

Knowledge, beliefs and mental treatment seeking practices of Black African and Indian outpatients in Durban, South Africa

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Abstract

Mental illness is a major contributor to the global burden of disease in the world. Patients' knowledge of mental illness and their treatment options play an important role in the effectiveness of service delivery and health outcomes in developing countries. The objectives of this study were to assess the knowledge, attitudes and beliefs of mental health outpatients about mental illness and its treatment, and their knowledge and satisfaction with traditional and Western/allopathic health systems. A self-designed questionnaire was used to assess the knowledge, attitudes and beliefs of mental health patients about mental illness and its treatment. Of the 157 outpatients who identified themselves as having a mental illness, 77.7% were aware of their condition, 33.8% only knew it as a mental illness and 21.5% patients did not know what caused their mental illness. Of the 195 patients interviewed, the majority (76.9%) preferred Western treatment, believing that taking medication would help their condition. Sixty-three patients reported that they did access both Western clinics as well as traditional healers. Overall, the majority of patients (82.5%) expressed satisfaction with their current treatment, with 76.9% indicating preference for consulting a medical practitioner, and 13.8% indicating preference for a traditional healer. Indian and African patients with mental illness attending two urban psychiatric clinics expressed confidence in Western treatment with a minority preferring traditional healing. Future research should focus more exclusively on the various categories of alternative treatment, the healers involved, the reasons for seeking these treatments, the roles that they play in the South African context.

Keywords: South Africa, mental health outpatients, mental health literacy, traditional health.

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Introduction

Mental illness is a major contributor to the global burden of disease in the world (WHO, 2008). Despite this, the treatment gap for mental disorders remains very large (Kohn, Saxena, Levav & Saraceno, 2004; Patel et al., 2010), reaching 90% in low resourced countries (Patel et al., 2010). In South Africa, inequitable funding, inadequate facilities and staff shortages constitute major challenges in addressing this gap (Burns, 2010). Contributing to this treatment gap may be poor knowledge and beliefs about mental illness preventing people seeking appropriate help. Many people with chronic or severe psychiatric disorders may be unaware that effective treatment is available (Hugo, Boshoff, Traut, Zungu-Dirwayi & Stein, 2003); they may have poor mental health literacy and knowledge of causation and negative views of mental illness (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley & Kola, 2005), resulting in stigma and negative community attitudes (Hugo et al., 2003).

In this context, traditional healing methods could play an important role in developing countries (Sorketti, Zainal & Habil, 2012). A Nigerian study reported that 6% of religious healers referred their clients to medical practitioners (Agara, Makanjuola & Morakinyo, 2008). It is estimated that 80-85% of Black African South African people in both urban and rural areas consult with traditional healers (Stafford, Pedersen, van Staden & Jäger, 2008). Also, in a study of a community sample of South African patients, Black Africans were more likely to consult a traditional healer for emotional and mental health concerns (OR=0.06, 95% CI 0.02–0.3) than the other race groups (Sorsdahl et al., 2009). The promulgation of the Traditional Health Practitioner's Act No 35 of 2004 has significant implications for mental health service delivery in South Africa (Janse van Rensburg, 2009) where there is parallel use of Western and traditional healthcare systems (Campbell-Hall et al., 2010). While there is a serious shortage of mental health personnel (Burns, 2010), it has been estimated that the number of traditional healers outnumbers the allopathic doctors by at least ten to one (Morris, 2001).

There is little research on the knowledge and beliefs towards mental illness and the use of traditional healers in existing mental health patients in specific cultural groups in urban settings within the South African community (Hugo et al., 2003). The objectives of this study were therefore to assess the knowledge and beliefs of Black African and Indian mental health patients from the outpatient department of two public hospitals in KwaZulu-Natal, South Africa about mental illness and its treatment, their knowledge and satisfaction with the respective health systems and the frequency of alternate health practitioner consultation.

Methodology

A survey was conducted at the psychiatric outpatient departments of two large public hospitals in the south central area of eThekweni, Durban in KwaZulu-Natal (KZN), South Africa. The two public hospitals with large mental health outpatient departments were purposively selected, as Hospital A services a catchment area with 99.4% Black African residents and Hospital B a catchment area of 60.03% Indian residents and 38.2% Black African residents (Statistics South Africa, 2015).

The target population was adult outpatients (18 years and older) attending a mental health outpatient clinic during the time of the survey. Ethical approval for this study was obtained from the University of KwaZulu-Natal, and permission was granted from the KZN Department of Health and both hospitals. Written informed consent was obtained from the patients.

A self-developed questionnaire was used for data collection. Questionnaires included knowledge about the history of mental illness and history of help-seeking behaviours. Each participant was interviewed by a student researcher, while a second student also recorded their answers to ensure reliability. The questionnaire was translated into IsiZulu for those who could not understand English. Data were captured and analysed using Statistical Package for Social Sciences (SPSS) version 21.0. Differences between the two groups were measured using Pearson's Chi-square Tests and, where appropriate, Fisher Exact Tests. A probability level of 0.05 was set for significant statistical analysis.

Results

A total of 195 mental health outpatients participated in the study, 100 from hospital A and 95 patients from Hospital B. Of these, 104 (53.3%) were Black Africans and 91 (46.7%) were Indian patients. There were 113 males (57.9%) and 82 females (42.1%). The patients were evenly represented in the age groups, with 46 (23.6%) below 30 years of age, 44 (22.6%) between 30 and 39, 47 (34.1%) between 40 and 49, 38 (19.5%) between 50 and 59 and 20 (10.3%) over 60 years of age. Most of the patients were single or divorced (147, 75.4%), with only 18 (9.2%) employed and 123 (65.1%) with an education level of Grade 8 or below (10 years of schooling). There were major significant differences between the two groups in terms of gender, age and marital status and the data were subsequently reported separately for each group (Table 1).

Table 1: Demographics of study sample

Variable	Black African Patients (n=104) No (%)	Indian Patients (n=95) No (%)	Test Statistic X^2 (df,n)	p- value
Gender:				
Male	75 (72.1%)	38 (41.8%)	18.4(1,n=195)	<.001*
Female	29 (27.9%)	53 (58.2%)		
Age Group:				
< 30	39 (37.5%)	7 (7.7%)	42.4 (4,n=195)	<.001*
30-39	27 (26%)	17 (18.7%)		
40-49	25 (24%)	22 (24.2%)		
50-59	10 (9.6%)	28 (30.8%)		
60+	3 (2.9%)	17 (18.7%)		
Marital Status:				
On own	91 (87.5%)	56 (61.6%)	16.8 (1,n=194)#	<.001*
With partner	13 (12.5%)	34 (37.4%)		
Residence:				
Rural	25 (24%)	3 (3.3%)	4.0 (1,n=195)	<.001*
Township/City	79 (76%)	88 (96.7%)		
Employment:				
Yes	8 (7.7%)	10 (11%)	0.7 (1,n=194)	.413
No	96 (92.3%)	80 (87.9%)		
Years of Education:				
=< Grade 10 and > Grade 10	63 (61.8%)	60 (65.9%)	0.9 (1,n=189)	.344
	38 (36.5%)	27 (29.7%)		

Differences were tested with Pearson Chi-square and Fisher's Exact Test. *Significance was set as $p < .05$.

The majority (89.7%) of the patients attended the mental health outpatients' clinics monthly. Nearly all of them, 191 (97.9%), reported collecting medication from the clinic. When asked if they suffered from a mental illness, 157 (80.5%) agreed, though 192 (98.5%) stated that they took medication for a mental illness (Table 2). More Black African patients (89.4%) than Indian patients (70.3%) agreed that they suffered from a mental illness ($p = .001$) (Table 2).

The most common conditions reported were depression (34, 17.4%) and schizophrenia (22, 11.3%), with significant differences in self-reported diagnostic profiles between the two groups ($p < .001$). About 35.6% Black African patients reported non-specific mental illness as compared to 3% of Indian patients (Table 2). Of the 192 who reported taking medication for mental illness, 182 (94.8%) were taking daily medication as prescribed, but 37.5% of the patients on medication reported problems or side effects with taking the medication (Table 2).

Table 2: Self-reported mental illness profile

Variable	Black African Patients (n=104) No (%)	Indian Patients (n=95) No (%)	Test Statistic X^2 (df,n)	p-value
Mental Illness:				
Yes	93 (89.4%)	64 (70.3%)	11.3(1,n=195)	.001*
No	11 (10.6%)	27 (29.7%)		
Diagnosis:				
Schizophrenia	5 (4.8%)	17 (18.7%)	53.7(8,n=121) #	<.001*
Depression	7 (6.7%)	27 (29.7%)		
Bipolar	1 (1%)	22 (24.2%)		
Other	11 (10.6%)	13 (14.3%)		
Mental Illness NS	37 (35.6%)	3 (3.3%)		
Not known	43 (41.3%)	31 (34.15)		
Medication taken	103 (99%)	89 (97.8%)	4.3(1,n=194)#	.115
Monthly visit	104(100%)	86 (94.5%)	5.0 (1,n=195)#	.021*

Differences were tested with Pearson Chi-square and Fisher's Exact Test#. *Significance was set as $p < .05$.

One third of the patients (66, 33.8%) reported a family history of mental illness. There were significant differences between Indian and Black African patients with 32.7% of Black African patients compared to 50% of Indian patients reporting a family mental illness ($p=.025$) (Table 3). Of the 66 patients who reported a family history of mental illness, 46 (69.7%) knew that their family member was on treatment and 46. 82.5% were Indian patients.

Of the 157 patients who identified themselves as having a mental illness, 122 (77.7%) were aware of the condition they were receiving treatment for, though 40 of the 122 (33.8%) only knew it as a mental illness. Nearly a quarter of the patients did not know what caused their mental illness (42, 21.5%) and this was much higher in Black African patients than in Indian patients (Table 3). The most common causes of mental health problems were attributed to stress and family problems (25 patients each) (12.8%); substance abuse 18 (9.2%), trauma and accidents (17, 8.7%), followed by bewitchment (15, 7.7%) (Table 3).

Of the 192 patients on medication, 183 (93.8%) reported taking the medication as prescribed (no significant group differences), 186 (95.4%) stated that they believed that the medication was helpful and 66 (34.4%) knew the name of the medication they were taking (no significant group differences). Seventy-three (37.4%) reported side-effects with their medication and these were more commonly reported by Indian (46.5%) than Black African patients (31.1%) ($p=.033$) (Table 3).

Table 3: Self-reported knowledge of mental illness and treatment

Variable	Black African Patients (n=104) No (%)	Indian Patients (n=95) No (%)	Test Statistic χ^2 (df,n)	P Value
Knowledge of Family History:				
Family History of MI	33 (32.7%)	33 (50%)	5.0 (1,n=194)	.025*
Family Member Dx	12 (23.1%)	22 (64.7%)	14.9 (1,n=86)	<.001*
Member on treatment	18 (34.6%)	28 (82.5%)	18.8 (1,n=86)	<.001*
Knowledge of own illness:				
MI	93 (89.4%)	64 (70.3%)	11.2 (1,n=195)	.001*
Diagnosis	61 (58.7%)	61 (67%)	1.5 (1,n=195)	.228
Treatment collected	104 (100%)	88 (96.7%)	3.5 (1,n=195)#	.100
Treatment taken	103 (99%)	89 (98.9%)	0.1 (1,n=195) #	.918
Taken as prescribed	98 (94.25)	85 (94.4%)	1.1 (1,n=194)	.949
Name of medication	31 (29.8%)	35 (38.9%)	1.8 (1,n=194)	.183
Medication helping	102 (98.1%)	84 (93.3%)	2.4 (1,n=194)#	.148
Problems	32 (31.1%)	41 (46.5%)	5.8 (1,n=192)	.033*
Beliefs on cause of mental illness:				
Stress	8 (7.7%)	17 (18.7%)	42.6 (14,n=194)#	<.001*
Family problems	6 (5.8%)	19 (20.9%)		
Trauma & accidents	11 (10.6%)	6 (6.6%)		
Ancestors/bewitchment	12 (11.5%)	3 (3.3%)		
Substance use	15 (14.4%)	3 (3.3%)		
Loss	3 (2.9%)	12 (13.2%)		
Don't know	30 (28.8%)	12 (13.2%)		
Beliefs about treatment				
Medication	77 (74%)	61 (67%)	1.2 (1,n=195)	.283
God	3 (2.9%)	23 (25.3%)	21.1 (1,n=195)	<.001*
Lifestyle	8 (7.7%)	13 (14.3%)	1.5 (1,n=195)	.138
Counselling	6 (5.8%)	4 (4.4%)	0.18 (1,n=195)#	.753
Traditional	7 (6.7%)	0 (0%)	6.4 (1,n=195)#	.015*

Associations were tested with Pearson Chi-square and Fisher's Exact Test#. *Significance was set as $p < .05$.

Nearly three-quarters of the patients believed that taking medication would make them better (138, 70.8%), compared with faith in God (26, 13.3%), counselling (10, 5.1%) and traditional treatment (7, 3.6%). The only group differences in beliefs about treatments were in the different spiritual systems of beliefs, namely beliefs in God by Indian patients (25.3% vs 2.9%) and traditional medicine by Black African (6.7% vs 0%) (Table 3).

Nearly all (187, 96.4%) of the patients stated that the health workers were friendly and most of the patients (173, 88.7%) were happy with the time they spent with their doctor or nurses. The majority (185, 94.9%) stated that the medication from the clinic was helping them. The most common reason for dissatisfaction with care was that the clinic visits took too long (n=14). When asked who they would prefer seeing, 150 (76.9%) preferred to see a doctor and

27 (13.8%) a traditional healer. The bigger proportion of these were made up of Indian patients ($p=.005$) (Table 4).

Table 4: Self-reported satisfaction with treatment

Variable	Black African Patients (n=104) No (%)	Indian Patients (n=95) No (%)	Test Statistic $X^2 (df,n)$	P Value
Satisfied with medical staff	88 (84.7%)	86 (95.6%)	7.2 (1,n=194)	.017*
Friendliness of staff	99 (96.1%)	89 (97.8%)	2.3 (1,n=194)#	.686
Medication working	101 (98.1%)	84 (94.4%)	2.8 (1,n=193)#	.184
Prefer to see a doctor	99 (98%)	51 (96.2%)	0.5 (1,n=154)#	.608
Prefer to see an alternate healer	13 (13%)	14 (33%)	7.9 (1,n=142)	.005*

Differences were tested with Pearson Chi-square and Fisher's Exact Test#. *Significance was set as $p<.05$.

When asked about alternate health care, 63 (32.3%) stated that they had consulted alternate health practitioners before, with more Black African (40, 63.5%) compared to Indian patients (23, 36.5%) ($p=0.049$) (Table 5). Twenty-one of the 63 patients, 19 of whom were Black Africans, did not know their diagnosis.

Significant differences were observed regarding methods of treatments favoured, with prayer being utilised more by Indian patients (19, 82.6%) and medication (29, 85.3%) by African patients ($p=.001$). Traditional medications included: 'umuthi' for 'ukugquma' and ukuphalaza (induced vomiting). The most common diagnoses given by the traditional healers were ancestor issues (14, 22.2 %), followed by bewitchment (9, 14.3%) (Table 5).

Table 5: Self-reported Satisfaction with Alternate Treatment

Variable	Black African Patients (n=40) No (%)	Indian Patients (n=23) No (%)	Test Statistic $X^2 (df,n)$	P Value
Would seek out alternate Treatment (n=63)	40 (38.5%)	23 (25.3%)	3.9 (1,n=195)	.049*
Type of treatment			42.6 (4,n=57)#	<.001*
Traditional medication	29 (85.3%)	2 (8.7%)		
Prayer	2 (5.9%)	19 (82.6%)		
Diagnosis	34 (85%)	14 (60.9%)	5.7 (1,n=62)	.017*
Satisfaction with alternate treatment	31 (56.4.5%)	21 (91.3%)	8.9 (1,n=78)	.003*

Differences were tested with Pearson Chi-square and Fisher's Exact Test. *Significance was set as $p<.05$.

For the 63 participants who had previously used alternate treatment, the frequency of visits ranged from once (15, 23.8 %) to a few times (19, 30.2%), with 19 (30.2%) visiting regularly (daily to monthly). Fifty-two (82.5%) stated that they were happy with the treatment received. The most common form of

alternate treatment reported was traditional medication (31, 49.2%), followed by prayer (21 patients, 33.3%). Diagnoses (what was wrong with them) were given to 48 (76.2%) of these patients. Age, gender, living arrangements or places of residence were not significantly associated with the choice to seek alternate health care. Patients with \leq grade 10 education (44, 69.8%) were more likely to seek alternate health care than those with $>$ grade 10 (15, 23.8%) education ($X^2=3.6$ (1, $n=188$), $p=.059$).

Discussion

This study examined responses of patients attending mental health outpatient facilities at two large western clinics in the eThekweni area in South Africa. Though the most commonly reported mental health problems in the group were depression and schizophrenia, more than a third of patients reported non-specific mental illnesses, most of these being Black African patients. The reasons for this were not formally established but warrant further investigation. It is not clear whether it was more difficult to establish a formal diagnosis in these patients and, if so, why this was the case; or whether these patients could not remember names of their illnesses due to language, cultural factors or low mental health literacy. This was also observed in the group that reported that they would seek out traditional healers, with a third of the patients reporting having a non-specific mental illness. This was further confirmed through the specific examining of the knowledge of mental illness and treatment in these patient groups. Our findings are similar to a study in Nigeria that showed that knowledge of causation was poor (Gureje et al., 2005), with nearly a quarter of the patients not knowing what caused their mental illness.

Beliefs in alternate treatment (God and traditional medicine) were low with nearly three-quarters of the patients believing that taking medication would make them better and main group differences being in the different spiritual systems of beliefs in God and traditional medicine. A limitation in this study is the bias towards western medicine where the target population comprised patients already accessing western clinics on a chronic basis.

In terms of treatment-seeking behaviours, our study found that the majority of patients showed high degrees of satisfaction with treatment received at the outpatient clinics and they believed the medication received benefitted their health. However, nearly a third of the patients were simultaneously consulting a traditional healer and western mental health outpatient services. These findings were higher than the population-based findings in the South African Stress and Health (SASH) study which found that 20% of participants with a lifetime DSM-IV diagnosis obtained treatment from alternative practitioners, traditional healers were consulted by 9% of the respondents and 11% consulted a religious or spiritual advisor (Sorsdahl et al., 2009). The findings were, however, lower than

the Nigerian psychiatric patient study which reported that 45% of patients had previously sought religious healing (Aghukwa, 2012). The reasons for seeking out alternative treatment could be due to each system addressing different meanings, with western mental health services providing symptomatic relief and traditional services offering more culturally meaningful explanations and solutions for illnesses through the performance of rituals to appease ancestors or gods. Another possible explanation may be linked to the high number of people suffering from either depression or an 'unknown' mental illness in our study. This was also shown in the SASH study where people in the community suffering from depression reported that they were almost three times more likely to have consulted a traditional or religious/spiritual healer than a mental health professional (Tomlinson, Grimsrud, Stein, Williams & Myer, 2009).

The patients seeking alternative care in this study were mostly Black African and patients with lower education but with no discernible differences in age or gender. This was also confirmed in the study by Sorsdahl (2009) who found that use of traditional healers was predicted by older age, black race, unemployment, lower education and having an anxiety or a substance use disorder (Sorsdahl et al., 2009). A study in Sudan also found that visitors to traditional healers were less educated compared to the general population in the area (Ahmed, Bremer, Magzoub & Nouri, 1999).

Though nearly a third of the patients in the study reported seeking other forms of treatment for their mental condition, overall 13.8% preferred to see the traditional healer and 76.9% reported that they preferred to see a doctor. For the patients who had received treatment from both services, these patients revealed general satisfaction with both systems, which was also confirmed by other studies (Ensink & Robertson, 1999). This suggests that these dual systems meet different needs and that there is a role for them to work synergistically.

Although the study has a number of limitations, the purposive nature of the sampling and the settings could have introduced bias; the study does however provide some insight into the knowledge, beliefs and treatment-seeking behaviours of Black African and Indian outpatients in these specific settings

Conclusion

This study found reasonable knowledge of patients' mental health problems and a preference amongst outpatients, attending a psychiatric clinic, for a western type of treatment. In South Africa, a multitude of cultures, belief systems and traditions exist. Therefore, an understanding of local patient perspectives of common mental disorders will allow modern medicine to provide culturally sensitive and locally acceptable health care (Shankar, 2006). Future research should focus more exclusively on the various categories of alternative treatment,

the healers involved, the reasons for seeking these treatments, the roles that they play in the South African context and the assessment of their effectiveness in the management and treatment of mental illness.

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