

Traditional Healing of Psychiatric Patients in Saudi Arabia

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Abstract

Traditional Healing is a popular alternative therapy in Saudi Arabia inspite of the wide spread of health services. This study attempts to determine the frequency, socio-demographic and clinical characteristics of traditional healer (T.H.) visiting among psychiatric outpatients in Al-Khobar area. A random sample of 227 cases was drawn from patients attending the psychiatric outpatients of King Fahd Hospital of the University, AlKhobar, Saudi Arabia. A structured questionnaire consisting of 32 items including socio-demographic and clinical characteristics of patients, as well as their experience with T.H was completed for each subject. Seventy percent of all studied patients reported having resorted to T.H. sometime during the course of their current illness. Of these 60% had visited the T.H. Before seeking psychiatric treatment. The frequency of attending traditional healers was found to be significantly associated with female gender, elder age group, low mother's education, psychiatric hospitalization and a diagnosis of schizophrenia. Traditional healers have a great impact in management of psychiatric morbidity and in the utilization of psychiatric services in the community. The impact of T.H. practices on the frequency of psychiatric service utilization are discussed

Introduction

Traditional healing (T.H.) is a popular alternative form of therapy despite the relative availability of modern health services. Though people seek the help of T.H. for a wide range of medical conditions, it is particularly with reference to psychological complaints that they are most frequently consulted.

Goldberg and Huxely (1980) describe the levels of psychiatric morbidity and the pathways (filters) through which psychiatric patients reach the health care systems. Only a proportion of the total psychiatric morbidity in the community seeks medical care (total primary care morbidity); of these only some are recognized as mental disorders (Conspicuous primary care morbidity); of these only proportion is referred to psychiatrists (all psychiatric patients); and

of the latter only some are admitted (Psychiatric in-patients).

Patel and Colleagues studied the pathways to primary mental health care in Harare, Zimbabwe. Different factors have been found to operate in the decision-making process of choosing to consult either the biomedical or the traditional care providers. The latter more often provided their clients with explanations than did the biomedical care providers; explanations were most often spiritual (Patel et al, 1997).

Prevailing socio-cultural concepts about the aetiology of mental illness are powerful determination of help seeking attitudes. (Razali et al, 1996), investigating a sample of mentally ill patients using 20-items check-list, found that 53% of the patients attributed their illness to some supernatural agent, particularly witchcraft and

possession by evil spirits. The belief in supernatural causes of mental illness was found significantly more among those who had consulted T.H.

A study from Ethiopia showed that T.H. there use amulets, holy water, herbs and cautery to treat headaches, seizures and mental disorders (Gerhard, 1990).

In Arab Culture, the conceptual attribution of mental illness swings between the biomedical and spiritual models. In Saudi Arabia community most T.H. operate on the widely accepted traditional belief that mental disorders are caused by magic, evil eye or possession by devil. This seems to be a powerful determination of help seeking behavior among vast segments of the population and of the types of therapeutic procedures employed by the traditional healers.

The present study attempts to probe the frequency of resort to T.H. among psychiatric patients, and to analyze the main socio-demographic and clinical correlates of individuals who seek the help of T.H. in this part of Kingdom of Saudi Arabia.

Subjects and Methods

The study sample was randomly drawn from the attendants of the psychiatric outpatient department at King Fahd Hospital of the University in Al-Khobar. It includes new as well as old patients coming for follow-up of their treatment. A total of 227 of such patients were investigated.

The interview was conducted by a structured questionnaire specially designed for the present study. It consisted of 32 items. The first section (items 1-18) covered various socio-demographic and clinical characteristics including: age, sex,

nationality, religion, occupation, marital status, residence, income, family structure and atmosphere, parental education and occupation; presenting symptoms, onset, duration, course, treatment and diagnosis.

The second part (items 19-32) was devoted to the patient's experience with T.H., including its occurrence, frequency, timing, expectations, attitudes as well as forms of therapeutic interventions and their outcome. The clinical psychiatric assessment was done by the investigators, and diagnoses were made according to the ICD-10 Criteria.

Data entry and analysis were performed using SPSS WIN 7.5, statistical package for social science. Continuous variables were compared by means, standard deviations and Student-t-test or F-value as appropriate. Normal and ordinal variables were compared by Contingency tables and chi-square tests. To determine the predictors of resorts to T.H., the presence or absence of such an experience, as a dichotomous outcome variable was entered in a logistic regression analysis against all the independent socio-demographic and clinical variables with which it was found to be significantly associated at the level of bi-variate analysis.

Results

Socio-demographic data:

Demographic characteristics of the study sample are presented in table (1). The bulk of the patients were Saudi nationals (83.9%), there was slight insignificant predominance of females (53.3%) in the sample. The mean age of (31.79 ± 13.29), was slightly younger in females (30.76 ± 13.68) than in males (32.73 ± 13.9). About two third of the patients (64%) were in the age range 20-39 years.

About one quarter (26.9%) of patients were illiterate, 38.1% were of middle education (up to 9 grades of schooling), and the rest were either of secondary (22.9%) or university education (12.1%). Two third (67%) of the patients had no out-door occupation. This unemployment was twice as common among females (85.3%) as among males (43%), ($P < 0.01$). About half of patients (51.3%) were married, the remainder were either single (39.7%), divorced (6.3%) or widowed (2.7%). Males were significantly more frequently of single status (51.9%) while females were more commonly married (59.3%), ($P = 0.01$).

Regarding the father's education, more than half of fathers (54.1%) was completely illiterate. And only 14% had an education beyond 9 grades of schooling. The level of mothers' education was considerably lower than that of fathers, with 77% of them being completely illiterate.

Clinical Characteristic of the study sample:

Table (2) and figure (1) shows the frequency of various ICD-10 diagnoses among patients. Mood disorders were the most common diagnosis (44.9%), followed by "Neurotic, Stress Related and Somatoform Disorders (21.3%), and schizophrenia (19.6%). Mental Retardation (4.9%), Behavioral and Emotional Disorders with onset specific to Childhood and Adolescents (4.4%), Personality Disorders (1.3%), Substance Use Disorders (1.3%) and Organic Mental Disorders (0.9%).

Females were over represented in the group of mood disorder (54.2%), while males were more frequent in the groups of Schizophrenia (24.3%), Mental Retardation (7.5%) and Behavioral and Emotional

Disorders with Onset Specific to Childhood and Adolescents (5.6%).

The Prevalence of Visiting TH:

One hundred and fifty eight (70.50/o) of all patients have resorted to TH sometime During the course of their psychiatric illness. Females consulted T.H. significantly more frequently than males (56.3% and 43.7. % respectively) ($P < 0.05$), Figure (2,3). The mean age of those who had visited T.H. was significantly higher than that of patients who had not. (33.2 ± 13.44 and 28.54 ± 12.5 respectively, $P < 0.05$). However, there was no significant difference in the mean age between males and females who visited T. H. ($P > 0.05$).

Table (3) shows that the frequency of resorts to T.H. did not vary significantly with patients' nationality, level of education, occupation, marital status, father's education and occupation and mother's occupation. But mothers' level of education was found significantly lower among those patients' who had visited T.H. than among those who had not: (mothers' were illiterate in 76.6 % of the former and only 50% of the later. $p < 0.001$).

From a diagnostic point of view, patients suffering from schizophrenia visited T. H. more frequently (86.4%) than those with Mood Disorders (71.3%), Neurotic Stress Related and Somatoform Disorders (70.2%), and Personality Disorders (66%). The least frequent rate of visiting T.H. was observed among the groups of Mental Retardation, disorders with onset specific to Childhood and Adolescents Disorders of Psychological Development (39.1%). Figure (4) shows the distribution of psychiatric diagnoses among patients who visited and who did not visit T.H.

There was no significant difference in the frequency of visiting T.H. in-patient's with various duration of illness.

However, patients who were hospitalized for their psychiatric disorder had more frequently consulted T.H. (82.3%) than the patients who were not hospitalized (61.8%) ($P < 0.001$).

Characteristics of T.H. visitors:

Most Patients who visited T.H. Did that on family advice (61.8%), they frequently had other family member being seen by T.H. (43.2%). The patients expectations from their visits to T.H. varied from skepticism in (42.7%), to confident hopefulness in (43.3%) of cases.

The majority of patients who had ever visited T.H. did so prior to seeking psychiatric treatment (60.6%), while the rest did so either simultaneously with or some time after their psychiatric consultation (21.2% and 16.6 % respectively).

The 'diagnoses' given by T.H. were either Evil Eye (21%), possessions by the Devil (19%) or magic (2%); for the remaining patients the T.H. did not comment themselves to a particular diagnosis. Reading Quran was the most common form of treatment offered by the T.H. (33.1%); other forms included herbs (22.3%), Rughia (8.9%), Cautery (5.1%) or mixture of Quran and herbs (19.1 %).

Approximately (72%) of patients did react well to T.H. visiting, and (63.5%) were complaint on their therapy.

The majority of patients who had visited T.H. shifted to psychiatric services. This was more frequently made on family than personal decision (45.9%, and 23.6% respectively). About two thirds (63%) of

patients, who had been to T.H. prior to seeking the help of psychiatrists, stopped visiting their T.H. subsequently.

Gender differences in Visiting T.H:

On the whole females tended to visit T.H. upon their family decision and they were more complaint with T.H. therapy, showed better response to T.H., were likely to have visited T.H. before psychiatric services and were more satisfactory with T.H. therapy than males ($P > 0.05$).

The only difference, which was significant between males and females that visited T. H., was the reason behind of their shift from T.H. To psychiatric, services ($P < 0.05$). Males did so more frequently upon their own decision (30.7%) than did females (17.8%). For females the shift was more frequently decided by the family (47.8% versus 42.7%). Only a small proportion of patients were advised by their T.H. to seek psychiatric consultation (6.7% of males and 17.8% of females).

The results of Logistic Regression revealed that the factors which significantly contributed to the prediction of whether a psychiatric patients in this community would at some stage of illness resort to a T.H. were: father's occupation ($P = 0.005$), mother's education ($P = 0.03$), psychiatric hospitalization ($P = 0.03$) and Diagnosis ($P = 0.03$).

On the other hand, the factors that predicted whether a psychiatric patient would consult a T.H. prior to seeking psychiatric help were: father's occupation ($P = 0.01$) and whether the patient would ever be hospitalized ($P = 0.01$).

Table (1): Socio-demographic data of the study sample

Variable	Male N=106		Female N=116		Total		Significance		
	No.	%	No.	%	No.	%	X ²	Df	P
Age:									
< 20 years	14	3.2%	13	11.2%	27	12.2%			
20-39 years	69	64.0%	73	63.0%	142	64.0%			
> 40 years	23	22.8%	30	25.8%	53	23.8%	0.5	2	>0.05
Nationality									
Saudi	95	90.5%	99	83.9%	194	87%			
Non-Saudi	10	9.5%	19	16.1%	29	13%	3.2	3	>0.05
Education:									
Illiterate	20	19%	40	34.2%	60	26.9%			
Middle	40	38.1%	45	38.5%	85	38.1%			
High	46	43.4%	32	27.3%	78	35.0%	8.5	2	* 0.01
Occupation:									
No	46	43%	99	85.3%	145	65%			
Yes	61	57%	17	14.7%	78	35%	52	8	* 0.00
Marital Status:									
Single	55	51.9%	34	28.8%	89	39.7%			
Married	45	42.4%	70	59.3%	115	51.3%			
Divorced	6	5.7%	8	6.8%	14	6.3%			
Widowed	0	0%	6	5.1%	6	2.7%	16	3	* 0.00
Mother's Education:									
Illiterate	75	70.1%	96	83.5%	171	77%			
Middle	29	27.1%	13	11.3%	42	19%			
High	3	2.8%	6	5.2%	9	4.1%	9.3	2	* 0.00

- *Statistically significant*

Table (2): Illness Characteristics of the Study Sample:

Variable	Male		Female		Total		Significance		
	No.	%	No.	%	No.	%	X ²	Df	P
Diagnoses:									
Organic Mental Disease	2	1.9%	0	0%	2	0.9%			
Substance use Disease	2	1.9%	1	0.8%	3	1.3%			
Schizophrenia	26	24.3%	18	15.2%	44	19.6%			
Mood Disorder	37	34.6%	63	53.5%	100	44.9%			
Neurotic, Stress Related Somatoform Behaviour syndrome	23	21.5%	25	21.2%	48	21.3%			
With Psychological Personality Disorders	1	0.9%	0	0	1	0.4%			
Mental Retardation	0	0	3	2.5%	3	1.3%			
Disease of Psychological Development.	8	7.5%	3	2.5%	11	4.9%			
Behaviour & Emotional with Childhood onset.	2	1.9%	0	0	2	0.9%			
	6	5.6%	4	3.4%	10	4.4%	19	9	* <0.05
Duration:									
< 1 Year	12	11.2%	27	22.8%	39	17.4%			
= 1-5 Years	37	34.6%	40	33.9%	77	34.2%			
> 5 Years	58	54.2%	51	43.2%	109	48.4%	5.6	2	=0.05
Hospitalization:									
Yes Ever	43	40.2%	51	43.2%	94	41.8%			
No Never	64	59.8%	67	56.8%	131	58.2%	0.2	1	>0.05

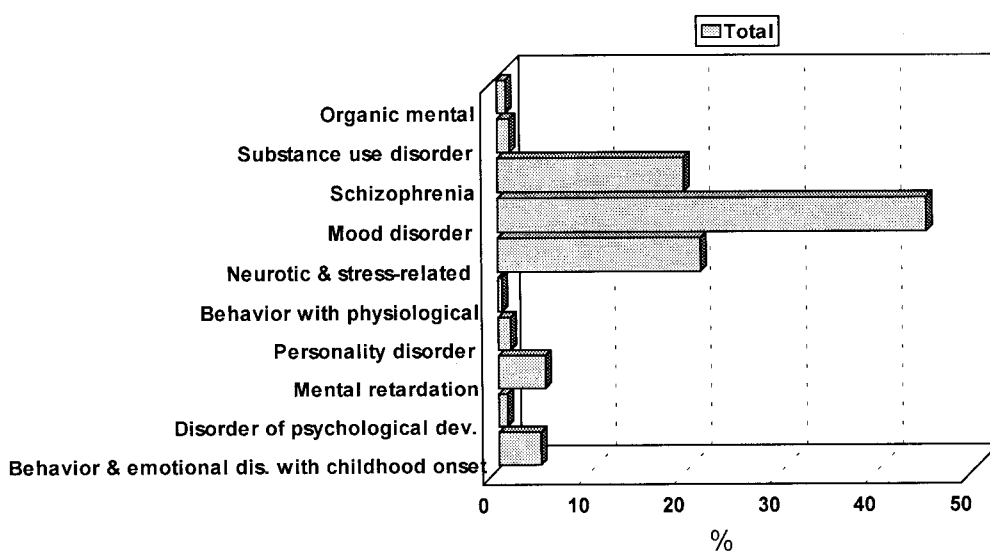
* Statistically significant

Table (3): The differences between patients who visited and who did not visit T.H.

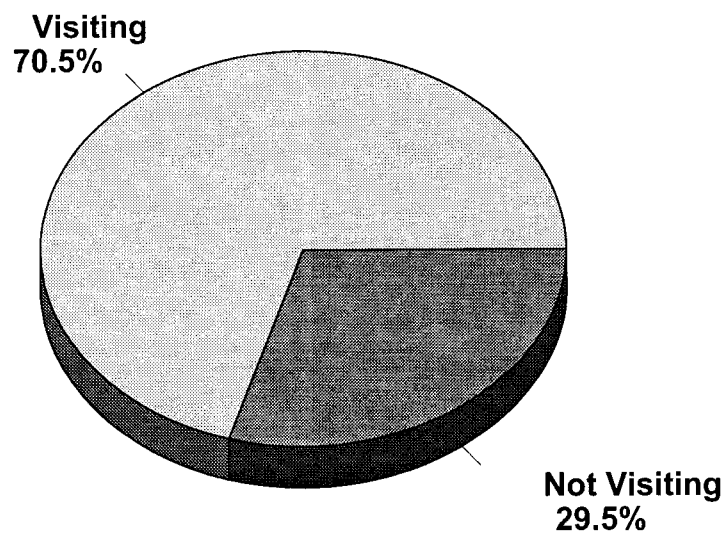
VARIABLES	VISITING T.H.		NOT VISITING T.H.		SIGNIFICANCE		
	N=158	%	N=66	%	Value	D.F	P
Personal data:							
Sex : Male	69	43.7%	38	57.6%	3.6	1	*0.04
Female	89	56.3%	28	42.4%			
Age:							
< 20	13	8.4%	14	21.2%	8.1	2	*0.01
20-40	104	67.1%	42	63.6%			
> 40	38	24.5%	10	15.2			
Education:							
Illiterate	41	26.3%	19	29.2%	1.4	2	0.4
Middle	64	41.0%	21	32.3%			
High	51	32.7%	25	38.5%			
OCCUPATION:							
Not working	104	65.8%	40	63.5%	0.22	1	0.6
Working	54	34.2%	24	37.5			
Marital Status:							
Single	58	36.7%	31	47.7%	4.9	3	0.1
Married	85	53.9%	29	44.6%			
Divorced	12	7.6%	2	3.1%			
Widow	3	1.9%	3	4.6%			
Mother's Education:							
Illiterate	131	84.0%	40	61.5%	13.1	2	*0.001
Middle	21	13.5%	21	32.3%			
High	4	2.6%	4	6.2%			
Source of Referral:							
Self	42	26.8%	21	31.8%	13.9	6	0.05
Medical	50	31.9%	25	37.9%			
Family	55	35.0%	17	25.8%			
T.H.	8	5.1%	0	0			
Duration of Illness:							
< 1Year	3	1.9%	1	1.5%	1.2	2	0.5
1-5 Years	82	51.9%	29	44.0%			
> 5 Years	73	46.2	36	54.5%			
Hospitalization							
Never	80	51.3%	48	75.0%	10.4	1	*0.001
Ever	76	48.7%	16	25.0%			

* Statistically significant

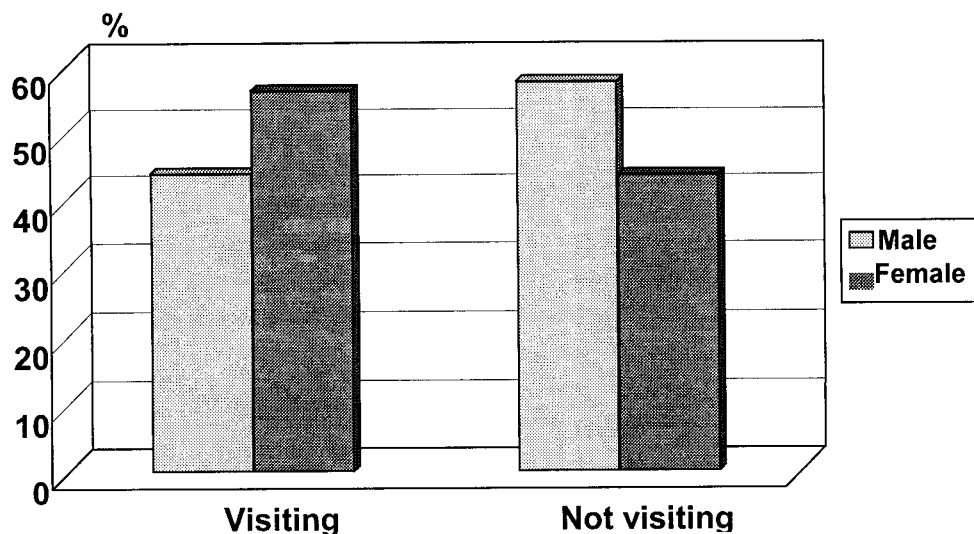
(Fig 1) The distribution of psychiatric diagnoses in the study sample



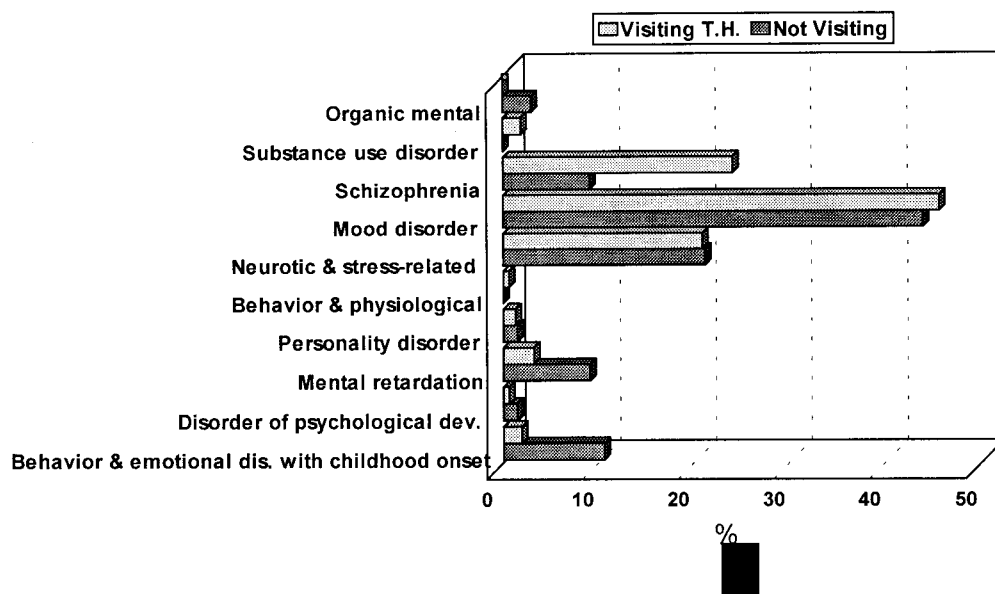
(Fig 2) Frequency of visiting T.H. among



(Fig 3) Gender Difference among patients visiting



(Fig 4) The distribution of psychiatric diagnoses among patients visiting T.H.



Discussion:

The central finding of the present study is that nearly three quarters of all psychiatric patients have resorted to T.H. sometime during their index illness, and that they most frequently did so as a first choice of treatment. This tendency did not seem to be significantly influenced by such individual characteristics as the patient's own education, income, locality or marital status. This was in agreement with Veroff et al., (1981) El Amin & Refat, (1997) and Sato et al., (1995). However the only factors that significantly contributed to predicting the likelihood of preferring T. H. were being a female, of an elder age, being either jobless or of a military occupation, having an illiterate mother, being schizophrenic or depressed, and being ever hospitalized during the course of the illness. Religious and other socio-cultural beliefs, shared by the patient or his family, are major determinants of help-seeking behavior. Rakhawy (1996) ascertained that psychiatrists in this part of the world hardly receive patients who had not been passed through T.H.. Kenneth et al. (1996) Observed that many patients with mental illness begin the process of receiving treatment through non-psychiatric services, and that this choice of alternative routes protects the patients from the stigma of psychiatric treatment. Patel et al. (1997) argued that psychiatric patients prefer T. H., because the latter tend to give them culturally acceptable interpretations of their conditions.

Female patients in our study were more likely to have been to T. H. than men did. This may be attributed to different factors. To start with, females in this culture are generally less educated, homebound, economically inactive and generally less

exposed to incoming socio-cultural influences. Rahim and Cederblad (1986) studying the psychosocial effects of rapid urbanization in Sudan, found that women in that community more adherent to inherited values and traditions than men. Secondly, the stigma of mental disease seems to have more devastating effects on the social status of women than it is to men. For single girls it might reduce their chances of getting married; for married women it might become an excuse for divorce or polygamy.

An interesting finding was that the level of education of the patient's mother, rather than that of his father, determined whether he would be taken to a T.H. or to psychiatrist. It is not easy to find a ready explanation of these findings. Perhaps mothers in this culture are more influential in decision-making related to what therapy is to be sought. On the other hand, as educated women are most likely to be married to educated men it is perhaps the parental consensus, and not just the mother's education, which determines the choice of treatment.

Another interesting finding was that schizophrenia and other psychotic disorders requiring hospitalization were over-represented among the psychiatric patients who had been to T.H.. One would have expected that the T. H. group would be predominantly composed of minor psychiatric morbidity, which can be effectively helped with counseling, reassurance, therapeutic suggestion and social support. However, there is the likelihood that patients with these milder disorders, who have consulted T. H., might have been sufficiently helped by T. H., and had no need to see psychiatrists afterwards, while schizophrenic and other psychotic

patients did not improve with T.H. interventions, and had to be taken to psychiatrists and to be hospitalized.

Moreover, the nature of the symptoms, it's likelihood acceptance by the community and the way they explained these symptoms influence the selection of health services providers. For example, in schizophrenia the presence of delusions and hallucination are a new experience which can not be accepted as a normal phenomena by the society; always explained as odd and eccentric and usually attributed to spiritual reason. So schizophrenics are brought to T.H. more frequently than to psychiatric services.

On the other hand, disorders related to children and adolescents; Disorders of Psychological Development, Mental Retardation and Behavior and Emotional Disorders, were found to seek psychiatric services more frequent than visiting T.H. This could be explain in the view of early and easy discovery of these disorders by Pediatrician or family doctors who tend to transfer them to psychiatric services. Moreover, parents might not prefer their children to be subjected to any frightened experience while visiting T.H..

Okasha (1996) and Jilek (1990) mentioned that alternative medicine provide effective therapeutic management of neurotic, stress related and somatoform disorders, transient psychosis, culture bound syndromes and treatment, prevention and rehabilitation of alcohol and drug dependence. However, they may be ineffective in schizophrenia and other psychoses, though delaying effective modern chemotherapy.

Conclusion:

The conflict experienced by the modern psychiatrist when faced with traditional

healing practices should be no more exists. Moreover, the role of T.H in the community must not be neglected.

The level of the mother's education, patients occupation, psychiatric diagnosis and it's need for hospitalization at any time during the course of the illness, all act together to determine the help seeking behavior.

In addition, social and religious beliefs and fear from stigma of mental illness influence the help-seeking behavior of mentally ill patients- Moreover illiteracy, especially among women, has a major role in the selection of health services providers. So eradication of illiteracy should be one of the most important priorities in the community.

WHO is already advocating the adoption of a policy of close collaborations between health mental system and traditional medicine in general, especially in places where mental health personnel is scarce. Instead of the apparent schism between traditional and modern medicine it may be advisable to create cooperation between these services.

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