measures of compliance than questionnaires possibly due to the greater anonymity afforded by the latter (89).

iii) We did not specify a time period when asking about compliance and perhaps asking about compliance during a discrete period with the assistance of questionnaires and diaries would have improved the accuracy of our data.

8.4 Factors found not to be significantly associated with having consulted a traditional healer

Although there are other factors such as age, gender, employment status, length of illness etc. which were hypothesized as influencing a consultation with a traditional healer, this study did not support this.

8.4.1 Age

Age was not found to be associated with having consulted a traditional healer. This was an unexpected finding in light of the report by Sorsdahl et al (68) that older age was found to be a significant predictor of having consulted a traditional healer. The study by Sorsdahl et al was conducted by means of a survey of the general population (n=3651) and examined the twelve month

prevalence of traditional healer visits. In contrast, a smaller study (n=222) by Peltzer and Mngqundaniso (52) surveyed people leaving a traditional healers rooms and found that over eighty percent were between the ages of 18 and 45 years.

Since we examined lifetime prevalence of traditional healer consultation our results represent cumulative risk throughout the individual's life and not necessarily current behaviour. Our results suggest that despite the probable increase in westernisation of younger individuals in this community there had been no reduction in the prevalence of healer consultation. The fact that there was no association with age despite the increased cumulative risk in older individuals by virtue of their age may mean that individuals who had consulted healers began doing so at a young age.

8.4.2 Gender

There was a tendency for more males than females to consult a traditional healer; however this was not statistically significant. This finding was not in keeping with studies conducted in Zimbabwe (63), Sudan (64) and South Africa (52) which all found that females were more likely to consult traditional

healers than males. However a large national survey conducted in South Africa found no association between gender and having consulted a traditional healer (68). To our knowledge there are no studies examining gender in relation to traditional healer consultation in Xhosa schizophrenia sufferers. Factors specific to this population group may be responsible for this lack of association. Families or individuals with traditional cultural beliefs symptoms of schizophrenia may prompt traditional healer consultation independent of the sufferer's gender.

Male participants in this study largely outnumbered females. This sample was drawn from patients who had contact with psychiatric services. It is possible that this disparity arose from factors which may have contributed to more men actually attending these psychiatric services and hence the sampling bias. These include: a more favourable illness course, decreased rates of negative symptoms and better prognosis in women (90, 91); women generally have less physically aggressive and disruptive behaviour when psychotic (92); and a later onset of illness in women also leading to a better prognosis (93, 94).

8.4.3 Current Employment Status

This was not found to be statistically significant. Employment status should be considered in the context of South Africa's high levels of unemployment (19th highest worldwide) (95) and the limited opportunities for sheltered employment and vocational rehabilitation.

High levels of stigma may also be a factor in precluding someone with a mental illness from being employed. A study by Botha, Koen and Niehaus (96) conducted on a Xhosa speaking sample in the Western Cape reported high levels of perceived stigmatisation with almost forty percent of participants also reporting being physically abused as a result of their illness.

Sixty one percent of participants were formally or informally employed at some stage of their lives, however only 3% of participants were currently working. This is similar to findings by Mosotho, Louw and Calitz (97) who reported that 9% of their sample of schizophrenia sufferers was informally or formally employed and 65% were receiving a disability grant. A study conducted in the Free State also showed high levels of unemployment (80%) but these were less than in the present study (98).

International studies have also shown high levels of unemployment and occupational disability. A study conducted in London showed unemployment rates in schizophrenia sufferers had increased from 88% in 1990 to 96% in 1999. (99). In a large American study examining 1400 patients with schizophrenia only 14,5% were competitively employed in the month before the study (100). Even when patients are able to work they are often still compromised because of their illness. Many of the participants in this study had worked in the past but were now unemployed, this may reflect the progressive decline in function often seen in schizophrenia. It must also be considered that the sample may be biased as participants who were unemployed would be more likely to participate in research.

8.4.4 Marital status

The lack of any significant relationship between marital status and having consulted a traditional healer was in keeping with the survey conducted by Sorsdahl et al (68). In addition neither the South African studies (66) nor the African studies (63, 64) showed any association.

Eighty eight percent of patients were single and only 6% were married. This is similar to another South African study where 16% of schizophrenia sufferers were married (97). The onset of the illness in adolescence and early adulthood and its chronic nature may contribute to the inability to establish or maintain lasting romantic relationships.

Almost 98% percent of patients lived with one or more cohabitants. Only two participants (2,17%) lived alone and two were staying in group homes or shelters with an unknown number of cohabitants. This differs somewhat to findings from a study conducted in Mangaung Township in Bloemfontein which reported that 14% of the sampled schizophrenia sufferers lived alone (97). This finding is very different from findings from developed nations. A study by Jabelnsky (101) which reported that, of people with psychosis in Australia, 31% lived alone and 35% have no frequent face to face contact with a relative.

A European study found that 18,5% of people with schizophrenia were living alone (102). In that study individuals who were living with family (other than a partner) were significantly more likely to be employed and the authors hypothesized that this may reflect the positive effects of social support on recovery.

It is unclear if the number of cohabitants in this study reflects a desire to live together or an economic necessity due to wide spread poverty in the area.

8.4.5 Duration of illness

The mean duration of the illness was 20.5 years. The mean age (43.4 years) and mean illness duration suggest that the mean onset of illness was in the early twenties and is similar to other local and international findings (2, 3, 4). We hypothesised that those with a longer illness would be more likely to have consulted a traditional healer. However, the results of this study did not reflect this. A possible explanation for this is that participants who consulted traditional healers did so earlier in the course of their illness and that chronicity of illness was not a factor which prompted traditional healer consultation.

8.4.6 Substance use

The use of substances is regarded as a poor prognostic feature in schizophrenia and is associated with increased levels of violence and poor adherence to medication (103). A study conducted in Zambia found that women who had seen a traditional healer in the past were more likely to use alcohol in their pregnancy (75) and Sorsdahl et al (68) found that substance use was associated with traditional healer consultation in the general population.

We hypothesised those individuals who used substances may be more symptomatic, have poorer recovery and be more prone to relapse and would thus be more likely to consult a traditional healer.

We did not find such an association with substance use in this study. Unlike Sorsdahl et al (68), we did not use a diagnostic interview to diagnose substance use disorders. It was beyond the scope of our study to classify the severity of substance use and examine for features of abuse or dependence.

Differentiating individuals with “casual” or occasional substance use from those with substance use disorders may have given a more accurate determination of the relationship between substance use and traditional healer consultation.

In addition since we only looked at lifetime traditional healer consultation and lifetime substance use we would not be able to comment on the temporal relationship, if any, between the two.

There were high levels of substance use with substances from most used to least used being nicotine, alcohol, cannabis and methamphetamines. Participants were asked about any other substance they may have used or be currently using however none were reported.

It is possible that there was an under reporting of cannabis use in this study. A South African study by Koen, Jonathan and Niehaus (104) examined a sample of 547 schizophrenia sufferers and found a prevalence rate of cannabis use or abuse of 49,5%. Our result is, however, comparable with the results of a review of 53 studies by Green, Young and Kavanagh (105) which found the lifetime prevalence of cannabis abuse in schizophrenia sufferers to be 42,2%.

Previous research found rates of a lifetime alcohol use disorder in schizophrenia to be almost 40% (106). In this study more than 50 % of participants had a past or current history of alcohol use.

Nicotine is the most common form of substance abuse for people with schizophrenia. An Australian study showed smoking in 73% of men and 56% of women with schizophrenia, compared to the national averages of 27% and 20% respectively (101). The finding in this study that 66,30% of patients were currently smoking and 3,26% had smoked in the past was similar to that of the Australian study.

A recent study by Weich and Pienaar (107) conducted at Stikland Hospital in the Western Cape reported that 22% of patients with acute psychiatric admissions had a positive urine methamphetamine test. Our result of 10.87% (n=10) reporting a positive lifetime history of methamphetamine use is lower than this. The possible reasons as to why our findings may differ include the following. Only 38% of our study population presented with a psychotic disorder – metamphetamine use is more likely to present as psychosis. Urine testing for substance use is a more objective and removes reporter bias associated with patient reporting that was used in this study. Patients who use methamphetamines are also more likely to relapse and have levels of aggression which necessitate admission thus skewing the hospital sample to have more patients with history of methamphetamine use. Lastly our study focussed on an entirely black population who have previously been shown to have lower levels of methamphetamine use than coloured South Africans (108).

8.4.7 Suicide attempts

In their study of 9156 first admitted schizophrenic patients Mortensen and Juel (109) found deaths from suicide to be 20 times higher than that of the general population with the risk of suicide being particularly high in the year following diagnosis (SMR Men 156.0 SMR women 319.8). In a meta-analysis by Brown (110) suicide was found to be the single largest contributing cause of excess mortality in schizophrenia accounting for 28% of the risk of premature death.

Suicide attempts may be an indicator for severe disease and are a noticeable behavioural symptom and we hypothesised that this may prompt the family or patient to consult a traditional healer. Just over ten percent of participants in our sample had attempted suicide once or more. This figure is high compared to the national suicide rate of 15,4 per 100, 000 population (111). Since this is a prevalence sample where participants were recruited at all points of their illness it may not be a true reflection of suicide risk as the highest risk for suicide is in the years following diagnosis and patients with completed suicide in this period would not be accounted for in this study.

Our hypothesis that suicide attempts are an easily observable and distressing behaviour which may increase the likelihood of traditional healer consultation was not proven to be true in our sample. No studies could be found which had previously examined suicide attempts as a predictor for traditional healer consultation.

8.4.8 Physical illness

Schizophrenia sufferers are known to be at increased risk from a wide range of physical illnesses including cardiovascular disease (112, 113, 114), infections (115, 116, 117) and accidents. International studies have demonstrated that physical ill health is associated with the use of alternative forms of health care (57, 58). There is also evidence that individuals who consult traditional healers are less likely to comply with all forms of medication (75, 81) which may perpetuate physical problems and thus hospital admissions.

We were, however, unable to establish a relationship between admissions for physical ill health and having consulted a traditional healer. While asking about an easily identifiable indicator of ill health

such as hospital admission may have assisted in the accuracy of the data collected, it did not identify less severe or more poorly defined ailments which may also have prompted traditional healer consultation. In addition the shortage of hospital beds may have reduced the accuracy of admissions as an indicator of ill health.

8.5. Other significant findings

Internationally, patients with serious mental illnesses such as schizophrenia have been shown to be at higher risk for contracting HIV (118,119), with HIV seroprevalence levels that are 8 times higher (120). In South Africa, the national prevalence rate of HIV is 10,6%, which is the 4th highest worldwide (122). In addition, the level of knowledge about HIV is low and there are increased levels of high risk sexual behavior amongst schizophrenic patients (121). Yet, only 8% of patients in this study reported that they were HIV positive. This figure is also half of the prevalence rate in 15-49 year olds which is 16,9% (122).

This finding could be because a portion of the study population had not been tested or that they were reporting on a previously negative test, which was done some time ago. It is also possible that while all of the participants chose to disclose their HIV status, some may have provided false information for fear of stigma and possible confidentiality concerns.

The high proportion of HIV untested patients is concerning especially considering the fact they have all had contact with health professionals who should actively promote voluntary counselling and testing.

This finding is supported by a study by Joska (123) which showed extremely low rates of testing for HIV amongst psychiatrists in the Western Cape with only 2 of the 13 psychiatrists surveyed routinely testing patients for HIV.

9.0 RECOMMENDATIONS

Since almost a quarter of participants had made contact with a traditional healer optimising the quality of these contacts is important to improve illness outcomes. The following are recommended:

- a. Education of traditional healers by psychiatrists on the causality, diagnosis and treatment of schizophrenia
- b. Improved channels of communication to facilitate the referral to psychiatry of patients identified as suffering from psychosis to shorten the duration of untreated illness
- c. The development of programmes which optimise traditional healer's roles in the management of people with schizophrenia for example: empowering traditional healers to provide psychoeducation to patients and families and to monitor compliance to medication.
- d. Involving traditional healers in anti-stigma campaigns so that they can use their positions as respected members of the community to motivate for increased acceptance of people with schizophrenia

It is also recommended that clinicians regularly enquire about the use of traditional healer and actively enquire if patients are related to a traditional healer as to identify patients with a higher likelihood of consulting a healer. Establishing this early and the development of working relationship between the

doctor and the traditional healer will hopefully improve outcomes. Such a collaboration which acknowledges and values the patient's cultural beliefs would hopefully improve the acceptability of treatment as well as their satisfaction with the care received

10. LIMITATIONS

The sample size was small. There were high levels of unknown information for some categories such as HIV status and compliance, accessing other sources of collateral information such as clinical records would likely have improved the accuracy of this data. Due to the retrospective nature of the study we cannot exclude an element of recall bias.

We did not collect data regarding at which points in the illness patients had consulted a traditional healer which would have added to the understanding of traditional healer use. It would also have been useful to clarify whether participants were consulting traditional healers they were related to or those outside of the family in order to better understand their help seeking behaviour patterns. When compiling the database patient level of education was not included and since this was shown to be significant in other studies this would have been useful.

This study was retrospective review of a database and thus dependent on the accuracy and completeness of data recorded in the database which are limitations of the study design.

11. CONCLUSION

This study found that a high proportion of the participants had consulted a traditional healer, which was significantly associated with having a traditional healer as a family member. It emphasises the importance of the family network in terms of treatment decisions, shared cultural beliefs between family members and the role that increased accessibility to traditional healers may play.

Since traditional healers are frequently consulted by Xhosa schizophrenia sufferers it would be useful to investigate how their involvement in the patients care could be optimised to ensure that their services conform to accepted standards and norms for the treatment of schizophrenia. Programmes which improve the mutual understanding and co-operation between Western practitioners and traditional healers may improve the outcomes in this illness and should be developed and their effectiveness continuously monitored.

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13. APPENDIX

13.1 Approval for the study

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Dr Taryn Sutherland

CLEARANCE CERTIFICATE

M10211

PROJECT

Mortality in a Cohort of Xhosa Speaking
Schizophrenia patients, a Longitudinal Study

INVESTIGATORS

Dr Taryn Sutherland.

DEPARTMENT

Department of Psychiatry

DATE CONSIDERED

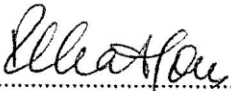
26/02/2010

DECISION OF THE COMMITTEE*

Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 20/04/2010

CHAIRPERSON 
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Prof Y Jeenah

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

13.2 Approval of change in title

M10

M10M10

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Dr Taryn Sutherland

CLEARANCE CERTIFICATE

M10211

PROJECT

A Retrospective Review of Lifetime Prevalence
of Traditional Healer Consultation by an Out-
Patient Sample of Xhosa Schizophrenic

Sufferers (new title)

INVESTIGATORS

Dr Taryn Sutherland.

DEPARTMENT

Department of Psychiatry

DATE CONSIDERED

26/02/2010

DECISION OF THE COMMITTEE*

Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 22/03/2011

CHAIRPERSON
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Prof Y Jeenah

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress report.

13.3 Data collection sheet

Date:

Participant no:

Age	
Sex	M/F
Marital Status	Single/Married/Divorced/Cohabiting
Ever employed	Y/N
Currently employed	Y/N
Number of cohabitants	
Duration of illness	
Number of hospitalisations for mental illness	
Number of hospitalisations for physical illness	
Medication compliance	Complete/partial/not at all
Subjective report of medication side effects	
HIV status (self-reported)	Positive/Negative/Untested/Wishes not to disclose
Substance use history	Substance 1: Current use/Previous use Substance 2: Current use/Previous use Substance 3:

	<p>Current use/Previous use</p> <p>Substance 4:</p> <p>Current use/Previous use</p>
Suicide attempt/s	Y/N
Previous traditional healer visits	Y/N
Traditional healer in family	Y/N

Aretrospectivereviewoflifetimedprevalenceoftraditionalheale..

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