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This thesis is dedicated to my late parents, my brothers, sisters and my lovely wife
for their courage and moral support.

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1. Introduction

This study involves a close view of schizophrenia patients in different cultural environments in Africa (Nigeria) and Europe (Germany). The aims and objectives of this study are to find out differences in symptoms, incidence rate, diagnostic means, treatments and as well as the inter-cultural influences on schizophrenia if any!

History of schizophrenia

Eugene Bleuler first introduced the term “schizophrenia” in 1911. In a layman’s language, schizophrenia can be defined as a mental sickness, which affects the entire human personality (but without a reduction of the human intellectual potentials)

The main root of schizophrenia is still unknown. While many attribute the cause of the sickness to an over-proportional availability of dopamine (neurotransmitter) in some parts of the brain, other hypotheses claim that schizophrenia is more or less a mental sickness of the developed nations, an illness of the civilisation (sickness of the “well to do”) It is certain that over-stimulation in form of psychotherapies, psychoreactive and so on, could lead to the development of schizophrenia.

In all cultural groups, the incidence rate is more or less 1% of the population, which however suggests a genetic disposition, though there have been claims of a higher incidence rate in one cultural group or the other. Unfortunately these claims were not proved.

1.1 The risk of relatives of schizophrenia patients also suffering from the sickness is as follows:

| | |
|------------------------------------|--------|
| Parents: | 5-10% |
| Children: | 9-16% |
| Brothers and sisters : | 6-14% |
| Similar twin (mono-ovular) : | 15-78% |
| Dissimilar twin (two-egg) : | 6-28% |
| Children of both affected parents: | 36-60% |

1.2 Age of schizophrenia sickness

| | |
|---|-----|
| Patients less than 14 years of age : | 2% |
| Patients between 14 & 30 years of age : | 54% |
| Patients between 30 & 40 years of age : | 26% |
| Patients more than 40 years of age : | 18% |

Women are more but at later age affected than men

1.3 Prognoses of schizophrenia sickness

30% of the schizophrenia sickness heals without rest symptoms
30% of the schizophrenia sickness heals with rest symptoms
30% of the schizophrenia sickness turns to chronic stage
(Andreas Turm, Medi-learn Marburg 2002; personal information!)

1.4 Bridging tradition and modernisation

The publications of the British Journal of Psychiatry by Oyedele Ayonrinde, Oye Gureje and Rahmeaan Lawal (2004), showed that there was very little or no recognition and treatment of mental disorders in Nigeria with the western models of psychiatric service delivery until the early 20th century. The first asylum of the western model of psychiatric services was established in the southern city of Calabar in 1904, and after a short time (in 1907) the Yaba asylum was established in Lagos, also in the south. Just as in a few regional psychiatric hospitals today, medical officers ran these asylums, since there were no trained psychiatrists. These asylums provide essential emergency and custodial interventions. In 1954, the Aro mental hospital was established in Abeokuta by the British colonial government as a means of providing a solution to the rising need of mental health care. It also provided an opportunity for the country's first indigenous psychiatrist, Dr Lambo, who spearheaded chains of psychiatric services on his return from the UK in 1952. The hospital, later to be known as the Aro neuropsychiatric hospital, aimed to play a leading role in the development of psychiatry in Nigeria with community and World Health Organisation initiatives.

In almost all the communities in each locality, the practice and acceptance of faith healing and traditional medicine were seen as the order of the day. The reason was however not far fetched as lay views of mental illness are still "rooted in super natural belief systems and traditional illness models, orthodox psychiatric care faces the challenge of proving its efficacy in some sectors of the society.

1.5 History of Nigerian psychiatry

The British colonial history dominated the Nigerian psychiatric service and provided the country with the little western mental care the nation could use. The majority of pioneering Nigerian psychiatrists were trained in the UK in the 1960s. Currently, most psychiatrists in the country have contributed in training psychiatrists in other West African countries (encompassing Nigeria, Ghana, Liberia, Sierra Leone and The

Gambia) or in national postgraduate programmes instituted in 1976 and currently run at the West African Postgraduate College and the National Postgraduate Medical College. The examinations are conducted in three stages, culminating in a supervised research project and dissertation. Today, there are more than 210 resident doctors training in psychiatry, but the need for more resident doctors is also very high.

Nigeria was one of the key centres for the landmark International Pilot Study of Schizophrenia (IPSS), the ten-country study of the incidence and manifestations of schizophrenia. A significant and important outcome of the study was the better prognosis in Nigeria and other less developed countries. Currently, research programs are being carried out in the areas of neuroimaging, longitudinal social outcome, caregiver burden and cost of treatment. just to mention only a few.

Most of the psychiatric cases handled by the clinicians are in primary care. A number of studies have assessed psychological symptoms and morbidity in both rural and urban primary care settings (Abiodun, 1993; Gureje, 2002). In the World Health Organisation (WHO) 14 country study of psychological problems in general health care prevalence, course and prognostic factors influencing somatisation and pain related disorders were investigated in Ibadan, contributing to cross-national awareness of these disorders.

A large number (approximately 70%) of mental health service provision is delivered through non-orthodox means such as religious organisations and traditional healers, but only a little is known about them and research into these services and their implications for psychiatry are important. Some centres have looked into the role of traditional therapists in mental health interventions. A common finding was that traditional healers could recognise symptoms of severe mental illness of different types, but that they expressed a strong belief in supernatural forces as a cause of mental illness. Modernisation and psychoeducation were found to have played an important role towards improving their understanding of aetiology and to reduce their tendency to use corporeal interventions. There remain numerous opportunities for working closely with healers, who may be the first point of contact in some communities.

Research in the psychopharmacological fields in Nigeria is limited by the restricted pharmaceutical industry funding of trials and the unsubsidised cost of psychotropic medication. As a recent open-label study of risperidone in the treatment of schizophrenia carried out in Lagos and Kaduna observed a notable decline in total Positive and Negative Syndrome Scale scores, extrapyramidal side-effects and improved social functioning. Findings were generally similar to those reported from other countries in this multi-centre trial. The lack of significant subsidies for such medication prohibits its use beyond trial periods for many. Studies like these are all the more pertinent in a period of inter-national concern about the dearth of drug trials across geographical, racial and ethnic groups.

2. A look at the Nigerian clinical system compared to that of Germany

I served at the psychiatric department of the university teaching hospital Portharcult (Nigeria) during my practical year for a period of four months (08/12/03-28/03/04). Within this period I was fully involved in the day to day patient treatment and case handling of the hospital

My observations are as follows: Patients register their first attendance and obtain their attendance-card and a file is opened for them, after which the patients have to give the history of their mental ill-health to the record office. The file and recorded history are then sent to the doctor that would see the patient.

In most case patients come to the hospital with their partners, parents or close relations who assist them when and where the need arises, like in Germany too. After seeing the doctor, patients might be hospitalised if the need arises or given an appointment for the next consultation!

During the "Ward-round"(In-Patient's days) partners, parents or close relations of the patients are expected to be present. They are expected to have had enough time with the patient with the aim of assessing the progress of the health of the patient and as well noting his complaints before they saw the team of doctors, nurses and social welfare. Evidence has however proved that some mentally sick patients do

withhold personal and important information from medical staff and only make such information available to their trusted relatives! Unlike the Nigerian system, the relatives of the Germany patients are not allowed to be present during the ward rounds.

As in the German clinics, counselling is also done by doctors when the need arises.

Because of the lay belief of African society that mental ill-health is caused by evil spirits and has mostly been invoked by people who were wicked to one another, families are always in disputes with each other. In most cases the other levels allegations against the mother, father, brother or sister-in-laws of another family. This results in broken homes and more or less worsens the environment for the patient. In situations of this kind, the intervention in, clarification and settling of disputes for the parties involved become unavoidable!

From time to time and if the health condition of patient warrants, in-patients are given "trial leave under the watchful eyes of their partners, parents or close relations who bring them back to the hospital and provide the hospital with observations made on the patient's behaviour and compliance during the trial leave! If good improvements are recorded, the patient's trial-leave might be extended until the patient is transferred to the out patient group. This is also done in German clinics.

Notable differences in the symptomatic of intercultural schizophrenia in Nigeria compared with Germany lies very much in the religious delusions and the laymans belief that mental sicknesses are caused by supernatural powers (evil spirits) as noticed in Nigeria. For this reason, the journey of most mental ill-health patients to the psychiatric hospitals last longer than normal. Almost 70% of the mental ill-health patients do consult/visit many church organisations (priests and pastors) and traditional healers only see medical Doctors if and only if their mental health condition does not improve! Almost 50% of the mental ill-health in-patients seek permission from medical personnel to attend crusades or meet pastor/priests of different churches.

Religion has indeed eaten deep into the bone marrow of the society! This could be attributed to the fact that mental ill-health patients believe that the best treatment for sicknesses caused by supernatural powers is prayers. Another reason for the high interest in churches is that they are always around the corner and more or less free

of charge, while they have to travel a longer distance to reach the psychiatric hospitals which are mostly in big cities. At this point, poverty as a serious hindrance to the search of the clinical treatment has to be mentioned. Many patients cannot afford to shoulder the transport costs to the hospital to say nothing of paying the cost of the treatments and drugs!

One should also not forget the fact that some of medical Doctors working in these Psychiatric hospitals are not trained Psychiatrists & for this reason do not have the required skills.

3. “Is a combined traditional and western health service for black patients desirable?”

Dorothy Farrand’s publication (S. African medical journal 1984), in her Introduction, she pointed out that the interest in the traditional form of healing increases from day to day, the pressure for a provision of a combined western and traditional health care service for patients of non- western cultures also increases. The present study was aimed at investigating the attitudes of black South African psychiatric patients to their choice of healer and their manner of using isangoma (indigenous healers). They were found to have favoured a two-phase treatment plan which allow them to consult the western doctors while in the hospital and consult the tradition healers while at home.

In recent times, more and more attention has been paid to black psychology and the roles played by indigenous healers in South Africa. The increasing rate of the recognition by local and international bodies of roles playable by traditional healers in mental health services and, secondly, the limitations of western health care delivery systems in traditional cultures.

One of the main issues facing critics in South Africa when talking of the western doctors is that western doctors, although they are capable of curing illness symptom, fail to recognise the traditional beliefs of the patients. Western doctors see the traditional beliefs of patients as unfounded and self created superstitious. Due to this reason, western doctors therefore do not provide answers to critical questions like ‘why the illness occurred. This leads to a big misunderstanding and misinterpretation.

Unlike the western doctors, indigenous healers share the same views of the patients and their families and provide them with the expected answers to the question “why the illness occurred” and by so doing, provide interpretations and cures which fit to the traditional belief system.

For the South African blacks, a choice of two main categories of indigenous healers are always available. The first includes the *isangoma* (Zulu), *dingaka* (Sotho) and *amagqira* (Xhosa). Their major functions include divination and the prescription of herbal cures and medicines. Please note that in this article, the word *isangoma* refers to all healers of this category. Another major category is a more recent one and includes *umprofita*, who divine and heal within the framework of the African independent churches with millions of members that integrate both worshipping and healing within the indigenous belief system.

In spite of the fact that networks of indigenous healers are at the service of the patients in both rural and urban areas, black people also have the service of the western doctor as an alternative and consult them when the need arises.

Information gathered from a large modern hospital on the Witwatersrand where many black patients from different South African regions are treated suggests that a strong cultural belief about illness exists in the majority of patients, and despite hospital treatment with biomedical orientation, patients still feel unsatisfied. In some cases, patients abandon their treatment in the hospital in order to consult indigenous healers in their localities.

In a survey that was conducted in the psychiatric wards of the hospital (1984), 65 black patients were confronted with the following questions:

- a. What is your preferred type of treatment? That offered by medical doctors, *umprofita* or *isangoma*?
- b. Have you consulted an *isangoma* and/or used indigenous medicines in the last year?
- c. Would you like to see an *isangoma* about your present illness?
- d. If an *isangoma* was working at the hospital would you consult him/her?

This last question was interesting because there was increasing pressure for western and indigenous healing methods to be made available at treatment centres where non-western patients are treated. Although the behaviour of black patients to such health centres has not yet been investigated, but it is assumed that since they often

consult indigenous healers, they would maybe be happy to see one who had been appointed and paid by a hospital authority. Questions 2, 3 and 4 focus on *isangoma* rather than *umprofita* for two reasons.

Firstly, *umprofida* heal within a group in the context of a church or religious ceremony.

For this reason, to practice it in the hospital may not be allowed. Secondly the desire for the inclusion *isangoma* into western medical service is very high, this is however not the case with *umprofita*

Responding to these questions, 21 patients (32,3%) indicated that they would prefer consulting medical doctors only, 10 patients (15,4%) preferred consulting *umprofita* only, 8 patients (12,3%) preferred consulting *Isangoma* only, 5 patients (7,7%) preferred a combination of medical doctors and *isangoma*, 5 patients (7,7%) preferred the combination of medical doctors and *umprofita*, while 16 patients (24%) preferred consulting all the three groups (medical doctors, *umprofita* und *isangoma*) Meanwhile, 18 patients indicated that they have seen an *isangoma* in the last year, 27 patients did take indigenous medicines in the last year, 10 patients indicated that they did see an *isangoma* about their present illness, 35 patients said that they would like to see an *isangoma while being treated in the hospital*

The fact that no total reliance on indigenous healers as recorded here, could be traced to the critical influence of the western doctor who condemns traditional beliefs and practice by convincing patients and their families that western medical service is the only acceptable healing system. According to patients, their healing choice often depends on the type of sickness they are suffering from, different sicknesses are categorised differently. Indigenous healers could treat some categories of illness while a western doctor could treat other categories of illness better. A point of interest is the fact that many patients who reject indigenous healers and cures attribute the same magical properties to Western medicine that they formerly attributed to indigenous medicine.

Dependable information from black workers reveals that black workers do go to the hospital if they are sick. If the sickness does not get better, they understand it to mean that they should go home and consult their own *isangoma*.

The above finding is said to correspond with conclusion and observations made in different parts of Africa which shows that blacks residing in the urban areas have generated an unusual model of treatment that depends mostly on both western and traditional care. They see treatment as a two-stage process in which a sick person should go the western doctor to cure the symptom of the sickness and later go to the indigenous healers to find out and alleviate the cause of the sickness. Without any doubt, the above finding argues for a combination of Western and indigenous treatment but one thing is certain, namely that the idea might not be accepted by all patients. With reference to the present study, almost half of the patients (46%) did say that they would not consult an indigenous healer that might be working with the western doctors of the hospital. These are however patients that said they would either not consult indigenous healers at all or would prefer to consult healer at their homes if the need arises.

The cause of this belief was suggested by Leeson and Frankenberg and was supported by personal communication with the patients in the present study. Black people seem to regard all doctors as equally good or bad, while isangoma in general are regarded as villains and only a specific isangoma is seen as being good. The poor consultation of specifically the healers working in the urban area during last year (28%), could be attributed to the fact that they are regarded as suspicious and described as not giving true medicines. "Just there to take your money away from you like rogues". It seems that contract workers from the local areas usually take their medicines from home to their destination of work and allow more to be sent to them from if they need more.

In a nutshell, an interesting finding about the two categories of indigenous healers was the fact that the *umprofita* were as popular as the *isangoma*. This finding is of great interest because till now, the focus of the literature on the *isangoma* has always indicated that this category of healer is the most popular among black people. According to information from black patients, the popularity of the *umprofita* is recent and may be traceable to the belief that healing by an *umprofita* within the church movement is socially more acceptable than that provided by an *isangoma*. The *isangoma* is oriented more to an industrial and urban environment and mostly more expensive than *umprofita*.

Concluding her publication, Dorothy Farrand informs us that an average urban black person shows an increasing acceptance of western forms of healing, but the

indigenous healer continues to play a very important role in the life of the black man. In the light of the above facts, the need for a health service for blacks which consists of both western and traditional healers is necessary. Although one should bear in mind that there is a lot of variation among healers. In order to achieve good success, any integrated health service should be very sensitive to the individual needs and attitudes of the black patient.

Moreover, findings pertaining to the popularity of *umprofita* did show a need for more studies in areas of importance just as has been done with *isangoma* so far.

4. Patient and Family Experiences and satisfaction with Psychiatric services and African Indigenous Healers

Karin Ensink & Brian Robertson's transcultural psychiatry (S. Africa, March 1999)

In this study K. Ensink and B. Robertson aimed at uncovering the experiences and satisfaction of African patients and their families with psychiatric services and as well with indigenous healers. Also investigated was sickness concept and its impact on service use and satisfaction

Their selection was made at random and the sample was made up of 62 African patients from the first admissions to a large psychiatric institution, Valkenberg (32 patients), from another department, the psychiatric emergency unit of a tertiary hospital, Grootte Schuur (30 patients). Both of these departments are located within the greater Cape Town metropolitan area. This step was taken to ensure that the study included a wide range of patients, at the same time, measures were taken to equalise the number of males and females.

In all, 11 patients were unknown at the given addresses, or were living elsewhere, 4 patients refused, 7 addresses were not locatable, 2 patients lived in areas that were not safe for the interviewers and as such were not reachable. Notwithstanding these setbacks, the sampling continued until 62 patients were interviewed.

The adapted version of Weiss's Explanatory Model Interview Catalogue (EMIC: Weiss, 1997; Weiss et al., 1992) system of interviews was applied, along with questions revealing satisfaction with services. The EMIC was then developed and aimed at disclosing illness-related perceptions, beliefs and practices in the study of Leprosy and mental health in India,

The semi-structured format covers demographic information, perceived causes, explanations and understanding of illness from the family's point of view; and help-seeking history and referral pathways. To make the instrument suitable for local use, ideas were borrowed from the earlier research and interviews carried out with indigenous healers.

To explore experiences and satisfaction with services, a semi-structured format was applied after short-listing services that were used for the patient's present and past sicknesses. Patients were requested to describe their experiences and satisfaction with different service providers in their own words. They were also supposed to indicate whether they were satisfied, dissatisfied, or could not access their feelings and as well detail what they liked or disliked about the service. Patients were also given a list of causes and explanations that are common in South Africa and were asked to indicate which of them according to their beliefs could cause sickness.

At the end of it all, the instrument was translated into Xhosa by a bilingual university lecturer in S. Africa and retranslated by a Xhosa-speaking university student aiming at reaching conceptual instead of linguistic equivalence (Brislin, 1976). Though some difficulties were said to have encountered, feedbacks from the interviewers showed that the intent of the questions was well understood by the patients (Drennan, Levett, & Swartz, 1991).

Aimed at reducing biased interpretation of responses through the use of unskilled interviewers and especially those who did not have any allegiance towards

psychiatry, five Xhosa-speaking anthropology students who were trained for 12 hours, were said to have carried out an interview.

Most topics covered by interviewers were on critical views in regard to psychiatric services and were more favourably disposed towards indigenous healers. Interviews were mostly carried out at the residence of the patients along with somebody that took decisions when the patient became sick (on two occasions, patients took this decision). In general, patients were always present during the interview except when it became stressful for them. Comments of the patients were recorded verbatim on the interview schedule during each interview.

In order to facilitate a smooth procedure for the data analysis, information gathered in Xhosa language was translated into English by the interviewers, after that, quantitative data was analysed with descriptive statistics, while qualitative data was interpreted using content analyses and descriptive statistics wherever the need arose.

Results were as follows, the mean age of the patients used in the sample was 30 years (range: 18-55 years), 63% of the sampled patients were unemployed. The educational status of the patients ranged from standard 6 (grade 8) to standard 10 (grade 12) for the majority (65%).

Records showed that the majority of the 62 African patients, 38 (61%) in this study sought the service of indigenous healers within a period of 12 months preceding the study, while 21 (34%) had consulted a faith healer, 15 (24%) a diviner and 8 (13%) a herbalist. As records showed, some patients consulted more than one type of indigenous healer during this space of time. 5 respondents consulted both a diviner and a faith healer, and 1 had used the service of a herbalist and a faith healer. It was revealed that majority of the patients and their families consulted a range of services in search of help (see table 1). Apart from using tertiary and secondary level biomedical services, 21 (34%) of the patients tried to get assistance from a community health centre, 11 (18%) obtained help from a general practitioner while 6 (10%) got help from a community psychiatric clinic within a period of 12 months preceding the study.

Available records also showed that for 23 (37%) of the respondents, the Groote Schuur Hospital psychiatric emergency unit and the Valkenberg Hospital were their first source of help. Another 11 (18%) made their first request for assistance from the community health centres, 9 (15%) made their request for assistance from the private

practitioners, 8 (13%) requested assistance from diviners while 5 (8%) requested help from the herbalists.

In the past year, patients and their families consulted less indigenous healers for the following reasons; while some of the families did not believe that indigenous healers are good enough to handle the particular problem, some patients and their families saw it as a contradiction to their religious beliefs.

It was noted that out of the 32 patients that used indigenous names for the sickness or problem, 25 of them used a combination of western and indigenous services and 7 of them used only western services. The 30 patients who did use other names were more equally divided in terms of services used. 16 patients used a combination of western and indigenous services, while 14 patients used only western services. According to records, patients who used indigenous names were found to be more ambivalent when it came to satisfaction with the psychiatric services.

As recorded, patients and their families indicated a good level of satisfaction with the psychiatric services and herbalists. Patients were said to be satisfied with the services from faith healers while their families did not seem to be sure. It was clear that both patients and their families were totally unsatisfied with the services from the diviners. They were quoted as having said "Those people are just stripping people of their money but cannot cure" The diviners were more or less like a greedy and unreliable group of people in the eyes of the patients and their families.

A man was said to have tabled a case in which his daughter was brutally handled by a diviner, because of the bruises all over the body of his daughter, he wanted to lay charges against the diviner.

Although the satisfaction with psychiatric services was very high, there were also critics from the patients and their families, for instance, on the poor condition of the building, the lack of medical personnel, the poor hygiene and the inadequate safeguarding of patients against manhandling by other patients (Spiro 1991).

A few patients and their families were of the opinion that doctors alone cannot treat sicknesses caused by witchcraft. For this reason, they suggested that diviners be integrated in hospitals to work hand in hand with doctors.

The need for information about illness was seen to play an important role in the welfare of the patients. 50% of the respondents attending psychiatric services complained that the name of their sickness was not made available to them, 29% of the patients said that they were not sure that they were sick since no names were

given and nothing was said about their ill health. A patient was quoted to have said I quote “I do not even know what they saw while they were examining me, I do not like this but there is nothing I can do against it” unquote. Another respondent was said to have narrated the practical difficulties caused by lack of sufficient information since he does not know what he would name his sickness if he should ask somebody else for help because of his illness.

It was disclosed that 13 patients indicated that they had been given information about their illness by psychiatric services in form of nerves, worry, mental exhaustion or “imaginary pictures” like a film. Though some families did not accept these explanations on the grounds that the hospital did not understand the sickness of the black man, some patients said that they have now changed their belief regarding to the cause of their illness now, from bewitchment to ‘nerves’.

Like other healers, diviners were also expected to give names to the sickness. In this case, 15 patients (62%) reported that their illness was given names by diviners and usually in terms of *amafufunyana*, or bewitchment more generally. Though patients prefer to know the name of their sickness, but the confirmation of bewitchment by diviners did considerably increase the distress to many patients and their families. Comments of a family member to that effect are stated below, I quote “It was said that he was bewitched so that he will be mad for the rest of his life. This news troubles us and the elders back home too. We do not know what will happen or what we should do. It means that our son is in danger of being killed at any time through traditional medicine. That brings lots of hurt in our souls and minds” unquote.

Out of the 8 families who consulted a herbalist, only 1 indicated that a name was provided to them, while 8 (38%) of the families who consulted a faith healer could indicate that they were provided with names of their illnesses. Faith healers were typically not expected to provide names of illnesses by patients and families, but when this was the case, faith healers always gave names like evil spirits, demons, bewitchment and *amafufunyana*.

Like in any other part of Africa, transport costs and the service cost of different healers remain an obstacle to receiving services by the patients and their families. Reputable healers are scarce and to reach them, patients and their families have to travel a long distance. Most of the families indicated that they were not charged for the treatments that they received from psychiatric hospitals. The study results suggested that diviners charged the highest fees, on average R1335 for a course of

treatment (but sometimes as high as R2000-R5000), herbalists charged an average of R434 while the faith healers charged an average of R155.

Attending to psychosocial problems of the patients revealed that a majority of the patients (63%) were jobless and about (24%) had caretakers without any means of income, while 14% of the patients claimed that poverty or heavy financial problems contributed much to their illness. In most cases, there was no external financial assistance from any service to the families although it was clear that they needed help.

In terms of presenting problems, almost half of the patients 32 (52%) and their families used indigenous names for their illness. The most used names were *amafufunyana* and *ukuphambana*, each were used by 11 (18%) of the sample. Not only *amafufunyana* and *ukuphambana*, but also other names and combinations like Amafufunyana/ukuphambana/ ukuthwasa 1%, Isiphoso 2%, Umbilini 1%, Ukuthwasa 1%, Umlingo 1%, Ukuphoselwa 1%, nerves 2%, worried too much 2%, stress 2% Work load 2%, mental exhaustion 1%, depression 3%, brain injury 1%, diabetes 1%, damaged veins 1%, pregnancy problems 1%, overdose 1%, unsure/no name for illness 3%,
Missing information 4%.

Psychiatric diagnoses

Records disclosed that the above study did register chains of diagnoses. Most of the patients were presented with one or more diagnoses of acute psychosis, organic syndromes, parasuicide or mood disorder.

The diagnoses for some of the patients were said to be quite uncertain at the first time especially those handled at the psychiatric emergency unit. Information showed that the diagnoses of many patients admitted at the psychiatric hospital were unclear at the time of discharge.

Etiological understanding

Records showed that majority of the respondents, 34 (55%), believed that their illness had more than one cause. Some attributed the cause of their illness to a combination of indigenous, psychosocial and religious factor together.

In total, 45 (80%) of the respondents saw psychosocial problems as the cause of their sickness. 35 (63%) saw indigenous problems as the cause, 23 (46%) saw religious problems as the cause of their illness. 3 (5%) saw fate as the cause, while 4 (7%) attributed the cause of their sickness to physical problems. The most common indigenous cause was bewitchment. As Other indigenous causes, the following were named; failure to do a Xhosa ritual, stepping over dangerous track, evil spirits. Poisoned with soil and ants from the grave, and different types of `witch families` such as the snake of the river or of women, or *impundulu* (bird of evil or lighting bird) or *tokeloseh* (dwarf-like creature with baboon features) are also named as sickness causes too.

A lot of indigenous causes were connected with *amafufunyana*. In some cases, it includes poisoning with soil and ants from the grave. Approximately over 50% of patients who named the sickness *amafufunyana* looked at it as a range of causes including nerves, relationship and work problems, drug and alcohol abuse, and the will of God. Among those who named the sickness *ukuphambana*, all of them believed that a combination of indigenous and psychosocial explanations had to do with their illness, while only one saw that to have played no reasonable role. Seven out of eleven respondents saw alcohol and drug abuse as the most important cause of *ukuphambana*, happening either with or without bewitchment. Psychosocial causes alone, or together with indigenous and religious causes were considered associated with nerves and related problems like stress and overwork.

Case descriptions: *Amafufunyana*;

Patricia is said to be a lady of 23 years old student, who lives with her aunt, a domestic worker. Information from her aunt has it that Patricia's problems started when Patricia was preparing for her mathematics examination. Patricia was reported to have gone naked in the public and was taken home by her community members. Her aunt said that as soon as Patricia was sick, she became promiscuous and claimed that she was raped by people, but Patricia was used by the *amafufunyana* to

do evil things` she was then admitted to the psychiatric hospital for almost 4 weeks under the diagnosis of bipolar affective disorder (manic episode). Her aunt believes that the problem is caused by bewitchment, because "there are things that speak inside her, saying who sent the amafufunyana to her" and said, "the reason is jealousy, nothing else". Her aunt explained that the bewitchment involved "doing magic like mixing grave soil and ants, which is put in your food". She also did think that worry contributed to the illness. Her aunt was not quite certain which treatment Patricia was given at the hospital and said, "The problem is that we did not ask the name of the illness, because we are illiterate, and we do not know the name that the white doctors are telling us. We took everything for granted. White doctors do not know how to cure illness caused by blacks. The only thing that they can cure is T.B. The *amafufunyana* wants to be taken out by black people". After Patricia was discharged, she was taken to a diviner where she has to be treated with traditional medicines, among medicines that she was given there were purgative and emetic. She refused to drink these medicines and did not want to stay with the diviner since she did not like the treatments of the diviner. Also, her aunt did not welcome the treatment of the diviner because, according to her "The problem is that the diviners are liars, because she promised to take out the *amafufunyana*, but never did, Patricia still ran naked afterwards". Later, Patricia was taken to a faith healer and she stayed there for 4 weeks. At the time of her discharge, the faith healer said that 5 *amafufunyana* were sent out of her and that she is now free of them. The faith healers use prayer and holy water to heal.

Ukuphambana:

Sipho is said to be a 30-year-old applicant residing with his mother who is said to be a pensioner. Information from his mother revealed that Sipho was keeping distance from people and started talking and laughing while alone. Sipho became very fearful and wanted to run away. His mother thinks that drug abuse is the most important cause of the illness, and that Sipho was poisoned through his drugs by evil spirits, and also believed that the drug might have affected his brain. Sipho was hospitalised in Valkenberg hospital for approximately 10 days under the provisional diagnosis of alcoholic hallucinosis. His mother was satisfied with the treatment Sipho received at the hospital since the sickness was explained to her by the doctors and after the

treatment he stopped wanting to run in front of cars. This relieved them from the fear that he could be killed by car or be injured. The only thing Siphon's mother could complain about concerning the hospital was that there were very few nurses available to take care of the patients. She saw the diviners as big cheaters because, she had to pay a large sum of money (as large as one-third of her annual income), yet no good service was received from them! "Diviners must stop cheating people and stripping them of their cash" she added.

Nerves;

Nandi is said to be a 55-year old woman who resides with her sister who works as an assistant at a video outlet. Her sister commented "Nandi talked to herself and shouted and insulted people who we could not see. The reason for her illness is that she does not have enough money to send her children to school, and she worries about this problem, that is why I say she has nerves. I also thought that she might have *amafufunyana*. She was cured at the hospital, but I did not like the way they treated the Patients; they talk to them like small children, and it is terrible that they have to wear hospital night-gowns during the day. It was like a prison and now she walks like someone who is institutionalised and speaks as if her jaw is stiff". Nandi was hospitalised under the diagnosis of major depression with psychotic features. After being discharged, Nandi was taken to a faith healer but the family did not see any better result from the faith healer.

This Study was carried out in a metropolitan area of South Africa and indicated that majority (66%) of African psychiatric patients also use indigenous healing for the treatment of mental-health sicknesses. Reliable records revealed that faith healers were consulted more frequently than either diviners or herbalists. Almost all patients who consulted diviners lamented and expressed surprising disappointments and negative experiences. Diviners who always charge large sums of money, but rendered very little or no good service in return cheated them. Evidence that could show the `holistic` cure claim of diviners was completely lacking, according to a patient's description, diviner's treatment is mainly based on naming the illness and prescribing medicines. Diviners often confirmed and increased bewitchments fears

without providing any future support to patients. The diviner's system of health care may well have many positive dimensions and societal functions, especially for those members of the community who perceive themselves as *ukuthwasa* and become healers. An observation that two diviners could not find the solution to the serious mental ill-health of a relative, left the impression that diviners have little or no ability to treat mental sicknesses.

In spite of the fact that the majority of the families and patients used indigenous names, they indicated a high level of satisfaction with psychiatric services and said they would make use of them in the future. This does not mean that the respondents did not identify a need for service improvement, but suggests that patients and families are not grossly disappointed with psychiatric services. This is surprising considering the fact that the treatment was largely medical and psychiatric services are being severely handicapped by serious financial problems. (Ensink et al., 1995). There is no doubt that admission to the mental hospital and temporarily relieving families of the burden of residing with mental ill relatives may have contributed to their positive attitude towards psychiatric services. The satisfaction with the services of the psychiatric emergency service (which did not admit patients for more than 48 hours) cannot be explained on these grounds alone.

Results of the study disclosed that illness conceptualisation affects satisfaction with services, and also services use. It was clearly noted that respondents who used indigenous names were found to be more ambivalent regarding satisfaction with psychiatric services, and more likely to have used an indigenous healer.

Since the study sample was derived from users of psychiatric services, it would then not be surprising that respondents could be biased towards these services. In any case, this does not explain why they were mostly not satisfied with diviners or faith healers and herbalists. Also seen, as an additional limitation of this study is the fact that the sample was derived from stages where the patients would be likely to be referred for serious mental illness, this indicates that the sample did not represent the whole spectrum of psychiatric users. It also worth mentioning that no comparison was made between African patients of different ethnic groups, e.g. Xhosa, Zulu. Last but not the least, inter-racial reliability for the EMIC was not tested, although it has commendable satisfaction in other studies.

A very important finding of this study is that majority of African patients and their families interpret mental-health problems in terms of a combination of indigenous,

psychosocial and other causes. It is obvious that patients and their families construct multiple, complex and very contradicting understandings of mental sickness through the combination of indigenous and many other lay understanding to forge meanings that spread across discrete indigenous categories. It remains a fact that patients and their families mostly use indigenous names as explanatory categories, which often include psychosocial or other understandings.

The interpretations of categories and their relationships to one another differ considerably from individual to individual, though there are also similarities noticeable within categories.

Amafufunyana was most frequently claimed to have indigenous causes such as bewitchment and believed to be curable only by indigenous healers. In any case, the results of the study did not provide any support for the existence of a ritualised possession sequence as described by the literature (F.S. Edwards 1983; Mdleleni, 1990; Ngubane, 1977; Thorpe, 1982) when lay people use the term. Compared with *amafufunyana*, *ukuphambana* was understood less frequently in indigenous terms. The results did provide further support for the conclusions of Ensink and Robertson (1996) that *ukuphambana* may be used for a wide range of psychiatric disorders, including mood disorders, and not only in the context of psychotic illness.

The use of 'nerves' as an explanatory category has rarely been described among African patients (Lund, 1994; Spiro, 1991) and the finding that a significant minority of respondents in this study used the term may be attributed partly to its use by psychiatric staff as an explanation. Mostly, nerves were seen in forms of psychosocial causes and psychological explanations such as lack of parental love, or inability to express feelings. Counselling was mostly believed to be a potential cure for nerves. Similarly to *amafufunyana* and *ukuphambana*, nerves appears to be used as an explanatory category in the context of a many other psychiatric diagnoses like adjustment disorder and schizophrenia. It is interesting to note the use of other infrequently cited indigenous names like *isiphoso umbilini*, *umlingo*, *isiphepheto* and *ukuphoselwa*. Notably, the descriptions from the respondents show remarkable difference to those in the literature (De Villiers, 1984; Schweitzer, 1972; Thorpe, 1982). Certainly, the lay people use the explanatory categories in some contradicting manners, these manners could be reflected in the example below.

The parents of a young man said he suffered from nerves, although they noted that he spoke in a changed voice (Usually considered characteristic of *amafufunyana*).

Another example, the parents of a young woman thought she had *ukuphambana*, although she was behaving exactly like somebody who has *amafuunyana*, she was talking in funny voices and had a lot of strength. Many respondents thought that *amafuunyana* was caused by nerves, while others believed the opposite. These findings reveal the importance of exploring understandings and experiences at the individual level rather than depending on erroneous notions about indigenous syndromes.

Results of the study indicated certain areas where psychiatric services need to be improved. The recent problems which respondents experience shortly after been discharged from the hospital is evidence that much still has to be done towards seeing improved out-patient and community services which are accessible to African communities (Spiro, 1991).

Feedback from patients who received counselling disclosed that it helped significantly,

Patients also appreciated successful symptom control through the use of medicines, but relapse rates are expected to be higher without counselling, or information about the cause and long term management of the problems. Like in other countries (Bernheim & Switalski, 1988; Carscaddon, George, & Wells, 1990; Holden & Lewine, 1982), families often felt excluded from discussions about admission, treatment and discharge. A family-oriented approach has been shown to have improved family adjustment, improve treatment compliance and reduce readmission (Gillis, Koch, & Joyi, 1989).

Reliably, the interviews uncovered big social and economic difficulties that many patients and their families are facing in many developing countries. The alarming rate of food, medicines and welfare scarcity requires urgent community-development approach and international concern.

In the light of the above information, one can now draw the following conclusions. Patients and family experiences of psychiatric services and African indigenous healers were investigated as a first step towards exploring a possible basis for collaboration between these services. The study findings are as follows, while patients who tend to have more traditional explanations of psychiatric sicknesses also favoured the indigenous healing system, it was noted that they still frequently enjoy a parallel use of the services. Really criticising indigenous healers and at the same time enjoying their services does not tell good of patients and their families. In

spite of that, they still could not hide their conclusion that indigenous healers still have much to do towards getting approval and for this reason, working together with them might attract a lot of criticism. The need for more and a direct study of indigenous healing practices for individuals with mental sickness were strongly indicated.

Areas of psychiatric services where immediate improvements are needed were also pointed out in the study. It however remains an unquestionable fact that poor finance is seen as the main limitation to important studies.

5. The Study

The research/interview was carried out at the psychiatric department of teaching hospital Portharcourt (Nigeria).

5.1 Sampling

The selection of patients was at random. A sample of 18 schizophrenia patients in a large psychiatric hospital was interviewed. The sample was made to include equal numbers of men and women irrespective of their age or any special quality or qualifications. All the 18 patients were in-patients of the hospital under the Schizophrenic characteristics of ICD 10, F20.

5.2 Instruments and procedure

Interviews were conducted orally and all patients were personally and privately confronted with the same questions with the aim of getting useful information about their mental health illness.

Interviews were carried out under a non-standardised questionnaire and non-standardised diagnoses. This type of interview was possible because both the patients and myself had many things in common, (we speak the same language, belong to the same cultural group and developed great trust and confidence in each other!)

The interview focuses more on the issues listed below

Psychopathology

Age at the beginning of the sickness

Information about their marital status, educational qualifications, occupation

History of the sickness since it started

Information about drugs/medicines used shortly before the outbreak of the sickness.

Information about patient's present social interactions

Suicide attempts and death rate

Family's psychiatric history

Information about alcohol or drug abuse

Self treatments during the sick period

Hospital treatments

5.3 Results

The ages of the patients during the first diagnosis of the sickness range from 15 to 37 years.

9 patients were still single & have no children.

4 patients were divorced

5 patients were still married & have children

11 patients have occupation but only 4 of them were employed!

7 patients have no occupation & are jobless

3 patients were still schooling or university students before the sickness

6 patients had finished schooling (college/secondary) before becoming sick

5 patients were neither school nor university graduates before their mental sickness.

4 patients were university graduates before their mental sickness

Remission was recorded in 60% of the patient for a period of 6 months to 2 years before suffering another mental episode while 40% never experienced any remission since their mental sickness started.

5.4 Clinical symptomatic observed

Since this topic is the most important issue of the research/interview, special interest and attention was paid to it. To my utmost surprise the outcome of the interviews/researches showed nothing new or different from the symptoms that are common in Europe! Auditory hallucinations were more common than other symptoms.

Other symptoms include visual hallucinations,

Thought broadcasting

Somatic passivity experience

Delusional perceptions

Depressive and euphoric mood changes

Autism or grossly unrealistic private thoughts

Looseness of associations, illogical thinking

Depersonalisation

Poor insight

Unreliable information

5.5 Health history

In general, each patient has been hospitalised more than three times to date! The duration of their hospitalisations depended on their mental and physical state as at the time of their admission into the hospital and progress of the ill health during their hospitalised period.

5.6 Drug history /medicines used before the sickness started

Available information disclosed that more than 65% of the patients used anti malaria medicines shortly before the breakdown of their mental ill health, but no reliable involvement of anti-malaria medicines in their mental ill health could be traced. It is clear, however, that the high rate of anti-malaria usage can be attributed to the fact that malaria is one of the most prevalent sicknesses in this part of the world (Africa).

5.7 Social distance

It was noticed that more than 70% of the patients were removed from their usual social circumstances!

They had no interest in engaging themselves with the activities of the day. They had lost a sense of belonging to society and kept a big distance from their old friends/well wishers.

5.8 Suicide attempt

A large number, 75% of the patients according to records, have never attempted suicide. 2 patients did attempt suicide once while 2 patients attempted suicide more than once but less than 4 times.

The low rate of suicide attempts as provided by records could be traced back to the beliefs of society in general and psychiatric patients in particular, that psychiatric sicknesses are caused by evil spirits and wicked people who want to kill or render other people useless. So, the act of committing suicide is always seen as ones inability/weakness to withstand such evil-activities!

5.9 Patient's mental health history

50% of the patients have either parents and/or nephews and/or half-sisters/brothers that either died from psychiatric sickness or are suffering from it, while 50% of the patients have no family history of mental illness.

5.10 Alcohol / drug abuse

About 70% of these patients are non-smokers and non-alcoholics! This is to say that their mental ill-health more or less has nothing to do with alcohol/drug abuse. 30% of the patients abused alcohol/drugs at one time or the other, so that one can attribute the mental ill-health to the misuse of drugs/alcohol.

5.11 Self-treatment of the sickness

Nearly 85% of the patients used prayers and spiritual healing as their self-treatment. The reason for this act is that the majority in society believe that psychiatric ill health is being caused by evil spirits, and the best treatment against this would be devoted prayers and spiritual healing! 10% of the patients apply the use of roots and herbs while 5% consulted native doctors. A woman applied hot chillies mixed up with her urine!

5.12 Actual management

a: Most treatments are done with antipsychotics (haldol was the most applied) and when the need arises, supported with lithium, carbamazepines, benzodiazepines and/or reserpines.

b. Social therapy

c: Traditional treatment (herbalists, prayer and so on)

5.13 Case description

Evil Spirit

Jamabo is a 30 years old man from the middle-belt region of Nigeria, who was residing and studying at the University of Portharcult. His mother, a 67 years old retired high school teacher, responding to my question on when and how long Jamabo has been sick, commented “Jamabo joined a secret society along with his friends in the Campus a year ago. He came home and started refusing food prepared by me, but would prefer cooking for himself alone. When my husband and I asked him why, he told us that eating food prepared by a woman is forbidden for him since a couple of days past by their *Brother-link society*. Because we are Christians and also know the implications of this type of society, we then instructed him to come out of it before it would be too late for him, which he did but was tortured by the Evil spirit for living them so quick without providing them with any human blood”

According to Jamabo, he sees strange things and hears commanding voices “remain a man of Timber and Caliber or we deal with you” he was admitted in regional psychiatric Hospital for the period of 6 weeks under the diagnosis of Schizophrenic delusion without much remarkable improvements. He was then referred to the teaching Hospital where he was placed under Antipsychotics, benzodiazepines and social therapy, but his mental condition could only improve a little after 7 weeks. One Sunday morning, his mother requested for a permission to attend a Christian Crusade held by one popular Pastor Chris Oyakelome with him. Her request was granted. They left and did not come back to the hospital same day as we agreed.

To God be the Glory, he appeared two days later in the Hospital alone to testify his deliverance at the Crusade. Jamabo told us that when the man of God was praying for him, something in form of a human left him!!

Infact, we could not believe it but the young man was healed! This incident took place 2 months before i left the teaching Hospital. Almost every Friday afternoon he was visiting the Hospital and encouraging other patients to give God a chance in their life.

Poison

Charity is a 25 years old university student from Enugu in Eastern part of Nigeria. She was residing with her senior brother who owns and runs a road-side Cosmetic shop. Her brother commented “Charity talks to herself and sees the dead since she became sick 6 months ago and believes that everybody reads her mind,” i am sure that she was poisoned with garden eggs by our enemies because she got scholarship award to study in the university. She was first taken to a traditional local healer with the hope that she might be given Herbs that would make her vomit poison. She was there for a week and was taken to a pastor for prayers since she could not vomit any Poison. She spent 3 weeks in the prayer house. Her brother then brought her to the teaching Hospital because she had not completely recovered. Under the diagnosis of paranoid Schizophrenic disorder, she was treated antipsychotics, antidepressants and social therapies and was discharged after 8 weeks to the out-patience section in a sound mental condition. When I asked her brother, how he sees Charity`s present mental condition, he expressed his satisfaction towards the Hospital treatments and added “Charity has stopped talking to herself and behaves normal now”.

Queen of the Ocean

Oshodi is a 26 years old woman who resides and works in Lagos, a popular and former Capital city of Nigeria, located in western part of Nigeria. Her mother, a 60 years old house wife complained “Oshodi is running mad since a year now” she talks with evil spirits that we do not see, she eats leaves that are not edible and claimed

that small car drive round her head 100 times daily and that our co-tenant has the same voice like one of the car drivers. We strongly believe that she is being influenced by the *queen of the Ocean* (the marine mother), she added. Oshodi was taken to a diver, to a spiritualist and later to Herbalist before she was brought to the teaching Hospital as her health condition could not improve since the sickness started a year past.

Under the diagnosis of delusional disorder, Oshodi was admitted and placed under antipsychotics, antidepressants, and social therapy treatment. Remarkable improvements were seen in her after 7 weeks clinical treatments. She was then granted a weekend trial leave at the ninth week, but reports from her Mother after the trial leave made us to retain her for another 3 weeks before discharging her to the out-patient's unit.

Her poor compliance was a big barrier to her treatment because she told me that drugs given to her in our Hospital are not better to her health than her personal urine which she considers very active.

Bewitment

Eleonu is a 30 years old lady, her father, a 59 years old farmer from Owerri, in Eastern part of Nigeria commented "Eleonu my Daughter suddenly started starving herself and keeping distance from everybody without any reason, the worst is that she believes that she can study Business administration, law and medicine at the same time while working 10 hours daily as a receptionist". We are afraid that she might end up overloading herself and that would make her sickness worst, he added. When I asked him of measures he has so far taken towards treating Eleonu, he told me that immediately the sickness started, he took Eleonu to a well known church for prayers because the best treatment of Bewitment is the use of prayers, she was already taken to 3 different churches in the last 12 months before coming to the Hospital but she is noted for running out of churches.

Eleonu was admitted and treated under the diagnosis of Bipolar Manish disorder. Notable improvements were recorded in her health after 6 weeks of clinical care (antipsychotics and Lithium). She could be granted a weekend trial leave after 8 weeks treatment and later discharged to the out-patient unit. Her mental sickness

started 3 years past, she could return to her normal life for a period of 2 years before the present episode.

The impacts of Religion on Psychiatric therapy in Africa today

In most African countries nowadays, Christianity has become the Alpha and Omega. Days brake and end with Christianity. It reflects on the day to day activities of most people. On a serious note, God is doing wonders to many of his worshipers! Miracles rain day and night without limit. Seeing is believing, believing is Fait!

The impact of Christianity as a religion on sicknesses in general and Psychiatry in particular could be traced back to the root of the ideology, Faith and believe of most Africans that most sicknesses are the hand-work of Satan.

Uncountable chronic sicknesses are healed without rest symptoms, to sicknesses that could not be healed by modern medicine, miracles of God remain the only hope and answer! The bible book Hebrew Chapter 11, vers. 1-11, i quote *“And the prayer of Fait shall save the sick and the Lord shall raise him up and his sins be forgiven”* It should also be made clear that many false prophets exist in Africa for the sake of money making in the name of God. .

Though most psychiatric sicknesses have no supernatural roots, yet, real healings of psychiatric sicknesses take place.

In some aspects of life, *Europe and Africa are two different worlds!* Many things, good and bad, happening in Africa cannot be imagined in Europe.

Hardship is the mother of all inventions. The natures of sicknesses combined with the hardship in Africa make them get stronger hold of any available solution.

Healings carried out by true Men of God are real and free of cost!

For example, the German born Man of God, Pastor Reinhardt Bohnke is one of the few real prophets of God that are in charge of the whole Africa today, though in Germany his home country, he is not recognized! The Bible book of Matthew Chapter 21, vers.21; i quote *“ And the Lord answered, if you have Faith and doubt not, you can command the Mountain to move and nothing will stop it from moving”* In a nuts shell, most Africans believe strongly that God has answer to all their problems. As I did comment earlier, Christianity has eaten deep into the born-barrow of the society!

The big question is, why have Christianity gained much ground in Africa, the answer is, churches have become very accommodative, they give the sick the sense of recognition and belonging by making the sick feel that they are in the mist of their family. Many problems of the sick are looked into, financial helps, unemployment, just to mention a few, are taken care of.

To drive this topic home, Life without Faith in God almighty, the only hope of the helpless, is like a Billion worth of soup prepared without Salt!

6. Research carried out at the Psychiatric department of the Tuebingen teaching hospital (Germany)

6.1 Sampling

The selection of patients was also at random and without any special consideration to sex, qualities or qualifications. 22 patients from the open wards, locked-up wards and day clinic (only 2 patients) were orally, personally and privately confronted with the same questions with the aim of getting useful information about their mental illness. At the end of the diagnosis I discussed it with doctors in-charge of the wards and corrected mistakes in my records.

6.2 Instruments and procedure

The Interviews were focused on the following issues

1. Psychopathology
2. Age during the first mental sickness.
3. Information about marital status, educational qualifications, family, occupation, future plans e.c.t
4. Up to date history of the mental ill-health
5. Information about drugs/medicines used shortly before the outbreak of the sickness.

6. Information about patients present social engagements.
7. Suicide attempts
8. Family's psychiatric history
9. Information about alcohol and drug abuse.
10. Self treatment while sick.
11. Clinical actual treatments

6.3 Results

Out of the 22 patients that were confronted, one was 14 years old before his mental sickness, 12 patients were between the age of 18 & 24 years while 9 patients were between the age of 26 and 40 before the outbreak of their mental sickness. The general average was 24 years of age!

64% of the patients were men while 36% were women

4,5% of the patients lost their partner (widowed)

18% of the patients were married and have children

81% „ „ „ were still single and have no children

27% „ „ „ were still in the secondary school or university students before their mental sickness.

42% of the patients have just finished their apprenticeship (Ausbildung: Deutsch)

13% „ „ were already university graduates before they were mentally sick. 18% of the patients were still employed

6.4 Clinical symptoms observed

These includes,

Auditory and visual hallucinations

Thought broadcasting

Somatic passivity experiences

Delusional perceptions

Depressive and euphoric mood changes

Autism or grossly unrealistic private thoughts

Looseness of associations, illogical thinking

Depersonalisation

Poor insight

Unreliable information

6.5 Health history

36% of the patients were hospitalised once or twice

73% „ „ „ „ „ more than 3 times

50% „ „ „ said that their mental sickness has remarkably improved, while 50% of the patients claimed that they did not record any improvement in their mental sickness.

6.6 Medicines used before the sickness started

27% of the patients abused drug usage

4,5% „ „ „ used homeopathic medicines before their mental sickness

68% of the patients claimed that they did not use any drugs/medicines at all.

6.12 Actual treatment

Most therapies are done with antipsychotics and when the need arises supported with lithium, carbamazepines, benzodiazepines and/or

Social therapy (while applying this system, over-stimulation and under-stimulation are avoided because of the danger of enhancing plus-symptoms or minus-symptoms)

7. Graphical demonstrations

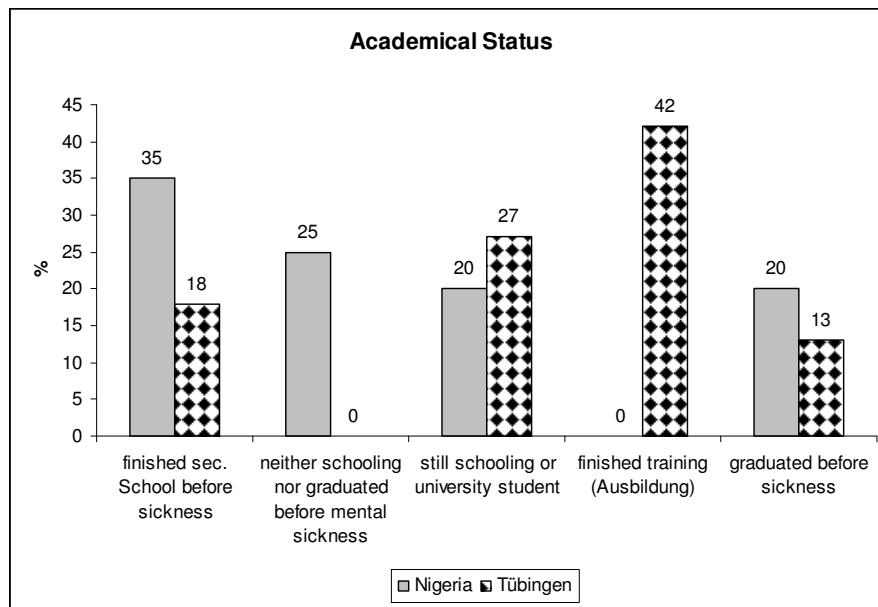


Fig.1. 25% of the Nigerian patients were neither in post-primary school nor have graduated from the university before their mental sickness.

The system of undergoing training after the primary and post primary school (Ausbildung: Deutsch) is practised more in Germany than in Nigeria! This makes a difference in comparing the educational status of the two countries.

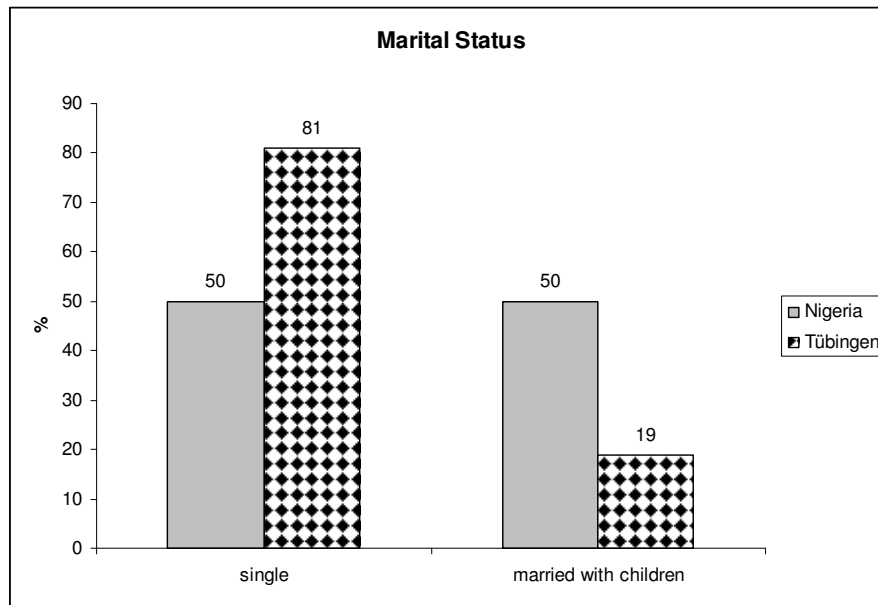


Fig. 2. A look at the marital status of both Nigerian and German psychophrenia patients shows that less German patients were married compared to their Nigerian counterparts during the period of the study, but this result cannot be generalised!

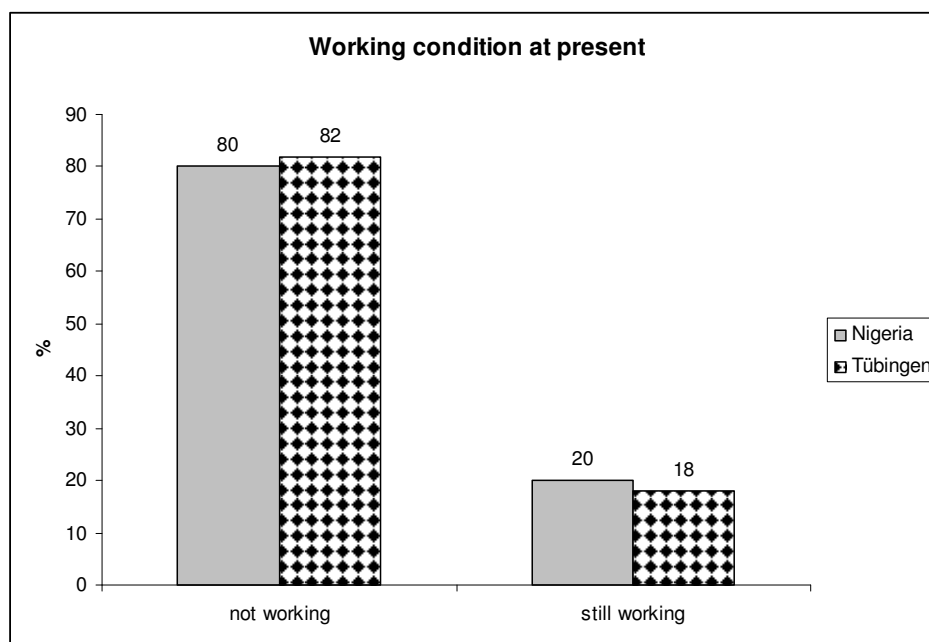


Fig.3. There is little or no difference in the working situation of patients from both countries

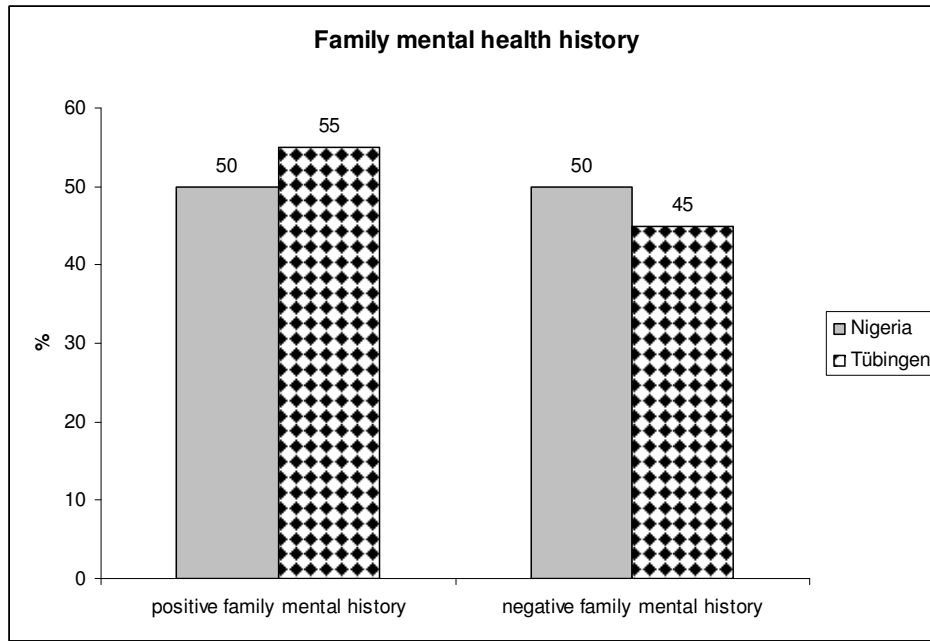


Fig.4. As records reveal, Germany had more or less the same family history like Nigeria

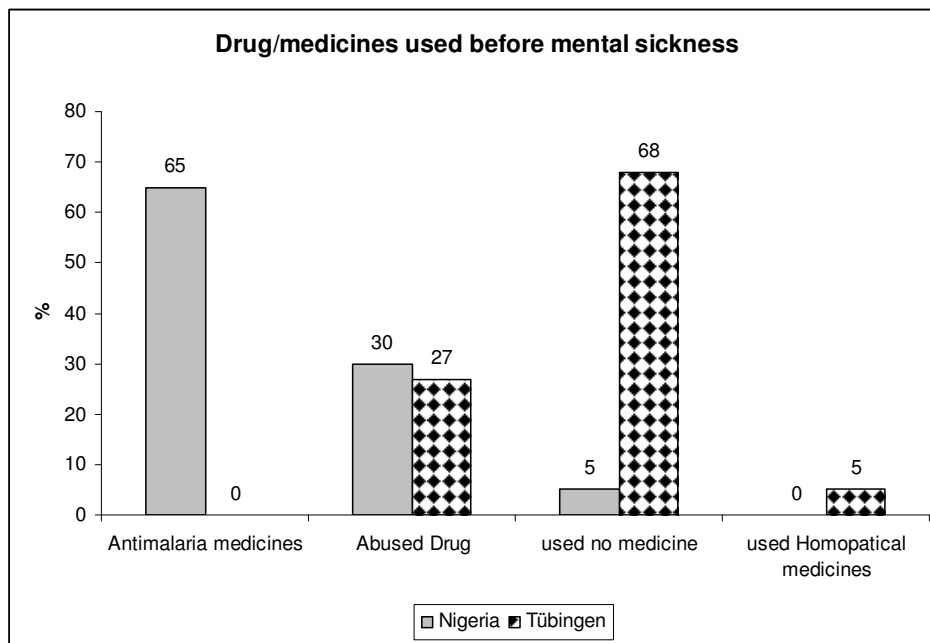


Fig.5. Clearly most of the Nigerian patients used anti-malaria medicines because malaria is one of the most common sicknesses of this society! No involvement of anti-malaria medicines in mental sicknesses was found.

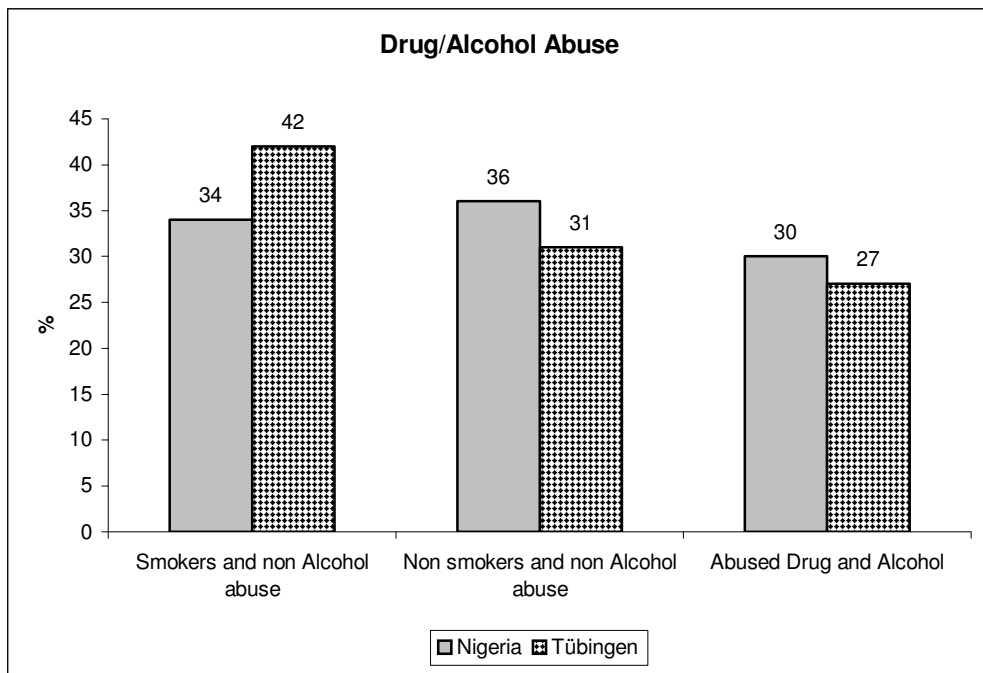


Fig.6. Records show that Nigerian patients did have almost same rate of drug/ alcohol abuse like their German counterparts but in general the rate of alcohol and cigarette consumption are much higher in Germany than in Nigeria. This could be attributed to the fact that alcohol and smoking are always being criticised by African (Nigerian) society!

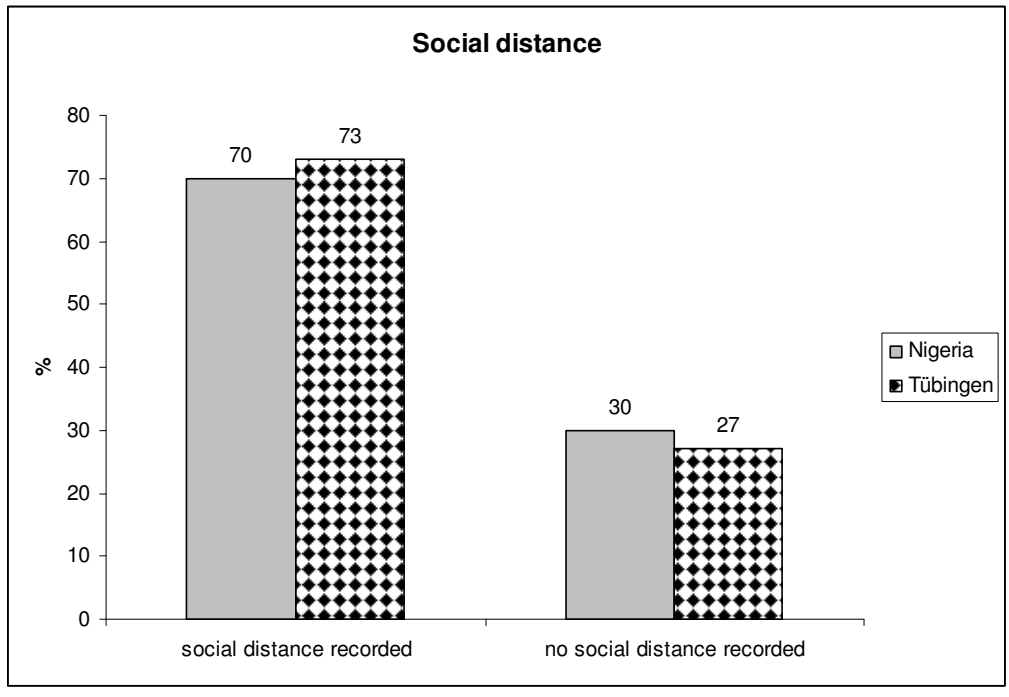


Fig.7. There is no difference in the social distance and suicide attempt of patients from both countries

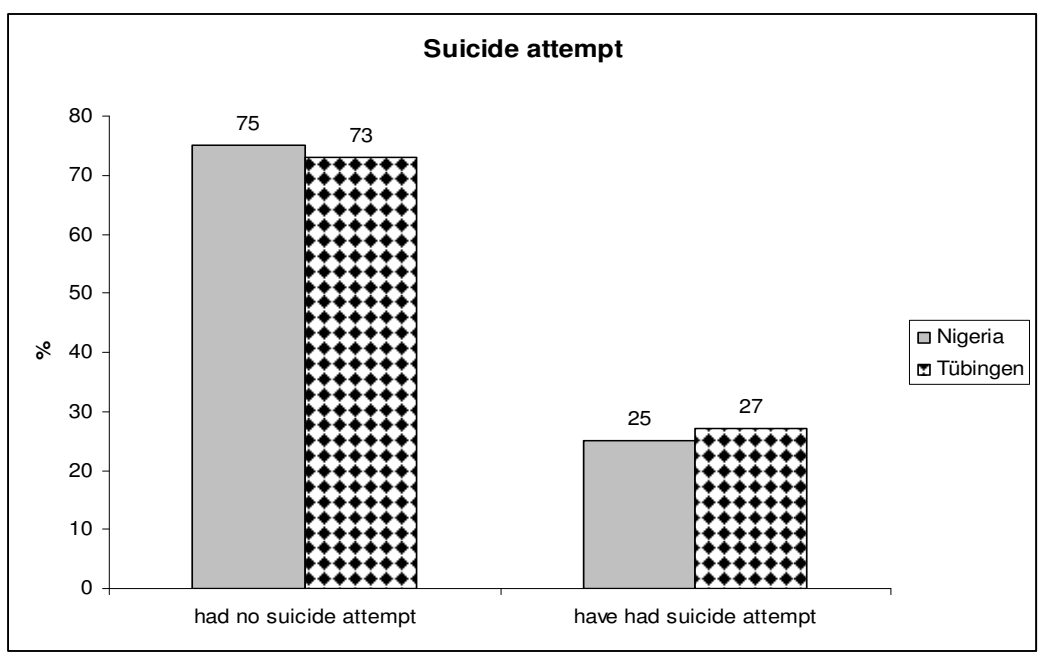


Fig.8. As seen above, there is no significant difference in the suicide attempt of both countries.

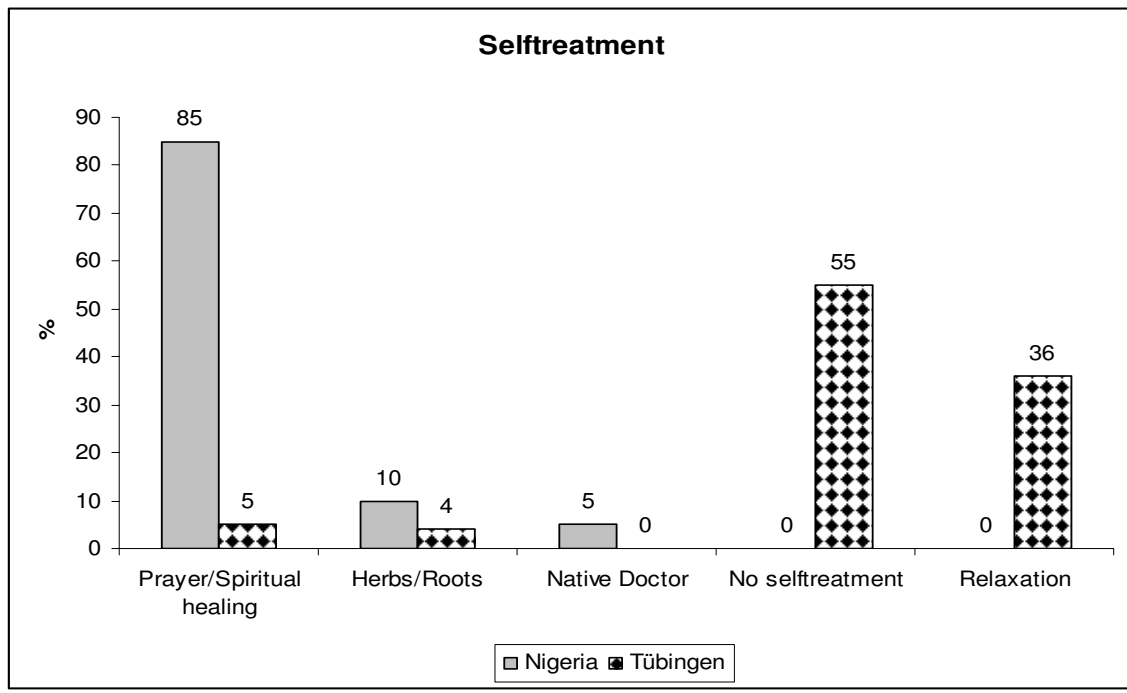


Fig.9. The graphical representation of the self-treatment shows the mirror image of the cultural and religious differences between the two nations. Religion does not only dominate the life of African (Nigeria) society but also plays an important role in their delusional symptomatic and otherwise!

8. Discussion

As the key purpose of this study, symptomatic differences of intercultural schizophrenia were the point of interest. My investigations could not provide any concrete and dependable differences regarding to the symptoms of intercultural schizophrenia except in the case of the Religious delusions. The importance of religious delusions to the symptoms of intercultural schizophrenia in Nigeria is comparable to the importance of the high rate of anti-malaria drugs recorded among schizophrenia patients in Nigeria which played little or no role in the course of patients mental problems. This is more or less in concordance to the outcome of a cross-cultural study of schizophrenia by M. Taleb, F. Rorillion, F. Petitjean and P. Gorwood from "Service de Psychiatrie, Hôpital Louis-Mourier, Colombes et Rene-Dubois Pontoise in 1996.

The above study included 3 groups of patients. The first group was made up of second generation North Africans living and raised in France. The second group was made up of native French patients and the third group consisted of schizophrenia patients raised in North Africa (Algeria), their native country. Necessary data and intimate observations of these patients were thoroughly analysed, like many other studies the result of this study was that culture has no major influence on schizophrenia symptoms.

Contrary to my study, a controlled clinical study on schizophrenia cultural differences, carried out by Christian Haasen, Oktay Yagdiran, Reinhard Mass and Michael Krausz in 2001 at the psychiatric hospital of the Eppendorf university, Hamburg, Germany, in which 74 patients of Turkish origin and 48 patients of Germany origin , all suffering from schizophrenia disorder were followed up under the application PANSS and HAM-D.

In comparison to the German patients, the Turkish schizophrenia patients were said to have showed an absolute higher rate of depressive symptoms as the key psychopathological difference to the German patients. Concerning this point, I must clearly state that there were no such indications noticed in my German patients and for that reason I cannot share this view in this study.

In another study on the polydiagnostic approach to differences in the symptoms of Schizophrenia in different cultural and ethnic populations, carried out by Maslowski.

J, Jansen van Rensburg. D, and Mthoko. N of the department of psychiatry, Windhoek Central Hospital Complex, Windhoek, Namibia in 1998.

Under the application of present state examination (PSE) and Landmark's manual for the assessment of schizophrenia, 113 schizophrenia patients made up of 57 coloured and 56 black patients were examined. The blacks represented 6 different tribes of Bantu, Negroid and Khoisan origins that have different languages and cultures. The result of the study showed that while core symptoms were basically the same in two groups, the contents of positive symptoms recorded were influenced by culture. Although, auditory hallucination was common among my patients in Nigeria, but no significant difference was recorded from the German patients too. Findings of the above study that showed an absolute higher rate of depression contradict many studies.

8.1 My personal experience about the combination of western and indigenous treatments

The above study and result gathered by Mrs. Dorothy Farrand about the combination of traditional and western health service in South Africa is a total reflection of the treatment system in many parts of Africa and could be generalised as such.

At this point, I would like to give just a few examples of the combined treatment which took place in my own family a couple of years back.

a. When I left college, I travelled to one of our biggest cities (Lagos) where I was to stay with my senior brother who was residing and working there. After a short while he felt sick and was rushed to the hospital in Lagos for treatments. As his ill health could not improve, we then decided to take him home (to our village) because the western medicine could not help him. I was then delegated to travel with him to the elders in the village, which I did. As soon as we arrived at the village 8 hours later, the elders gathered and arranged for indigenous medicine, which was ready within an hour. While treatment was going on, our village elders sent out people for the consultation of the oracle. My family is a Christian family that prefers prayer to the use of the oracle, so that church members and other prayer-warriors were informed. Within 7 days my brother recovered from the sickness and went back to his work in the big city.

b. My father died some years back. While he was sick, he was hospitalised for 3 weeks and was asked to come back 3 weeks later. Before he left the hospital, he was given drugs that would sustain him till the next appointment. Just only a week after his discharge, even when his sickness was improving, the people around him decided to keep the modern medicine aside and continued with traditional treatment. Shortly after the indigenous medicine was applied, he died! As at this time, my family was not yet a Christian family.

Now to my point. The combination of western and indigenous treatment in Africa has come to stay! To eradicate this system is a dream that would never come true.

As one can see, this two-way system could be advantageous or a disadvantage to the patient and family depending on the sickness in question and when and how it is being applied. There would only be an advantage if and only if it was applied when the Western treatment failed to provide a solution, as in the example of my senior brother's illness. On the other hand, using it to treat all sicknesses could regrettably end up with lost lives as was the case with my father.

In a nutshell and to my personal opinion, the combination of traditional and western treatments would be a good idea if well applied.

The traditional healing method has no laid down procedure. The traditional healers are made up of different groups of individuals with more or less different ideologies and different opinions on the healing process. The healing act differs from healer to healer and from one locality to another.

While some healers (e.g., herbalists) mostly practice the usage of herbs and roots, others combine the application of herbs and roots with the consultation of their local gods e.g. „the Queen of the River“ and other earthly gods that according to their beliefs could be of help and influence on the healing of sicknesses.

Diagnosis: The diagnoses take an entire different form. While the herbalists diagnose according to their experience and understanding of mental disorder, most other healers diagnose through the consultation of the oracles and other invisible informants.

The offering of sacrifices and other rituals to the gods as a kind of pleasing and tribute paying is commonly practised by most of the traditional healers.

For the traditional treatment to be carried out, patients are requested to provide (buy) certain things that the healer considers necessary for the treatment and possibly for

the rituals too. (Please note that not all traditional healers engage themselves in the so called rituals/sacrifice!).The individual healer's prerequisite for treatment differs from individual to individual but in most cases the following are often seen on the list:

1. A cock (or other animal)
2. Cola-nut and alligator pepe
3. A piece of cloth
4. Local mood
5. A hot drink (alcohol)
6. Special herbs/roots e.t.c

The patient should not eat any animal slaughtered for the ritual! The cock could be killed and it's blood poured into a hole dug in the ground as part of the sacrifice to the gods, or the healer takes it alive with him to his house for his personal use. In some cases, healers request many things that they later take home and never use them for the treatments at all! This goes in line with the proverb that „He who pays the piper calls his tune“

So, a lot of self-interest and satisfaction are noticed among most healers!

8.2 Therapy success of indigenous medicines

Indeed, there has been very little success with the traditional treatment of schizophrenia, most of the successes are recorded by the herbalists who could identify the sickness and apply herbs and roots which according to their experience and knowledge could have a positive effect on mental ill health. Unfortunately the success of their treatments is being limited by the inadequate diagnoses and uncontrolled application of herbs and roots.

Worth mentioning, of course to my personal belief, is that the success of other healers as far as schizophrenia is concerned could be compared to the success of a „placebo treatment“ in modern medicine! This however affects the satisfaction of patients and as the result, the majority of them continue the search for a lasting treatment and better health condition. “Prayer can move mountains” this fact is noticeable from day to day in Africa as incurable sicknesses are miraculously cured!

In the actual sense, traditional treatments are effective in curing certain sicknesses in Africa but provide very little solution to mental sicknesses compared to modern medicine.

8.3 My critics

The brutal way in which psychiatric patients in general are treated is very alarming, for example the chaining of aggressive psychiatric patients as a means of limiting their freedom of movement and aggression which mostly lead to non- cardiac, non-kidney foot oedema causes a great harm to their health.

Also worth criticising is the attitude of the public to the psychiatric patients, for example, whoever suffers any type of psychiatric sickness, is considered a mad person and isolated! This treatment increases the rate of depression among the psychiatric patients.

9. Topic Analysis

All said and done, an overview of the findings so far, allows for the following conclusions:

Beyond any reasonable doubt, the high rate of religious delusions and the lay belief regarding the cause of mental ill health (schizophrenia) in Africa (Nigeria) is seen as the only major difference in comparing the symptomatic of schizophrenia in Africa with Europe (Germany). At the same time one should not forget that religion is the order of the day in Africa today, hence the high rate of religious delusions should not be allowed to raise much dust when looking at the symptoms of intercultural schizophrenia.

It is also worth mentioning that there is very little or no notable difference in symptoms recorded between the two countries (Nigeria and Germany) as shown above. The reason for this surprising outcome could be traced back to the fact that most of the African psychiatric doctors were trained in Europe where they get used to the European symptoms.

Delusional perceptions

Thought broadcasting

Audible thoughts

Voices arguing, discussing or commenting

Depressive and euphoric mood changes

Depersonalisation

Paranoid ideation

Derealisation

Poor insight

Unreliable information

Looseness of associations, illogical thinking, etc.

To drive the above and obvious fact home, the graphical representations of the self-treatment by the schizophrenia patients provide us with the mirror image of the difference between the countries concerned. While almost 70% of the African (Nigerian) patients use prayers as their self treatment, more than 60% of the European (Germany) patients appear to have no self treatment. Reliable findings revealed that most of the European (Germany) patients see relaxing as a key means of improving their mental sickness.

Also worth mentioning are other findings which to my personal belief could show considerable differences in the countries in question, though not for the symptoms. For example, a majority of the Nigerian patients are found to have used anti malaria medicines before their mental sickness started, but no evidence of these medicines causing their sicknesses could be proved.

Available records also show no clear difference rate of drug/ alcohol abuse by the in both Nigeria and Germany patients before the outbreak of their mental sickness, but in general the rate of alcohol consumption and cigarette smoking is higher in Europe than in Africa.

The therapy of mental ill health (schizophrenia) provides us with another notable difference! While the treatment of schizophrenia in Europe is purely modern medicine, the treatment in Africa takes a diverse dimension. Apart from the modern medical treatments, the application of traditional medicines for the treatment of schizophrenia also plays an important role in the African society.

Indeed, the modern clinical systems of Nigeria and Germany also appear to have some dissimilarities. For example, while the Nigerian clinical system demands the presence and active participation of the relatives of the patients/ families during the ward-rounds, the German clinical system prohibits it. Before the ward-rounds in Nigeria, relatives of patients are expected to have interacted with them, found out the innermost state of mind of the patients, assessed the progress of the sickness and provided useful information to the team of doctors, nurses and social welfare.

10. Conclusion

This study involves a close view of schizophrenia patients in different cultural environments in Africa (Nigeria) and Europe (Germany). The aims and objectives of this study are to find out differences in symptoms, incidence rate, diagnostic means, treatments and as well as the inter-cultural influences on schizophrenia if any!

The research/interview was carried out at the psychiatric department of teaching hospital Portharcourt (Nigeria) and Psychiatric department of the Tuebingen teaching hospital (Germany)

The selection of patients was at random. A sample of 40 schizophrenia patients from these psychiatric hospitals were interviewed. The sample was made to include equal numbers of men and women irrespective of their age or any special quality or qualifications. At the end I came at the following conclusions below.

Beyond any reasonable doubt, the high rate of religious delusions and the lay belief regarding the cause of mental ill health (schizophrenia) in Africa (Nigeria) is seen as the only major difference in comparing the symptomatic of schizophrenia in Africa with Europe (Germany). At the same time one should not forget that religion is the order of the day in Africa today, hence the high rate of religious delusions should not be allowed to raise much dust when looking at the symptoms of intercultural schizophrenia.

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Caution: This thesis and its findings are limited to these countries and regions involved and should not be generalised!

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