

**A survey of the perceptions and management of ADD/ADHD by
homoeopathic practitioners in the
Johannesburg Metropolitan Area.**

By

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I, Susan Margaret Nagle, do hereby declare that this mini-dissertation represents
my own work both in concept and execution.

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DEDICATION

**I WOULD LIKE TO DEDICATE THIS TO MY PARENTS, JENNY AND
CONRAD, FOR THEIR LOVE, SUPPORT AND GUIDANCE AND TO THE
LORD, MY GOD, WHO STRENGTHENS ME IN ALL I DO.**

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ABSTRACT

The epidemic proportion of ADD/ADHD diagnosis is gaining widespread attention from parents, educators, doctors and other health care providers. Parents are seeking alternatives, as they are concerned about the use and side effects of methylphenidate hydrochloride (e.g. Ritalin®, Adaphen®, Concerta®) and other conventional drugs used to treat the symptoms of ADD/ADHD (Badat, 2004 and Picton, 2004).

The aim of this research was to document the current practices of registered homoeopathic practitioners, with regard to Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). In addition, their perceptions regarding aetiology, treatment, management and success rate was investigated. This research took the form of a qualitative-quantitative survey (questionnaire) targeting homoeopaths practicing in the Johannesburg Metropolitan Area.

Sixty-three homoeopaths currently practising in the above-mentioned area were sent questionnaires to complete; of these, 41 participated in the survey, i.e. a response rate of 65% was achieved. The questionnaires were distributed and collected by the researcher. At the time of collection, an interview was also conducted. The raw data was captured and analysed by STATKON (The Statistical service of the University of Johannesburg).

The majority of the responding homoeopaths practised in the “northern suburb” of Johannesburg, qualified at Witwatersrand Technikon, were female and were between 25 and 30 years of age.

A practitioners training enables them to look beyond the diagnosis and to focus on the person as a whole (physical, mental and emotional symptoms), and then to prescribe a remedy specifically for that patient. Homoeopaths do not usually label patients with a diagnosis, so patients consulting with a homoeopath would either be pre-diagnosed or have some suspicion that they or their child has ADD/ADHD. Majority of the homoeopaths thought that ADD/ADHD was either misdiagnosed or overdiagnosed. 61% of the homoeopaths interviewed thought that there was a difference between childhood and adult ADD/ADHD, therefore treatment for adults and children would be different, but the principle of treating each patient as an individual remains the same.

Homoeopaths trained at DIT prescribed simplexes more frequently than those trained at Uni-Jhb and complex treatment was prescribed more frequently by those trained at Uni-Jhb. Complexes were prescribed statistically more frequently by homoeopaths from Uni-Jhb for the 5-9 year old age group. Simplexes were prescribed statistically more frequently by practitioners with more experience - in the 10-14, 15-18 and older than 18 age groups. The most frequently prescribed simplex was *Datura stramonium* and the most frequently prescribed complex was *Ignatia-homaccord*.

Vitamins and dietary changes were the most frequently prescribed additional treatment for patients with ADD/ADHD. Regardless of qualification or institution, all practitioners prescribed vitamins at least once to children 5-9 years old.

As can be expected the more experience a practitioner has the more confident they become in prescribing not only simplexes but also in prescribing vitamins, diet and other treatments and so their success rate also improves.

Most practitioners reported that they are having moderate to great success in treating/managing those with ADD/ADHD. Although this is subjective, this is significant for those seeking treatment for ADD/ADHD to try homoeopathy first rather than as a last resort.

It would be recommended that in future studies (that involve practitioners), other listings in addition to the register provided by the Allied Health Professions Council of South Africa be used as one the most challenging aspects of this research was contacting practicing homoeopaths in the specified area. It is also recommended that a patient benefit survey in the form of a treatment outcome based questionnaire be given to patients and/or parents to complete. This would help to accurately quantify the response rate to treatment (success rate).

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DEFINITIONS OF TERMS AND ABBREVIATIONS

1. **Attention Deficit Hyperactivity Disorder (ADHD)** - a disorder of attention and impulse control with specific DSM-IV criteria, appears in childhood and may continue through to adulthood though it usually subsides during adolescence. Hyperactivity may be a feature but is not a requirement for diagnosis (Stedmann's Medical Dictionary, 1995).
2. **Clinical Picture** - The presenting pathological or functional disorder, or existing syndrome named according to conventional medicine (Bloch and Lewis, 2003).
3. **Constitutional remedy** - A remedy prescribed on the basis of temperament, character and general reaction of the person, as well as local symptoms of the disease (Bloch and Lewis, 2003).
4. **Complex Remedy** - A combination of two or more Homoeopathic medicines which are prepared from more than one stock and incorporated into one dosage form (Swayne, 2000).
5. **D.I.T. – Durban Institute of Technology**, as of 2002, now called Durban University of Technology, as of 2006 (ex- Natal Technikon).

6. **Dopamine** - a neurotransmitter secreted by the neurons that originate in substantia nigra. The terminations of these neurons are mainly in the striatal region of the basal ganglia. The effect of dopamine is usually inhibition (Guyton and Hall, 1997).
7. **DSM-IV** - Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) – refer to APPENDIX 5.
8. **Essential Fatty Acid (EFA)** - any long chain monobasic organic acid required for normal functioning of the human body and which must be obtained from a food source (Stedmann's Medical Dictionary, 1995).
9. **Gamma-aminobutyric acid (GABA)** - a neurotransmitter secreted by nerve terminals in the spinal cord, cerebellum, basal ganglia and areas of the cortex. It is believed to always cause inhibition (Guyton and Hall, 1997).
10. **Glutamate** - a neurotransmitter secreted by the presynaptic terminals in many sensory pathways as well as many areas of the cortex. It is believed to always cause excitation (Guyton and Hall, 1997).
11. **Johannesburg Metropolitan Area** - refer to APPENDIX 4 (MAP)
12. **Law of Similars** - "like cures like" (similia similibus curentur) – The remedy for any individual illness is the very substance that can produce similar symptom picture and pattern of illness in a healthy person (Bloch and Lewis, 2003).

13. **Miasm** - a mode in which the body reacts, the term used to reflect a certain predisposition, a defect that can be transferred from one generation to another (De Schepper, 2006).
14. **Neurotransmitters** - chemicals that make it possible for nerve impulses to travel from one cell to another and therefore play an essential role in the functioning of the brain (Guyton and Hall, 1997).
15. **Simillimum** - the single homoeopathic medicine, the drug picture of which most nearly approaches the total symptom complex of the patient (Gaier, 1991).
16. **Simplex Remedy** - A single medicine derived from a single source material (Swayne, 2000).
17. **Totality of symptoms** - The complete clinical picture of a patient during the “illness”, comprises all mental, general and local (particular) symptoms and signs; the complete symptom pattern from which the simillimum is found (Swayne, 2000).
18. **Uni-Jhb** – University of Johannesburg, as of 2005 (ex- Witwatersrand Technikon).

CHAPTER 1

1.1 INTRODUCTION

Attention deficit disorder with or without hyperactivity is the most frequent and fastest growing diagnosis among children in the USA and is increasing at a rapid rate in all developing countries. It is also currently one of the most researched conditions; yet it is not fully understood (Picton, 2004).

It is estimated that ADD/ADHD occurs in three to seven percent of the school age population, and boys are diagnosed three to four times more than girls. Without proper intervention ADHD can continue through adolescence and into adulthood with research indicating that it occurs in approximately two to four percent of adults thus the prevailing belief among professionals that children “outgrow” ADHD by adulthood is false. Despite increased awareness, ADHD remains under-recognised with less than half of the affected individuals receiving treatment (Janessen-Cliag, 2005). Thus the number of children affected by this condition is potentially higher than stated by formal statistics. It is thought that ADHD could be more common in rural areas since families do not have adequate access to health care and nutrition, their awareness and understanding of the condition is also minimal (Badat, 2004; Byram, 1998; Jannssen-Cliag, 2005).

ADD/ADHD is primarily a neurophysiological disorder, caused by an imbalance in neurotransmitters. There is evidence to suggest it is also hereditary; that is, there is a genetic predisposition (Naude, 2004). A deficiency in Essential Fatty Acids as well as other vitamins and minerals seem to either contribute or aggravate the symptoms associated with ADD/ADHD; therefore nutrition, diet and supplementation form an important part of the treatment process (Picton, 2004). There is also a tendency for these patients to be ultra-sensitive to their physical and emotional environment. These children also frequently have learning, behavioural and social problems, which need to be addressed (Allen and Harrison, 2004).

A diagnosis can only be given once a comprehensive (multidisciplinary) evaluation has been conducted. An assessment should include, neurological, medical and developmental history, a thorough physical examination, psychometric testing and a concurrence with the DSM IV criteria (Erasmus, 2004). Although it seems that many children are hyperactive, only a relatively small percentage are truly sick. Many children have boundless energy, get bored easily, and have little interest in learning certain school subjects (Ullman, 1991).

The prescribing of the stimulant Methylphenidate Hydrochloride (the active ingredient in Ritalin®, Adaphen® and Cocerta®) is the conventional form of treatment used by neurologists and doctors. Depending on the symptomatology and the severity of the symptoms (such as emotional issues or sensory defensiveness), the use of other disciplines can be incorporated into the treatment plan such as: psychology, occupational therapy, speech and hearing therapy and nutrition. In addition, other complementary therapies are available such as Homoeopathy, Chiropractic, meditation and relaxation and can be an alternative and/or adjunct to conventional treatment. The ideal way to manage an individual with ADD/ADHD is with an integrated approach (Picton, 2004).

Homoeopathy is becoming a preferred choice of treatment as parents seek to find alternatives to Methylphenidate hydrochloride (Badat, 2004). Anecdotal evidence indicates that homoeopaths consult with a significant number of ADD/ADHD patients but no formal evidence/study exists to support this. This is one of the rationales for this research project. It will explore the homoeopathic practitioners' approach to patients as well as the treatment, management and success rate in treating ADD/ADHD. This research will also include a demographic study of the practitioners and their practices.

1.2.1 PROBLEM STATEMENT

A survey to determine the perceptions and management of ADD/ADHD by homoeopaths in the Johannesburg Metropolitan area by means of a self-administered questionnaire and interview.

1.2.2 AIMS AND RATIONALE

- To document the current practices of Homoeopaths with regard to Attention Deficit (ADD) and Attention Deficit Hyperactivity Disorders (ADHD).
- To determine the perceptions of homoeopaths towards ADD/ADHD with regard to aetiology, treatment and management.
- To establish links or trends with regard to aetiology, management and treatment by homoeopaths as certain trends were noticed by psychologists when they were taking the history of ADD/ADHD children.
- To provide formal statistics on the numbers of ADD/ADHD patients being treated by homoeopaths and the homoeopathic treatment they received. Anecdotal evidence indicates that homoeopaths consult with a significant number of ADD/ADHD patients, however no formal evidence/studies exist to support this.
- To provide information to the public, Attention Deficit and Hyperactivity support Group of Southern Africa (ADHASA), the Homoeopathic and medical fraternities about the homoeopathic approach to ADD/ADHD.

CHAPTER 2

REVIEW OF RELATED LITERATURE

2.1 ADD/ADHD – EPIDEMIOLOGY, PREVALENCE and PROGNOSIS

ADD/ADHD is currently one of the most researched childhood conditions, yet there is still so much controversy and misunderstanding about it. It is also one of the most commonly diagnosed disorders of childhood development (Picton, 2004).

Although official statistics are not available for South Africa, the Hyperactivity Attention Deficit Disorder Support Group of South Africa (ADHASA) believes that about 5% to 10% of all South African children are affected (Health24, 2004). Unfortunately, statistics are affected by many variables, including the child's socioeconomic status, gender and even place of birth (Epanchin and Paul, 1987).

More boys than girls are diagnosed with ADHD, the ratio of male to female being 6:1. ADHD tends to be under diagnosed in girls the reason for this is thought to be that boys more frequently present with the hyperactivity/impulsivity symptoms, which are easily identified, whereas girls more frequently present with the inattentive symptoms, which are more difficult to identify (Riordan, 2004). It has also been suggested that ADHD could be more common in rural areas since

these families do not have adequate access to good health care and nutrition as well as there is minimal awareness and understanding of the condition – some even believe it to be witchcraft (Badat, 2004; Byram, 1998; Janssen-Cilag, 2005).

There is a research project underway, in the South Western Township in Johannesburg, with the main aim being to investigate the incidence of ADD/ADHD in this area (ADHSA Seminar, October 2006).

It would appear that statistics vary from country to country; this could be because the definition of the disorder varies in different countries (Epanchin and Paul, 1987). About 33% of children who are diagnosed with ADD/ADHD have reading problems and are also likely to have difficulties in mixing with other children; often because they are aggressive, these problems could extend into adulthood if not treated (Byram, 1998).

Research indicates that this condition occurs in approximately 2% to 4% of adults. The gender ratio of adult males to females is 2:1 or lower. The belief among some professionals that children outgrow ADHD by adulthood is false, this is due to symptoms becoming less severe and presenting differently in adolescence and adults because of the development of coping mechanisms to compensate for their impulsivity and disorganization (Janssen-Cilag, 2005; Wallis *et al*, 1994). At least 20-30%, and possibly as much as 80% of children with ADHD will continue to exhibit symptoms in adulthood.

Many adults only come to realize that they themselves have the condition when one of their own children is subsequently diagnosed (Stordy and Nicholl, 2002; Riordan, 2004) thus find relief that there is a name for their condition (Hallowell and Rately, 1996). A diagnosis of ADD/ADHD can help both the child and the family understands that these problems are not just willful bad behaviour. According to Diller (1999) “We’ve learned that in dealing with problem personalities, and the line between he won’t behave and he can’t behave is very hard to draw”.

Many people with ADD/ADHD have a normal or above normal intelligence and the symptoms of ADHD do not necessarily have to be an obstacle to leading a successful life (Janessen-Cilag, 2005).

Early diagnosis and appropriate treatment in children is the key to maximizing positive outcomes and minimizing the negative long-term effects of ADHD in adulthood (Janssen-Cilag, 2005). Many adults gravitate into the creative fields or work that provides an outlet for emotions. Unfortunately people with ADD/ADHD don’t function well in standard schools and typical office jobs. Increasingly, parents and lobby groups are demanding that accommodations in the classroom be made. About half the children diagnosed with ADHD receive help from inclusive-education teachers in their schools, as they commonly also have co-existing learning disabilities (Wallis *et al*, 1994).

Despite increased awareness, ADHD remains under-recognised with less than half of the affected individuals receiving the appropriate diagnosis; and of those persons diagnosed, few receive proper treatment (Janssen-Cilag, 2005). An NIMH (National Institute of Mental Health) study in 2000 found that only half of the children positively identified with ADD/ADHD actually received care in accordance with the guidelines of the American Academy of Child and Adolescent Psychiatry (Stordy and Nicholl, 2002).

There is “no cure” for ADD/ADHD but, without effective treatment, the risks associated with ADD are very great. Children with ADD fall out of the mainstream of positive social, educational and emotional life with their peers and family members and too often the label of ADD becomes a stigma with resultant long-term negative implications (Lawlis, 2005).

2.2 IMPLICATIONS OF SOCIAL FUNCTIONING

Generally on a social level, children with ADD/ADHD often have difficulty developing appropriate relationships with authority figures and peers. The disorder does not only impact on the diagnosed child but also on the child’s family and peers. A child with ADHD may often be labeled as disobedient or “strong willed”. This is often because of the difficulties in maintaining attention and missing important parts of the conversation or instructions. Several studies show that children with predominantly inattentive ADHD may be perceived as shy or withdrawn by their peers.

Research indicates that aggressive behaviour in children with symptoms of impulsivity/hyperactivity may play a significant role in peer rejection. Other factors that contribute to peer rejection are poor impulse control, inability to wait their turn and follow instructions and excessive talking (Janessen-Cilag, 2005).

Once a child is diagnosed with ADD/ADHD, many parents become upset or confused; others may be relieved once a cause for their child's problems is identified. Being a parent of a child with ADD/ADHD is not an easy task and can be very difficult and stressful, placing an enormous amount of pressure on family life. There are increased levels of parental frustration, marital conflict, siblings may feel neglected and family bonds can be broken. However, on the other hand, it can also strengthen family bonds (Janssen-Cilag, 2005; Lawlis, 2005).

ADD is also a problem for society as a whole. The challenges associated with this condition have enormous implications. The following statistics were taken from the Attention Deficit Association and from material provided by Children and Adults with Attention Deficit/ hyperactivity Disorder (CHADD) – these figures relate to the USA:

- 35% of students with ADD never finish high school.
- Individuals with ADD have significantly more hospital visits than non-sufferers.

- Parents of ADD children divorce three times more often than those whose children do not have ADD.
- 50 – 75% of incarcerated inmates in prison have some form of ADD.
- 52% of ADD sufferers abuse drugs at some time or other in their lives.
- 43% of male ADD students are arrested for a felony before the age of sixteen.

According to a study published in the Journal of American Academy of Child and Adolescent Psychiatry, the costs of ADD and ADHD are reflected in the entire family medical profiles. They would have more medical claims and the direct medical care costs per annum per family member were found to be twice as high than non-ADD/ADHD families. The indirect costs for disability and absenteeism were 61% higher than non-ADHD families (Lawlis, 2005).

2.3 AETIOLOGY

There is much debate over what exactly causes the symptoms of ADD/ADHD therefore it is thought that there is no single cause, but rather a combination of contributing factors. A major report from the British Psychological Society argues that the concept of ADHD as a single condition is controversial for a variety of reasons. Many factors affect the way attention is displayed in a particular situation and doctors should be wary of describing children as having ADD/ADHD without a thorough investigation (McConnell, 1997). All children and adults are unique and their reasons for thinking and behaving as they do will differ. In this chapter the contributing and aetiological factors will be discussed.

The Neurological and Biological Basis.

As ADD/ADHD, by definition, is a neurobiological condition, physicians and mental health professionals attribute symptoms to an imbalance in neurotransmitters (Reichenburg-Ullman & Ullman, 1996). It is thought that in individuals with ADHD there is a lower than normal level of the neurotransmitter dopamine in the frontal lobe (Riordian, 2004).

The frontal lobe, which is responsible for executive functioning (regulates impulse control, attention and other thought processes) is thought to be compromised in people with ADHD. Recent research was conducted in eight children aged 6 to 12, who had been diagnosed with the hyperactive-type ADHD and were taking

stimulant medication. These children were compared to eight children without ADHD. It was found, using a type of Magnetic Resonance Imaging (MRI), that in children with ADHD, levels of glutamate were increased while levels of GABA (Gamma-aminobutyric acid) were decreased. The decreased levels of GABA (causes neuro-inhibition) and the higher levels of glutamate (causes neuro-excitation) might explain the poor impulse control these children seem to exhibit. The levels of neurotransmitters were measured in relation to each other. Therefore, it is not the overall levels but rather the relative proportion of the neurotransmitters that seem to be of importance (health24, 2004).

Studies using PET (positron emission topography), a brain imaging technique that uses a radioactive tracer to show chemical activity of the brain, have shown significant differences in the frontal part of the brain between healthy subjects and those with ADHD (Janssen-Cilag, 2005; Prichard, 1996). In 1990 Dr Alan Zametkin and his colleagues at the National Institute of Mental Health (NIMH), USA, found that in the PET scans, people with ADD showed lower levels of electrical activity and decreased blood flow in the frontal lobes the area of the brain's cortex known to be involved in the control of attention, impulses and motor activity. This was compared to non-ADD adults and children. Those with ADD/ADHD showed slightly lower rates of metabolism, which could mean that they do not use as much glucose and therefore their need for oxygen would be less (Stordy and Nicholl, 2002; Wallis, 1994).

It has been proposed that ADHD could arise from a number of complications during antenatal and postnatal periods as well as any trauma to the head, e.g. forceps delivery (Byram, 1998; Allan, 2004). Brain damage due to an illness, such as meningitis or encephalitis or a lesion in the frontal lobes could also cause hyperactive behaviour. Studies, using MRI, have discovered that children with ADHD often have smaller right brains – a finding that makes sense as the right brain is responsible for self-control (Stordy and Nicholl, 2002).

Genetic and Familial Factors.

Experts have documented a hereditary aspect of ADHD because it often occurs in families. Most children with ADHD are born with this disorder, but it is only diagnosed at school going age. Clear evidence that ADD/ADHD runs in families comes from studies of twins. In as many as 80 to 90 percent of identical twins (who possess identical genes), if one had ADHD so did the other. In fraternal twins (who have just 25 percent identical genes) the likelihood of both having ADD/ADHD drops to 32 to 50 percent. The hereditary aspect can also be seen in children who are mirror images of a parent; they tend to share behavioural and learning styles. The influence of genes is unmistakable. Researchers at the University of California at Irvine reported finding the first abnormal gene associated with ADD. The gene controls dopamine receptors in the brain and this abnormality causes less sensitivity to dopamine (Reichenburg-Ullman & Ullman, 1996; Stordy and Nicholl, 2002).

Genetic research has also indicated that a problem of fat metabolism may be involved. They found that some of the gene locations could be linked to specific enzymes, namely Fatty acid-CoA transferase (associated with the incorporation of fatty acids into the membranes) and Phospholipase C (associated with the breakdown of phospholipid membranes) (Stordy and Nicholl, 2002).

Environmental Factors.

It is thought that the high level skills affected by ADHD are also influenced by the child's environment. ADHD behaviour could become manifest or be aggravated in unfavourable conditions and circumstances. Physical environmental conditions include: smoke, excess lead exposure, exposure to chemicals and pollutants. External factors such as birth injuries and maternal alcohol or tobacco consumption may play a role in less than 10% of cases (Wallis *et al.*, 1994). A disorganized, unpredictable or unstable family and personal life as well as any emotional stress (e.g. divorce) can affect behaviour and the ability to learn (Bryam, 1998 and Picton, 1997). Social factors have also been implicated by Richman, Stevenson and Graham, who decided after research that children who grew up with inadequate housing and lack of financial security were more likely to display behavioural difficulties (Middleborough, 2003).

DeGrandpre (2000) poses the question of whether ADD/ADHD is really a newly discovered medical disease or if it is a culture-induced brain dysfunction that results from our growing need for speed.

There is an idea of an over-stimulated, hurried society, i.e. as society moves faster so do the rhythms of our own consciousness. Children play Nintendo and watch TV rather than participate in sports or play outdoors, and movies are scarier and more violent. With the growing atmosphere of hurriedness, intensity, urgency and pressure to perform it is no wonder that children behave as they do. We eat fast foods and consume caffeine and drugs to go faster and stay awake longer. Our society places little value on tranquility, quiet, solitude and the joy of being in nature (DeGrandpre, 2000).

Dietary Factors.

It has been claimed that diet has an integral and influential role in ADD/ADHD symptomatology. Food can affect our moods, concentration and behaviour, especially the typical eating patterns of today's world, which does not necessarily ensure an adequate intake of essential nutrients (Picton, 2005).

Sugar has received much negative publicity, but it is not necessarily sugar per se but rather the type and amount of carbohydrates consumed that influence behaviour. The brain needs a certain amount of glucose to function but too much or the incorrect type of carbohydrate can cause symptoms associated with ADD/ADHD (Picton, 2005 and Merlin, SABC 3-Talk). Keeping the blood sugar level balanced is probably the most important factor in maintaining energy levels. The level of glucose in the blood largely determines appetite. When glucose

levels drop we feel hungry but can also feel symptoms of fatigue, poor concentration, irritability, nervousness, depression, sweating, headaches and digestive problems (Picton, 2005; Holford, 1997).

Essential Fatty Acids (EFA's) namely, Omega 3 and Omega 6, are required for optimal brain function and are also important nutrients required for healthy tissue production and they act as lubricants for the body. ADD/ADHD has been associated with a deficiency in the breakdown/metabolism of the EFA's. Zinc, Vitamin B6, Vitamin B3, Vitamin C and Biotin are some of the co-factors of EFA metabolism, so a deficiency thereof will interfere with conversion of Cis-Linoleic Acid to Gamma Linolenic Acid and Prostaglandin E₁ (enzyme delta-6-desaturase is inhibited).

A deficiency in EFA's can manifest in a variety of conditions including arthritis, eczema as well as allergies and hyperactivity. A deficiency seems to aggravate neurological and other symptoms. It was found that synthetic flavourants, colourants, some preservatives (including tartrazine) and certain natural foods (those containing salicylates) also had an adverse effect on behaviour (Picton, 2005; Holford, 1997). It has been stated that ninety percent of children's behavioural problems can be attributed to food allergies, chemical sensitivities, malnourishment and even high levels of toxic metals in the tissues (Warren, 2004).

The Gifted Child

A child displaying behavioural symptoms of ADD/ADHD could actually have a high Intelligence Quotient (IQ) and their perceived ability to stay “on task” might be related to boredom, curriculum, mismatched learning or teaching styles as well as environmental factors mentioned before. Gifted children may demonstrate ADD/ADHD behaviour in some settings but not in others. These children may spend from one fourth to half of their regular classroom time waiting for others to catch-up and even more time if they are in a mixed group class. (Reichenburg-Ullman and Ullman, 1996). The behaviour displayed by these children can closely resemble the behaviour of ADD/ADHD, that these children can be incorrectly diagnosed with ADD/ADHD.

2.4 DIAGNOSIS AND CHARACTERISTIC SYMPTOMS OF ADD/ADHD

Diagnosis.

The diagnosis of ADD/ADHD is currently based on subjective opinion, with no scientifically accepted test available (Prichard, 1996). As there is no single test to diagnose ADD/ADHD, a comprehensive evaluation is favoured in order to establish not only a diagnosis, but also investigate possible co-existing conditions and to rule out other causes of the presenting symptoms. Diagnosis rests primarily upon the history of the child (taken from parents, teachers, other care givers and the child itself) – this is the most reliable diagnostic tool. An assessment is made of the child's academic, social and emotional functioning (Riordan, 2005; Hallowell and Rately, 1996). ADD/ADHD is generally first diagnosed in childhood (during primary school years). The signs and symptoms (behaviour) are usually first noticed by teachers, who then inform parents (who may or may not have picked up on the same/similar behaviour patterns described by the teacher). The parents will then often take the child to the family doctor (GP), who does a complete medical examination to exclude any underlying condition (Wallis *et al.*, 1994; Picton, 2005).

Generally, if the doctor suspects ADD/ADHD, he will refer the child to a specialist for further investigations and assessments. Unfortunately there are some doctors that prescribe medication without referring to a specialist for further assessment/ investigation (Allan, 2004).

Further assessments can be made by a specialist (developmental) paediatrician, educational or clinical psychologist and occupational therapists (Picton, 2005; Erasmus, 2004) but the final definitive diagnosis should be made by a neurologist (Allan, 2004).

An educational psychologist assesses academic ability by means of verbal and non-verbal tests. They use the Wechsler Intelligence scale for children – Fourth Edition USA (WISC-IV) which provides a measure of general intellectual functioning and four index scores (verbal comprehension, perceptual reasoning, working memory and processing speed). The Conners Parent Rating Scale (CPRS), also available in a teachers version (CTRS), allows parents and teachers to rate the child's cognitive, emotional, and behavioural status on a number of dimensions, including conduct problems, learning problems, psychosomatic problems, impulsivity-hyperactivity, and anxiety. This scale has been found to be sensitive to the effects of prescribed medicine for hyperactivity. These tests are frequently used in pharmacologic research studies. Another test used is the Children's Checking Task (CCT), which is completed by the child. Psychologists are able to identify problem areas and will assess the child's behaviour as well as emotional well-being. The educational psychologist cannot prescribe medication but will refer the child to a specialist paediatrician or neurologist, who can prescribe medication if the case proves that it is needed (Epanchin and Paul, 1987; Picton 2005; Allan, 2004).

Paediatricians have been specially trained in childhood conditions and will conduct a full medical history and physical examination of the child. A

developmental and or behavioural paediatrician are the best qualified to diagnose this condition as they have been specially trained in behaviour and development and will conduct a comprehensive developmental, medical and behavioural assessment. A Neurologist will make the final decision by conducting a further test, by means of an Electroencephalograph (EEG), which measures brain activity (Picton, 2005).

Silberstein and his colleagues have developed a signal test that may provide the first objective and safe method for doctors to diagnose children with ADD/ADHD, but it is too early for the test to be made available for general use. The test (steady state probe topography) found significant differences in the activity in the frontal parts of the brain in 13 boys with the condition, compared with 18 “normal” boys. The test also seems to confirm that there is a biological basis for this condition (Prichard, 1996). Currently EEG’s, MRI and PET (positron emission topography) scans are being used to detect abnormal brain function.

In the past it was believed that brain injury was responsible for the condition and was therefore called Minimal Brain Damage, it was later changed to Minimal Brain Dysfunction. In the seventies the focus was placed on the over-activity and then came the idea that these children also had poor concentration, and so the name changed to Attention Deficit Disorder (ADD), which is now regarded as the umbrella term (Picton, 1997; Wallis *et al*, 1994).

Not all children (and adults) with ADD are hyperactive so the diagnosis is either made as ADD or ADD with hyperactivity (ADHD). The Diagnostic and Statistical

Manual of Psychiatric Disorders, 4th Edition (DSM IV) sets out the criteria that must be met in order for a diagnosis to be made (Picton, 1997; Wallis, 1994). For a person to be diagnosed with ADD/ADHD the problems of thinking and behaviour must significantly interfere with normal functioning: that is, it must severely influence or disrupt the child's life in more than one area: at school, at home or in social situations (Reichenburg-Ullman and Ullman, 1996).

The two most common errors in the diagnostic process are missing the diagnosis or making the diagnosis too often. The latter seems to be more common in today's society as there are a number of conditions that can present just like ADD and most "normal" children can be distractible, impulsive and restless at any time (Hallowell and Rately, 1996).

Before a diagnosis is made the following conditions should be excluded, as their symptoms can be similar or can mimic those of ADD/ADHD (Differential diagnoses):

- 1) Visual impairment or hearing impairment.
- 2) Language and learning disabilities: dyslexia; autism; speech and language disorders; auditory processing difficulties.
- 3) Neurological conditions: Tourette's Syndrome; seizure disorder (Petit mal epilepsy); sleep disorders; language disorders; mental retardation.
- 4) Food allergies.

- 5) Medical conditions: hypothyroidism; hyperthyroidism; lead poisoning; severe anaemia; chronic illness.
- 6) Emotional and psychological problems such as: anxiety; depression; obsessive-compulsive disorder; oppositional defiant disorder; conduct disorder; low self esteem; boredom in the classroom; relationship problems; significant life events or any change from normal routine.
- 7) Developmental disorders: low muscle tone, motor co-ordination difficulties, sensory modulation disorders (sensory defensiveness).

These conditions can also co-exist with and/or be complications of attention deficit hyperactivity disorder. (Erasmus, 2005; Kewley, 1998; Picton, 2005; Riordan, 2004).

Characteristic Symptoms.

ADD/ADHD can be divided into 3 subgroups according to symptom presentation:

1. Primarily inattentive type: Fails to give close attention to details or makes careless mistakes; has difficulty sustaining attention; does not appear to listen; struggles to follow through on instructions (does not complete tasks); has difficulty with organization; avoids or dislikes tasks requiring sustained mental effort; easily distracted or is forgetful in daily activities.

2. Primarily hyperactive/impulsive type: Hyperactivity symptoms: fidgets with hands or feet or squirms in chair; has difficulty remaining seated; runs about or climbs excessively (in a situation in which it is inappropriate); difficulty playing or engaging in activities quietly; often “on the go” or “driven by a motor” or talks excessively.

Impulsivity symptoms: Blurts out answers before questions have been completed; difficulty waiting or taking turns; interrupts or intrudes on others.

3. Combined type: individual meets both sets of inattention and hyperactivity/impulsivity.

The following criteria (summarized) must be met for the Diagnosis of ADD/ADHD:

1. Some of the symptoms of inattention and/or hyperactivity that cause impairment must be present before seven years of age.
2. At least 6 symptoms of inattention and/or hyperactivity/impulsivity must have persisted for a minimum period of six months, to such a degree that is maladaptive and inconsistent with the individual’s developmental level.
3. Some impairment from the symptoms is present in two or more settings.
4. There must be clear evidence of clinically significant impairment of social, academic or occupational functioning.

5. The disturbance must not occur exclusively during a pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and symptoms are not better accounted for by any other mental disorder (American Psychiatric Association, 1994). For the full details of the criteria, refer to Appendix 5.

Although ADD/ADHD is associated with “bad behaviour” and there seems to be a negative stigma attached to the diagnosis, children (and adults) with ADD/ADHD possess positive personality characteristics despite their difficulties in daily life.

They can be enthusiastic, especially about things they enjoy; creative, imaginative and original (have more ideas than they can actualize effectively); charming, humorous, entertaining and interesting to talk to and be with; spontaneous; intelligent and eager to please.

They can be highly energetic and active; inquisitive, take risks and have little or no fear, which is not always something good in the eyes of parents (Hall and Naude, 2003; Hallowell and Rately, 1996; Riechenburg-Ullman and Ullman, 1996).

2.5 MISDIAGNOSIS, OVERDIAGNOSIS OR UNDERDIAGNOSIS?

This is a controversial topic for all concerned, parents, teachers and all the professionals involved in the treatment process. Many experts question whether Methylphenidate Hydrochloride is being over prescribed and whether teachers, doctors and parents are too quick to diagnose a child as suffering from ADHD.

In reality, too often it is the teachers who are making the diagnosis. A Connecticut law prohibits schools and teachers from recommending psychotropic medication but a teacher could recommend a visit to a doctor (health24, 2001).

Many teachers mislabel children as having ADD because they don't have the time or the resources to develop real expertise. It is dangerous to label a child without a scientific basis for diagnosis and too often the treatment that follows treats only the symptoms and not the person affected (Lawlis, 2005).

The widespread labeling of ADHD (in North America) to difficult children means that most classrooms and many families have children so classified. Although ADHD is officially a term for a category of mental disorder, it has become so widely used that it has a prominent place in contemporary culture (McConnell, 1997). As Dr van der Merwe reports, ADHD has become a fashionable diagnosis that is made far too easily and quickly. There are innumerable studies of underdiagnosis and overdiagnosis and it is estimated that millions of children are incorrectly labeled and treated for nothing more than their immaturity. A review of these studies showed clearly that 50% of children diagnosed with

ADD/ADHD do not fit the officially accepted criteria and are therefore wrongly diagnosed (Goldberg, 2004).

While much of the debate has focused on overdiagnosis and over medication, some doctors say a bigger problem is that of the diagnosis being missed (health24, 2001). A report in the JAMA in 1998 concluded that ADHD actually is underdiagnosed in the general population (USA) when compared with other countries such as Germany and New Zealand (Stordy and Nicholl, 2002). In Britain, ADD/ADHD is reported as being underdiagnosed and undertreated, but it could also be overdiagnosed because hyperactivity is confused with more widespread difficulties (Kewley, 1998). An NIMH (National Institute of Mental Health) study in 2000 found that only half of the children positively identified with ADHD actually received care in accordance with the guidelines of the American Academy of child and adolescent psychiatry (Stordy and Nicholl, 2002). Also, too many “problem children” don’t have adequate access to good health care in the first place and so no informed decisions can ever be made (Warren, 2004).

Troublesome aspects of how ADD is currently framed in official psychiatry
(Diller, 1999):

- 1.) The process of establishing “objective” diagnostic standards for ADD has itself been quite subjective.
- 2.) Official guidelines for evaluating ADD symptoms are vague and open to interpretation, yet they lead to an all-or-nothing diagnosis.

3.) The ADD diagnosis has no definitive medical or psychological marker and so it is often made exclusively on the patient's history. Circumstances and biases of those reporting a child's behaviour are seldom taken into account.

4.) The diagnosis is overly focused on the individual and does not take sufficient account of family systems and other environmental factors.

5.) In its current phase as a "disorder for all seasons", ADD has become too inclusive. It has lost relevance to the age-related, developmental nature of some core problems.

6.) ADD as officially described can look a lot like certain other childhood psychiatric disorders. And many children meet criteria for some, but not all of the symptoms of several different conditions.

2.6 TREATMENT AND MANAGEMENT

Most professionals agree that a team approach is required and this includes medicinal, psychological, educational, behaviour management and life style changes. Parents, teachers and the child all need to be involved in the treatment and management process.

Lawlis (2005) a psychologist, offers advice and suggestions on methods that include drugs and medication, counseling and biofeedback, electromagnetic treatments, biocleansing, nutritional adjustments, strategies for sleep disturbances, neurotherapy, and self-development management. He will also touch on spirituality and examine how families can engage their own faith and beliefs in dealing with ADD.

2.6.1 Orthodox pharmaceutical intervention (medication).

The most common drug prescribed is Methylphenidate Hydrochloride (Trade names: Ritalin®, Adaphen® and Concerta®). Methylphenidate Hydrochloride is a central nervous system stimulant. It is a schedule 6 drug (formally schedule 7), is classified as a psychoanaleptic (antidepressant) and is chemically related to amphetamines. It is indicated for the treatment of ADHD and narcolepsy. Medication is available in the form of tablets in strengths ranging from 10mg to 80mg, depending on which variant is prescribed. Dosage will depend on the individual's age, weight, needs and response (Snyman, 2006; Novartis, 2002; Stordy and Nicholl, 2002).

This drug should be prescribed and its dosage monitored by a neurologist, by whom the definitive diagnosis was made (Allan, 2004).

When medication is effective, it can help the individual to focus better, sustain effort over long periods of time, reduce anxiety and frustration and reduce irritability and mood swings. These primary effects can lead to the secondary effects of increased confidence, greater self-esteem and sense of well being (Hallowell and Rately, 1996). Methylphenidate is also said to have a greater tendency to relieve the stress in the care giver than the child, and that the positive effects are important in preserving the self-esteem of the individual with ADD/ADHD and the sanity of their teachers, families and peers (Reichenburg-Ullman and Ullman, 1996). It is ironic that allopathic doctors prescribe Methylphenidate to children who are hyperactive. One would think that this drug would make the child even more hyperactive, but it has a noticeably opposite effect. Conventional physicians refer to the 'paradoxical action' of drugs as the reason it works the way it does. This 'paradoxical action' of a drug can also be seen in homoeopathic medicines (Law of Similars), a substance is capable of producing similar symptoms to a particular disease state is prescribed as a treatment for that very state. The drug does not further relax children who are already calm; it only calms those who are hyperactive. Methylphenidate can treat hyperactivity effectively, as it normally causes hyperactivity (Ullman, 1991).

As a stimulant, Methylphenidate Hydrochloride is known to increase the levels of dopamine in the brain. Stimulants prevent the reabsorption of neurotransmitters into nerve cells or cause more of the neurotransmitter to be released, they block the receptors and without sites to bond to, excess dopamine will remain in the system (Diller, 1999; Warren, 2004).

Stimulants seem to have a short-term effectiveness of 60-80% in reducing hyperactivity, distractibility and impulsivity in school-age children. When stimulant medication is not effective, individuals are prescribed other medication for example tricyclic antidepressants (Warren, 2004).

Other medications, which are used either in place of or together with methylphenidate, are:

- Atomoxetine (Strattera®) – inhibits the reuptake of noreadrenaline by the presynaptic neurons and is indicated for management of Attention Deficit Hyperactivity Disorder. Is a non-stimulant with a “favourable” side effect profile and does not seem to cause dependence (Korb, 2005).
- Dextroamphetamines (Dexedrine® and Eskatrol®) – more severe side effects have been reported, is habit forming and not recommended for children under twelve years old. Amphetamines cannot be prescribed for ADHD in South Africa.

- Pemoline (Cylert®) – is less effective than methylphenidate and takes up to one month before maximum effect is noted, can be habit forming and often leads to insomnia.
- Risperidone (Risperdal®) – is used for the aggression, behavioural and Conduct Disorder associated with ADHD. It may assist in concentration. Often used in connection with methylphenidate.
- Imipramide (Tofranil) - is used when a child reacts badly to methylphenidate especially where motor disorders exist (e.g. epilepsy). It is used when the child presents with depression or anxiety; is older than 5 years and still wets the bed. Can have severe side effects including heart irregularities.
- Citalopram Hydrobromide (Cipramil) – is an anti-depressant and is less cardio-toxic than Imipramide. It is often combined with methylphenidate to counter the relevant side effects.
- Thioridazine (Melleril) – is used for behaviour disorders, hyperactivity and aggression; especially aggression in toddlers too young for methylphenidate. In too high a dose it can over-sedate a child and affect his ability to learn. It does not increase attention span or reduce distractibility.
- Haloperidol (Serenace®) – is used for over activity, destructive, aggressive behaviour. It is used for children with Tourette's Syndrome. It is an antipsychotic tranquilliser that reduces severe anxiety and agitation.

- Sulpiride (Espiride®, Eglonyl® and Norton-Supiride®) – is an anti-depressant (antipsychotic), sometimes used to treat the side effects of methylphenidate. Used in the treatment of depression, schizophrenia and behaviour disorders.
- Carbamazepine (Tegretol) – is an anti-convulsant and anti-epileptic drug. Used for temporal lobe epilepsy and can have a mood stabilizing effect. Epileptic patients cannot take stimulant medication such as methylphenidate, so their symptoms are first controlled before stimulants are prescribed.
- Sodium Valporate (Epilim®) – is used for treating petit-mal epilepsy and can also have a mood stabilizing affect but can increase hyperactivity or aggression. Used to control epilepsy before stimulant medication is administered.
- Lamotrigene (Lamictin®) – an anti-convulsant used on its own or in combination with other anti-epileptic medication.

(Snyman, 2006; Picton, 1997)

Not all parents are convinced that their children should be given Methylphenidate because of the numerous side effects, special precautions and drug interactions as well as all the media and stigma attached to this drug. Much of the stigma associated with psychotropic drugs for the treatment of ADHD comes from their potential for abuse (health24, 2001).

The Drug Enforcement Agency (DEA), USA, classes Methylphenidate hydrochloride as a “highly addictive controlled substance” because of its amphetamine structure, this make it fall in the same category as cocaine, methadone and methamphetamine (speed) (Stordy and Nicholl, 2002). A report discovered that Methylphenidate is a more powerful stimulant than cocaine; research has shown that cocaine can block fifty percent of dopamine receptors, whereas a typical dose of methylphenidate, given to children blocked out 70% of dopamine receptors. A drug enforcement study in Wisconsin, South Carolina and Indiana found that as many as one-half of all teenagers in drug treatment centres said they had used Methylphenidate to get a high. As methylphenidate taken orally does not produce a high, many teenagers were crushing it and inhaling the powder – just like cocaine (Warren, 2004).

Possible Side Effects of Methylphenidate Hydrochloride:

Sleep disturbances such as insomnia, nervousness, decreased appetite, headaches, drowsiness, dizziness, dyskinesia, convulsions, choreo-athetoid movements, visual disturbances, hyperactivity, cramps, tics or exacerbation thereof, blood dyscrasias, Tourette’s syndrome, depression, toxic psychosis, cerebral arteritis and occlusion are all possible side effects (Snyman, 2006).

Special Precautions in the use of Methylphenidate Hydrochloride:

It should not be given in cases of Epilepsy, hypertension, emotional instability, and depression. It may exacerbate symptoms of behavioural disturbances and thought disorders in psychotic patients. It should not be used for the treatment of normal fatigue states.

Possible tolerance and dependence can develop, and mass loss and growth retardation can occur in children during prolonged therapy; therefore it is advocated that patients have one-month drug free periods or that the drug is not taken during holidays or weekends. Supervised withdrawal is recommended. Careful assessment is required before it is prescribed for children under the age of six years old (Snyman, 2006).

Drug Interactions with Methylphenidate:

It interferes with the antihypertensive effect of Guanethidine; and can cause decreased metabolism (inhibition) of coumarin anticoagulants, anticonvulsants and phenylbutazone (Snyman, 2006)

It is largely unknown what the long-term effects of these drugs have on children (Ullman, 1991) but some of the possible long-term effects include stroke, hyperthermia, hypertension and seizures.

2.6.2 Homoeopathy

The word Homoeopathy is derived from the words *homoios* meaning 'similar' and *pathos* meaning 'suffering' (Bloch and Lewis, 2003). Homoeopathic medicine is a natural pharmaceutical science based on three principles. First, the practitioner seeks to find a substance that would cause, in an overdose, similar symptoms to those that the patient is experiencing (Law of Similars). Second, when the match is found, that substance is prescribed in very small (micro) doses (Law of infinitesimal doses). Third, remedies are tested on healthy individuals, this is termed Provings (Koehler, 1989 and Ullman, 1991).

Homoeopaths aim to treat the person not the disease. Homoeopathic remedies are given in order to stimulate the patient's own immune system, to bring about an overall improvement and balance in that person; the results are curative rather than palliative. This means that ten patients presenting with ADD/ADHD may each receive a different homoeopathic remedy based on their individual pattern of symptoms.

In contrast, conventional medication is prescribed for its capability to act upon specific parts of the body, that is, one drug for each condition. Homoeopathy, of course, cannot cure everything or everybody, but it does offer the real possibility of cure for various deep-seated acute, chronic and hereditary diseases. As part

of their treatment, Homoeopaths address any vitamin, mineral or fatty acid deficiency that may exist (Reichenburg-Ullman and Ullman, 1996 and Ullman, 1991).

Homoeopathy in South Africa: Training, Registration and Scope of Practice

Homoeopaths are trained in diagnostics, anatomy and physiology along the same lines as orthodox training. The only training recognized for registration in South Africa is the Masters Degree in Homoeopathy - M.Tech.(Hom) offered at the Durban University of Technology and University of Johannesburg or SA Qualifications Standards Authority (SAQA) and AHPCSA approved equivalent. The M.Tech (Hom) consists of a five-year full-time course in classical, clinical, modern and conventional Homoeopathy as well as Homoeopharmaceutics, which is a legal requirement for registration. Medical practitioners registered with the Health Professions Council of South Africa (HPCSA) may also opt for the course offered by the SA Faculty of Homoeopathy. This is a three-year part-time course in Homoeopathy. Graduates are awarded the MFHom (SA). (Homoeopathic Association, 2004; Allied Health Professions Act, 2001).

Registration with the AHPCSA as a Homoeopath is necessary to legally practice homoeopathy and prescribe homoeopathic remedies. According a list supplied by the Allied Health professions Council of South Africa (May, 2005) there were 72 registered Homoeopaths in the Johannesburg Metropolitan Area (target population).

The Allied Health Professions Council of South Africa assists in the promotion and protection of the health of the population of South Africa; it governs, administers and sets policy relating to the professions registered with the council; controls the practice of the professions and investigates complaints relating to practitioners and students; and corresponds with the Minister of Health on any matter falling within the scope of the Act. The Homoeopathic Association of South Africa (HSA) is recognized by the AHPCSA as the official representative of the Homoeopathic Profession on South Africa (Allied Health Professions Act, 2001). HSA represents and promotes the Homoeopathic Practitioner, the Profession, Education and interests, for the better health and well-being of all South Africans and is the only organization that actively engages Government, Department of Health, Allied Health Professions Council and all other organizations and structures that influence the profession. Registration with the HSA is not compulsory (HSA, 2006).

Homoeopaths are able to treat the same range of conditions as orthodox medicine. Most Homoeopathic doctors will do a full medical assessment of the patient and will analyse the pattern of symptoms the individual presents with, taking into consideration the mental, emotional and physical states of the patient (Heritage Publishers, 1999). The Allied Health Professions Act stipulates that a homoeopath is qualified and registered to physically examine any person, taking into account the totality of symptoms for the purposes of diagnosing any physical

defect, illness or deficiency. Also within their scope of practice is the treatment or prevention of any physical defect, illness or deficiency in any person by prescribing remedies, dietary advice or dietary supplementation in accordance with and based on homoeopathic principles. Registered homoeopaths are entitled to personally compound, dispense or supply remedies which are prescribed by himself, for the use by the patient under treatment, new legislation dictates that the practitioners must have a Compounding and Dispensing Licence to be able to do this (HSA, 2006).

Homoeopathy and ADD/ADHD

Homoeopathic medicine has been successful in treating ADD/ADHD and other behavioural conditions using specific, individualized homoeopathic remedies (Reichenburg-Ullman and Ullman, 1996). The success rate is estimated to be at least seventy percent, when individually chosen homoeopathic remedies are used to treat ADHD for one year, (Reichenburg-Ullman and Ullman, 1996 and Warren, 2004).

Dr Weil (2004) claims that Homoeopathy has been successful when other methods have failed. The child is treated as an individual, and the cause of the behaviour/symptoms, including all mental, emotional and physical aspects are addressed.

Homoeopathy does not need a name for disease as practitioners prescribe medication (remedies) on the totality of symptoms. Homoeopathic remedies are safe, non-toxic, and relatively free from side effects. An aggravation (temporary worsening of symptoms preceding alleviation of symptoms) may occur. Remedies have lasting results (long-term effectiveness). Homoeopathic remedies do not suppress symptoms and even when given for long periods of time, are safe and do not cause dependency. Homoeopathy will not interfere negatively with other medication, however if taken with conventional medication they may not work as effectively (Lawlis, 2005; Reichenburg-Ullman and Ullman, 1996; Ullman, 1991). Homoeopathic medicines not only improve the health of infants and children, but probably also help them to become healthy adults (Ullman, 1991).

Research into the Homoeopathic Treatment of ADD/ADHD in South Africa has revealed the following:

1. Strauss, (1998) concluded that the use of the homoeopathic complex, Selenium Homicord, resulted in an overall improvement in the clinical picture of ADHD compared to a control group. Selenium Homicord consists of the homoeopathic preparations of Selenium in D10, D15, D30, and D200 potencies. Selenium Homicord is indicated for the treatment of diminished mental capacity; lack of concentration; forgetfulness; depression; exhaustion and deficiency of memory.

2. Muller, (1996) conducted a study involving the efficacy of mineral therapy in the treatment of ADHD, using mineralloid potassium phosphate in D6 potency. It was found that this decreased the overall hyperactivity of the ADHD subjects and mineral therapy was advocated as an alternative to stimulant treatment in some cases and reinforcing treatment in others.
3. Smith, (2001) investigated the use of Cerbo® and Nerva 2®, both of which are homoeopathic complex preparations whose composition includes remedies that would cover the symptoms expressed by the majority of ADHD individuals. Participants showed statistically significant improvement in teacher rating scores, however sustained attention did not show significant improvement. Although not conclusive, Cerbo® is indicated for impaired concentration and Nerva 2® is indicated for nervous hyperactivity.
4. Middelborough, (2003) conducted a study to determine and compare the relative efficacy of supplementation using Evening Primrose oil and Homoeopathically potentised GLA, in the management of ADD/ADHD. It was concluded that Evening Primrose oil was effective as an intervention as it managed to significantly improve the attention scores. Although the homoeopathically prepared GLA did not show any statistically significant improvement it was clear that there was slight improvement in the attention scores.

5. Lottering, (2005) conducted a study to determine and compare the relative efficacy of a nutritional supplement (Advanced Brain Food®) and a homoeopathic complex (Quietude®) in the management of ADHD. Constituents of Advanced Brain Food® are: Phospatidylcholine; Phospatidylserine; Vitamin B3; Ginko Biloba; Vitamin B12; Folic acid; Pantothenic acid and Pyroglutamate. Constituents of Quietude® are: Chamomilla vulgaris (9C); Gelsemium sempervirens (9C); Hyoscymus niger (9C); Kali bromatum (9C) and Passiflora incarnata (3X). It was found that Advanced Brain Food® was effective as an intervention as it managed to significantly improve the attention span of the subjects. Although Quietude (homoeopathic complex) did not show any statistically significant improvement, it was clear that there was a slight improvement in the sustained attention levels.

Homoeopaths have always based, and continue to base the evidence for the effectiveness of Homoeopathy on clinical results with many patients. These results are shared in the professional Homoeopathic journals and at conferences. Double blind clinical studies have shown the effectiveness of homoeopathic medicine as compared to placebo in research on common medical conditions. A 1991 review of over 100 homoeopathic studies published between 1966 and 1990 showed positive results in 76% of the studied conditions (Reichenburg-Ullman and Ullman, 1996).

Research conducted by Masters graduates from the University of Johannesburg and Durban University of Technology have illustrated a clear efficacy of Homoeopathy (HSA, 2004).

The following international trials conducted to test for effectiveness in the homoeopathic treatment of ADD/ADHD:

1. Lamont (1997), conducted a study on the homoeopathic treatment of attention deficit hyperactivity disorder. Forty three children diagnosed with ADHD were alternately assigned either placebo or homoeopathic treatment (similimum) in a double-blind, partial crossover study to determine the effectiveness of homoeopathy for this disorder. Statistical comparisons were made on the basis of parent or care giver ratings of ADHD behaviour before and after treatment. Statistically significant differences were found, supporting the hypothesis that homoeopathic treatment is superior to placebo treatment for ADHD. In the same study it was found that the following remedies were the most successful in treating ADHD: *Stramonium*, *Cina* and *Hyoscymus niger* and to a lesser degree, *Veratrum album* and *Tarentula hispanica*.

2. A trial in Europe provided evidence of the effectiveness of homoeopathic treatment of ADHD (particularly in areas of behavioural and cognitive functions). A total of 83 children aged 6-16 years, with ADHD diagnosed using the DSM-IV, were recruited for a randomized, double blind, placebo controlled crossover trial. Prior to the study; the children were treated with individually prescribed Homoeopathic medications. 62 patients, who achieved an improvement of 50% in the Conners Global Index (CGI), participated in the trial (13 patients did not fulfill eligibility criterion). At the beginning of the trial and after each crossover period, parents reported the CGI and patients underwent neuropsychological testing. At entry to the crossover trial, cognitive performance, impulsivity and divided attention, had improved significantly. The results of the trial provide scientific evidence for the effectiveness of homoeopathy in the treatment of attention deficit hyperactivity disorder, particularly in areas of behavioural and cognitive functions (European Journal of Paediatrics [online], 2005).
3. A pilot study was conducted to evaluate the effectiveness of homoeopathy in the treatment of attention-deficit/hyperactivity disorder (ADHD). This was a randomized, double-blind, placebo-controlled trial in which 43 children received a homoeopathic consultation and either an individualized homoeopathic remedy or placebo. Homoeopathic physicians saw patients every 6 weeks for 18 weeks. There were no statistically significant differences between homoeopathic remedy and placebo group

however, there were statistically and clinically significant improvements in both groups, suggesting that there may be some therapeutic value to the homoeopathic approach to ADHD (Jacobs *et al*, 2005).

2.6.3 Other Therapies:

(i) Psychotherapy:

Psychological therapy is mainly required for the secondary problems that develop such as low self-esteem, anxiety and depression. Psychotherapies are especially important for those children who are unable to tolerate, or whose parents prefer them not to take medication. The parents as well as the child need counseling, advice and coping skills. Cognitive and behaviour modification is recommended with the hallmark of treatment being structure; e.g. routine (establish a predictable schedule of activities), boundaries and rules and children need to be taught organizational skills (use of a diary to record homework and other tasks to be completed). Tasks need to be tackled one at a time and as each task is completed the child needs to be given praise and encouragement (Hallowell and Rately, 1996 and Wallis *et al*, 1994).

Support Groups such as the Attention Deficit Hyperactivity Support Group of South Africa (ADHASA) provide an important function for families, therapists, teachers and caregivers as well as the person with ADD/ADHD.

(ii) Diet & Supplementation:

Healthy eating, improving essential fatty acid levels and stabilizing blood sugar levels can make a huge difference in the overall performance of an ADHD child (Picton, 2004).

The diet should contain natural unrefined foods; avoid foods containing artificial flavourants, artificial colourants, anti-oxidant preservatives, and mono-sodium glutamate; and eliminate foods poorly tolerated by the patient. Eating regular, small wholesome meals will stabilize blood glucose levels. Meals should consist mainly of carbohydrates, which are released slowly into the blood stream (low glycemic foods), combined with a small portion of protein. As a deficiency of EFA's seems to aggravate neurological and other symptoms of ADD/ADHD, it is logical to increase levels of EFA's by supplementing the diet with Omega 6 (Evening Primrose Oil), and Omega 3 (Salmon Oil). In addition, supplementing with Magnesium, Vitamin B6 and Zinc will assist with the metabolism of the fatty acids (Picton, 2005).

By incorporating the above vitamins and minerals in the diet concentration will improve, as they are essential for brain development and function (Picton, 2004; Hall and Naude, 2003).

Anti-oxidants (proanthrocynidins), which protect the body from oxidation (destruction of the body's tissues) have also been recommended as an additional supplement for example Zinc, Vitamin E, vitamin A, vitamin C and Selenium (Holford, 1997; Hall and Naude, 2003).

Meyer, (2001) revealed a significant improvement in the experimental group, who used Melotone Syrup for sustained attention and vigilance as assessed by the Children's Checking Task (CCT). Melotone Syrup is a nutritional supplement specially designed for children and adults who require an essential Fatty Acid supplement in liquid form. This product contains: EFA'S (Evening primrose and Salmon oils); vitamin D; vitamin C; B vitamins; Calcium; magnesium; Zinc; Methyl Sulphonyl Methane; Glycine; Taurine; Chromium and Vanadium.

(iii) Herbs:

The following herbs could be of some benefit:

- Ginkgo Biloba – used to improve concentration by increasing blood flow to the brain and it also has anti-oxidant properties.
- Chamomile – is a calmative, relieving irritability and promoting sleep. It induces clear thinking and increases attention span.
- Valerian – is a calmative for restless children. In high doses can cause drowsiness so is used for insomnia.
- Passion Flower – is a calmative with less sedative effects.

- Lemon Balm (*Melissa Officinalis*) – is a relaxing tonic for anxiety, mild depression, restlessness and irritability.

It is best to use herbs under the supervision of someone suitably qualified as they can cause some side effects (Hall and Naude, 2003; Weil, 2004).

(iv) Bach Flower Remedies:

Bach flower remedies are a series of 38 preparations made from wild flowers and plants. Dr Edward Bach discovered and believed that the dew on the flowers was somehow “impregnated” with medicinal properties. The remedies are designated to treat the whole person, not just symptoms of illness. The principle behind their use is that every kind of disorder arises because of an inner imbalance for which nature has provided a cure in the form of healing plants, sunlight, spring water and fresh air. The remedies are chosen according to psychological and emotional symptoms (will also assist with physical ailments). These remedies are used in conjunction with other forms of treatment by therapists who practice herbal medicine, homoeopathy or naturopathy (Heritage Publishers, 1999).

(v) Biofeedback and Neurotherapy:

Biofeedback is a learning process, in which people are taught to improve their health and performance by observing signals generated by their own bodies – a method of self-regulation training. Brain waves (as well as muscle tension, heart rate, respiration, skin temperature and blood flow) are measured and recorded by sensors attached to the brain and other parts of the body. Neurotherapy is biofeedback for the brain, using an EEG monitor and software connected to a computer. It has been suggested that children with ADD have brain wave patterns low in beta waves, which are associated with alert concentration, and children with ADHD have excess beta and theta activity. The goal of neuro- or biofeedback is to retrain the brain and change the brain wave patterns thus improving concentration and focused attention (Weil, 2004).

(vi) Occupational Therapy

This is recommended for those individuals that suffer from “sensory defensiveness”. Occupational therapists use “sensory modulation”/ “sensory integration therapy” to assist patients overcome an over-reaction or under-reaction to everyday types of sensory input. Occupational therapists teach patients and parents activities/ methods specifically designed to meet the needs of the child’s own nervous system: calming activities/ alerting activities, organising activities and other suggested coping methods (Allen and Harrison, 2004).

(vii) Tomatis Method

This is a unique form of sound therapy developed by a French physician. This treatment is designed to stimulate the brain and help a person with ADD to focus on sounds without being distracted. The goal of this therapy in ADD is to correct poor sensory integration (Weil, 2004).

(viii) Cranial Therapy

This aims to adjust the body to allow the nervous system to function smoothly. It may be especially helpful for hyperactive children who have experienced birth or head trauma (Weil, 2004).

(ix) Applied Kinesiology

This is a therapeutic modality that focuses on the art of energy balancing by means of energy and muscle testing and is used to identify imbalances in the body's structural, chemical, emotional or other energy fields. It is based on the acupuncture meridian system and its connection to the muscles and organs (Weil, 2005; Bothes, 2005).

(x) Other

- Exercise or sport to release/ channel pent up energy.
- Meditation or anything to relax the body and mind (Weil).
- Art therapy – is the use of art materials for self-expression and reflection.

CHAPTER 3

MATERIALS AND METHODS

3.1 STUDY DESIGN

This was a qualitative-quantitative, exploitative survey to determine the perceptions and management of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder by Homoeopathic practitioners in the Johannesburg Metropolitan Area.

The survey was conducted by sending out a detailed questionnaire to the Homoeopathic practitioners. The researcher compiled the questionnaire, herself. The questions were drawn from various sources: Verhoogt, 2003; Faraone *et al*, 2004 and the feedback from participants in the focus group (Appendix 6). This was done in order to develop a questionnaire that was clear, concise, specific and non-time consuming (Appendix 1a, 1b and 1c). The demographic section (Appendix 1a) was adapted from Verhoogt and the remaining questions were based on other research conducted (remedies used to treat ADD/ADHD) and issues of debate (e.g. misdiagnosis/overdiagnosis and inappropriate treatment). Closed ended questions were used to make data collection easier. The open-ended questions were added for detail and allows for further discussion, which would have been difficult to ascertain from closed ended questions (e.g names of remedies).

3.2 STUDY POPULATION

Seventy-two homoeopathic practitioners were registered with the Allied Health Professions Council of South Africa (AHPCSA) in the Johannesburg Metropolitan Area as at May 2005.

3.2.1 Inclusion Criteria

1. Practitioners had to be registered as a Homoeopath with the Allied Health Professions Council of South Africa (AHPCSA).
2. Registered homoeopaths had to be practicing in the Johannesburg Metropolitan area: Diepsloot/Midrand; Sandton/Randburg; Northcliff/Rosebank; Roodepoort; Soweto; Alexandra/Modderfontein; Johannesburg Central; Johannesburg South; Diepmeadow; Orange Farm/Enerdale.

The researcher limited the areas to the above because the entire Gauteng province is too vast an area to cover on a limited budget. Even though the area was limited the area selected represented an even demographic spread that covers the socio-economic factors as well as ethnic groups (Appendix 4).

3. The homoeopaths had to be proficient in the English language as the questionnaire and interview was conducted in English.

Note: Although there are eleven official languages in South Africa for practical purposes the researcher chose to conduct the study using the English language.

3.2.2 Requirements of the participants

1. Completion of the questionnaire within two weeks of receiving it.
2. A half an hour of practitioner's time for the collection and checking of the questionnaire.
3. Participants were encouraged to reflect on personal issues and disclose personal principles and practices as a homoeopath.

3.3 STUDY SAMPLE

These were the practitioners who fitted the inclusion criteria and completed the questionnaire (n=41), initially 63 practitioners agreed to participate, so a final response rate of 65% was obtained

3.4 METHODOLOGY

Data collection started in August 2005 when initial contact with practitioners was made and continued until February 2006 when collection of the final questionnaires took place and raw data was handed to the to statistician for analysis.

3.4.1 Focus Group

Before the actual study could commence, a focus group was conducted at the Durban Institute of Technology on 24th August 2005 (Appendix 6). The aim of the focus group was to assess the face validity of the questionnaire. Face validity is determined when a group of experts in a particular field are required to judge the measuring tool, in this case the questionnaire. They must express their opinion as to whether, on the face of it, the measuring tool measures what it is supposed to measure.

The focus group consisted of five homoeopathic practitioners and three senior homoeopathic students from the Durban Institute of Technology. The participants were given the participant information letter and questionnaire and were required to make comments and suggestions on the layout, questioning style, grammar and content. The suggestions and comments were considered and the amendments/changes were made.

3.4.2 Initial contact

A list of registered homoeopaths practicing in Johannesburg Metropolitan area was obtained from the AHPCSA in May 2005. As this list was incomplete, the Yellow Pages was also consulted.

Initial contact was made with practitioners telephonically, informing them of the research being conducted and requesting their participation (Appendix 3).

3.4.3 Delivery of questionnaires

Upon receiving verbal consent a participant information letter (Appendix 2) together with the Questionnaire (Appendix 1a, 1b and 1c) was sent to participants, some were posted and some were hand delivered. Written consent was not necessary, as the completion of the questionnaire implied the practitioner had given his/her consent.

3.4.3 Collection of questionnaires

It was initially stated that a two-week period would be given for the completion of the questionnaires. Due to practitioners forgetting about the questionnaire or not having had time to complete it, an extension period was given (until January 2006). Practitioners were then phoned to remind them that the questionnaire needed to be completed and a date was set for collection and an interview. Any questionnaires not completed and collected by the end of January 2006 were not included in the study.

The collection of questionnaires and the interview was conducted by the researcher. At the interview, practitioners were given a chance to ask questions about the research or the questionnaire (if clarification was needed) and were able to explain their answers more fully if it was necessary.

Most interviews lasted only a few minutes, while some lasted up to an hour. When all the questionnaires were collected, they were taken to STATKON (Statistical consultation service of the University of Johannesburg) where the data was captured and analysed.

This method of delivery and collection of questionnaires was to ensure compliance and thus a high response rate was achieved in comparison to other research that was conducted utilizing only the postal method (Maharajh,2005)

3.5 CONFIDENTIALITY

The researcher assigned each practitioner a code so that the practitioner's name would not appear on the questionnaires or in the final dissertation. The answers could not be entirely anonymous, as the researcher conducted the collecting and checking interview when the practitioner had completed the questionnaires.

3.6 DATA ANALYSIS

The data was coded and captured by STATKON (Statistical consultation Service of the University of Johannesburg).

The results were analyzed by utilizing the SPSS for Windows Version 14 (SPSS 2006).

The following procedures were conducted:

3.6.1 Procedure1: Descriptive statistics were used in the form of frequency tables, bar graphs and pie charts to describe the data.

3.6.2.1 Procedure 2a: The Pearson's Chi-square test for independence was used to test the association between various combinations of variables at the 5% level of significance. As part of the Chi-square tests, cross-tabulations were constructed.

The Chi-squared test is a nonparametric statistical test which is used in the social sciences to examine the differences or associations for nominal and ordinal level data (Morgan *et al*, 2001), it is also useful when there are very small samples.

The chi-squared test for independence is used to determine whether two categorical variables are related. It compares the frequency of cases found in the various categories of one variable across the different categories of another variable. When a two by two table (mainly used in this research) is encountered by SPSS the output from the chi-square test includes an additional correction value (Yates Correction for Continuity). This is designated to correct or compensate for what some writers feel is an overestimate of the chi-square value when used with a 2 by 2 table. If a 2 by 2 table violates the assumption that the lowest expected frequency should be 5, then the Fisher's Exact Probability Test is used (Pallant, 2005).

3.6.2.2 Procedure 2b: To further assist in the interpretation of the association, effect sizes were used. This is only reported if the associations yielded a statistically significant result. Effect size is generally thought of as the magnitude of an experimental effect or as a measure of the strength of the relationship of interest. It assists in determining the meaningfulness and practicality of an effect. The effect size is measured by using Φ (phi coefficient) (Morgan *et al*, 2001; Hardy, 2006).

3.4.1 Hypotheses tests

The following hypotheses were tested:

3.4.1.1 The association between the type of Homoeopathic qualification and the additional modalities used in practice.

H_0 = Qualification and additional modalities used in practice are independent

H_1 = Qualification and additional modalities used in practice are dependant.

3.4.1.2 The association between the type of Homoeopathic qualification and percentage of practice that is homoeopathic.

H_0 = Qualification and percentage of homoeopathy practiced are independent.

H_1 = Qualification and percentage of homoeopathy practiced are dependant.

3.4.1.3 The association between type of Homoeopathic qualification and the number of patients with ADD/ADHD seen in the past 12 months.

H_0 = Qualification and number of patients are independent.

H_1 = Qualification and number of patients are dependant.

- 3.4.1.4 The association between the type of Homoeopathic qualification and treatment (simplex; complex; vitamins; herbal; dietary and Bach flower remedies) – this was analyzed per age group
- H_0 = Qualification and treatment are independent.
- H_1 = Qualification and treatment are dependant.
- 3.4.1.5 The association between the type of Homoeopathic qualification and the success rate of treatment (analyzed per age group)
- H_0 = Qualification and success rate are independent.
- H_1 = Qualification and success rate are dependent.
- 3.4.1.6 The association between the institution from which the practitioner qualified and the additional modalities used in practice.
- H_0 = Institution and additional modalities practiced are Independent.
- H_1 = Institution and additional modalities practiced are dependent.

3.4.1.7 The association between the institution from which the practitioner qualified and the percentage of homoeopathy practiced.

H_0 = Institution and the percentage of homoeopathy practiced are independent.

H_1 = Institution and the percentage of homoeopathy practiced are dependent.

3.4.1.8 The association between the institution from which the Practitioner qualified and the number of patients with ADD/ADHD seen in the last 12 months.

H_0 = Institution and number of patients are independent.

H_1 = Institution and number of patients are dependent.

3.4.1.9 The association between the institution from which the practitioner qualified and treatment (simplex; complex; vitamins; herbal; dietary and Bach flower remedies).

H_0 = Institution and treatment are independent.

H_1 = Institution and treatment are dependent.

3.4.1.10 The association between the institution from which the practitioner qualified and success rate.

H_0 = Institution and success rate are independent.

H_1 = Institution and success rate are dependent.

3.4.1.11 The association between the number of years in practice and the number of patients with ADD/ADHD seen in the last 12 months.

H_0 = Number of years in practice and number of patients are independent.

H_1 = Number of years in practice and number of patients are dependent.

3.4.1.12 The association between the number of years in practice and the treatment given (simplex; complex; vitamins; herbal; dietary; Bach flower remedies).

H_0 = Number of years in practice and treatment are independent.

H_1 = number of years in practice and treatment are dependent.

3.4.1.13 The association between the number of years in practice and the success rate.

H_0 = Number of years in practice and success rate are independent.

H_1 = Number of years in practice and success rate are dependent.

3.4.1.14 The association between the area/location of the practice and the number of patients with ADD/ADHD seen in the past 12 months.

H_0 = Area/location and number of patients are independent.

H_1 = Area/location and number of patients are dependent.

3.4.1.15 The association between the area/location of the practice and the type of practice.

H_0 = Area/location and type of practice are independent

H_1 = Area/location and type of practice are dependent.

3.4.3 Decision Rule

3.4.1 At $\alpha = 0.05$ level of significance, null hypothesis is rejected if $P < \alpha$ where P is the observed significance level or the probability value. Otherwise the null hypothesis is accepted at the same level of significance.

If $P < 0.05$ reject H_0
If $P \geq 0.05$ accept H_0

3.4.2 An effect size ($\phi = \Phi$) of 0.1 or smaller was considered negligible, while an effect size of 0.1 to 0.3 was considered to be indicative of a small effect, effect sizes between 0.3 and 0.5 were considered to be indicative of a moderate effect, while those above 0.5 were considered to indicate a large effect.

3.6 MATERIALS

See appendices for copies of the following:

- | | |
|--------------|---|
| Appendix 1a- | Questionnaire section A |
| Appendix 1b- | Questionnaire Section B |
| Appendix 1c- | Questionnaire Section C |
| Appendix 2- | Participant Information Letter |
| Appendix 3- | Telephonic proceedings |
| Appendix 4- | Geographic location (map): Johannesburg
Metropolitan Area. |
| Appendix 6- | Focus Group |

CHAPTER 4

1. RESULTS

4.1 INTRODUCTION

This chapter details the results from the statistical analysis of the data collected from the Questionnaires completed by the practitioners (Appendix 1a, b and c).

4.2 ADMISSIBILITY OF THE DATA

Only the data collected from the research was accepted for the use in this chapter. The data used for the analysis was collected in the manner described in Chapter 3.

4.3 RAW DATA

The raw data (questionnaires) will be stored for five year in a secure setting. Some of the statistical data has been included into this chapter as part of the results.

4.4.1 AGE GROUPS OF PRACTITIONERS IN THE STUDY

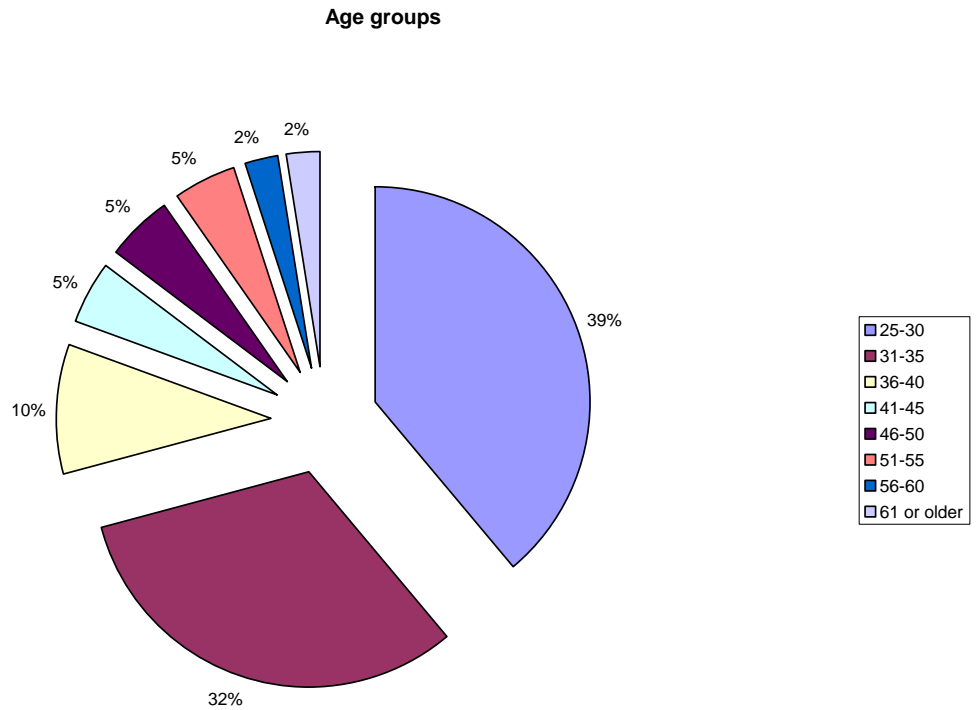


Figure 4.1 Pie chart showing the age group distribution of participant practitioners

It can be seen from Figure 4.1 that most ($n = 31$) of the practitioners are between 25 and 35 years old (71%), whereas there is only 1 practitioner older than 61.

4.4.2 GENDER OF PRACTITIONERS IN THE STUDY

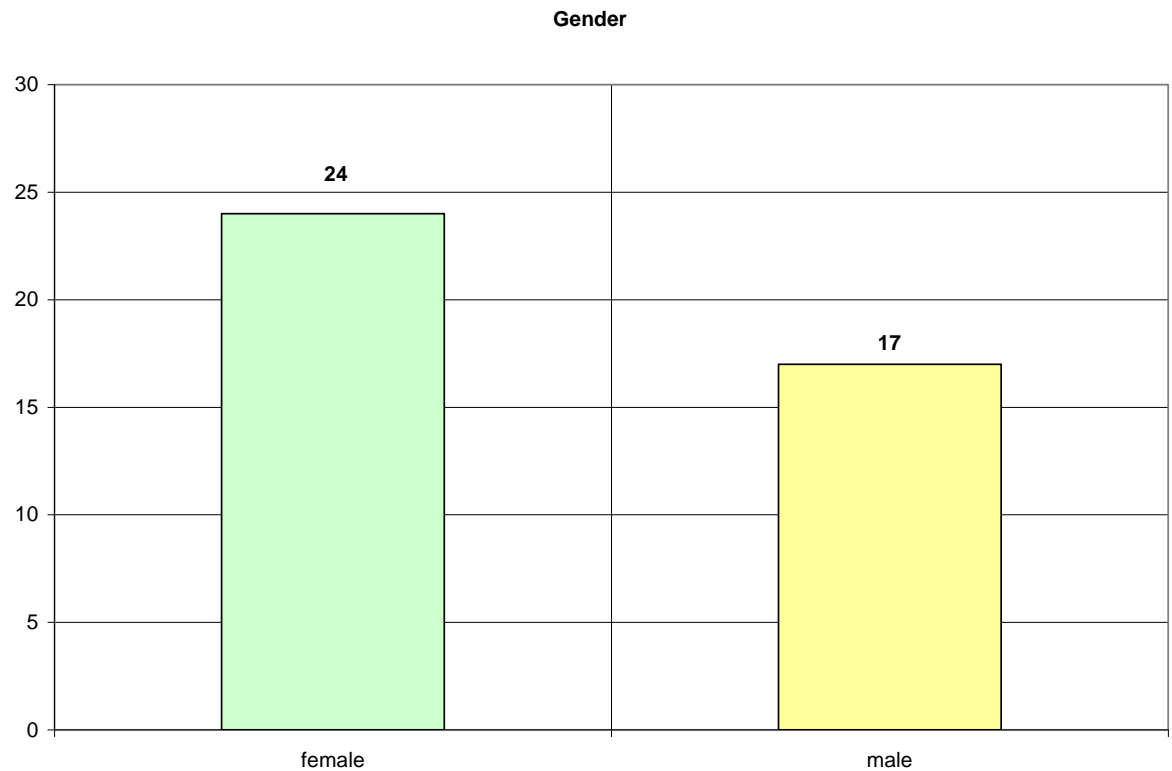


Figure 4.2 Bar graph showing the gender distribution of participant practitioners

Figure 4.2 shows that the majority of practitioners in this study are female (58.5%) whereas 41.5% are male.

4.4.3 PREDOMINANT HOME LANGUAGE

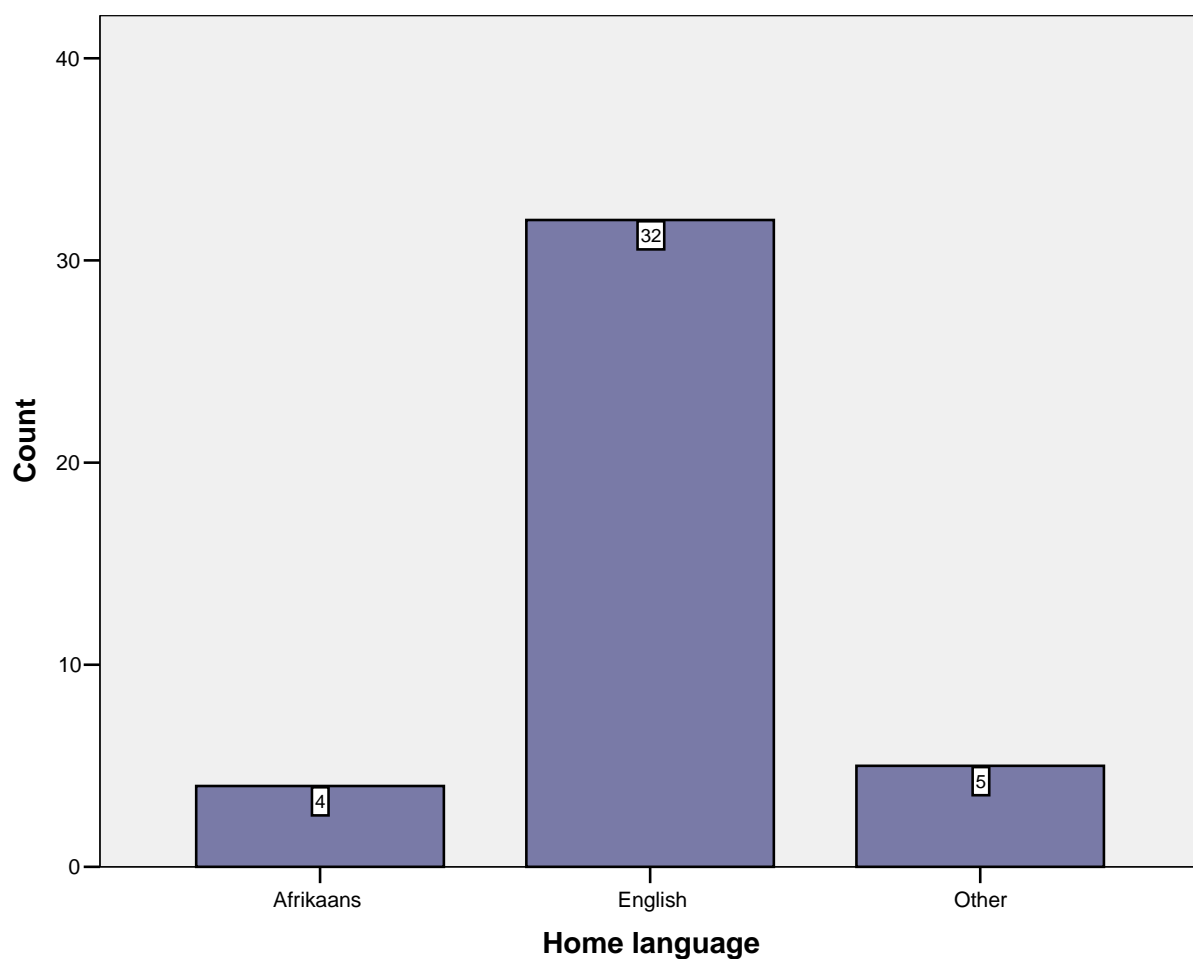


Figure 4.3 Bar graph showing the predominant home languages spoken by participant practitioners

32 practitioners (78%) speak English as their home language whereas only 4 practitioners are Afrikaans and the remaining 5 practitioners speak other languages. See Figure 4.3. The other home languages spoken by practitioners were: German (3), French (1) and Bulgarian (1).

4.4.4 HOMOEOPATHIC QUALIFICATION

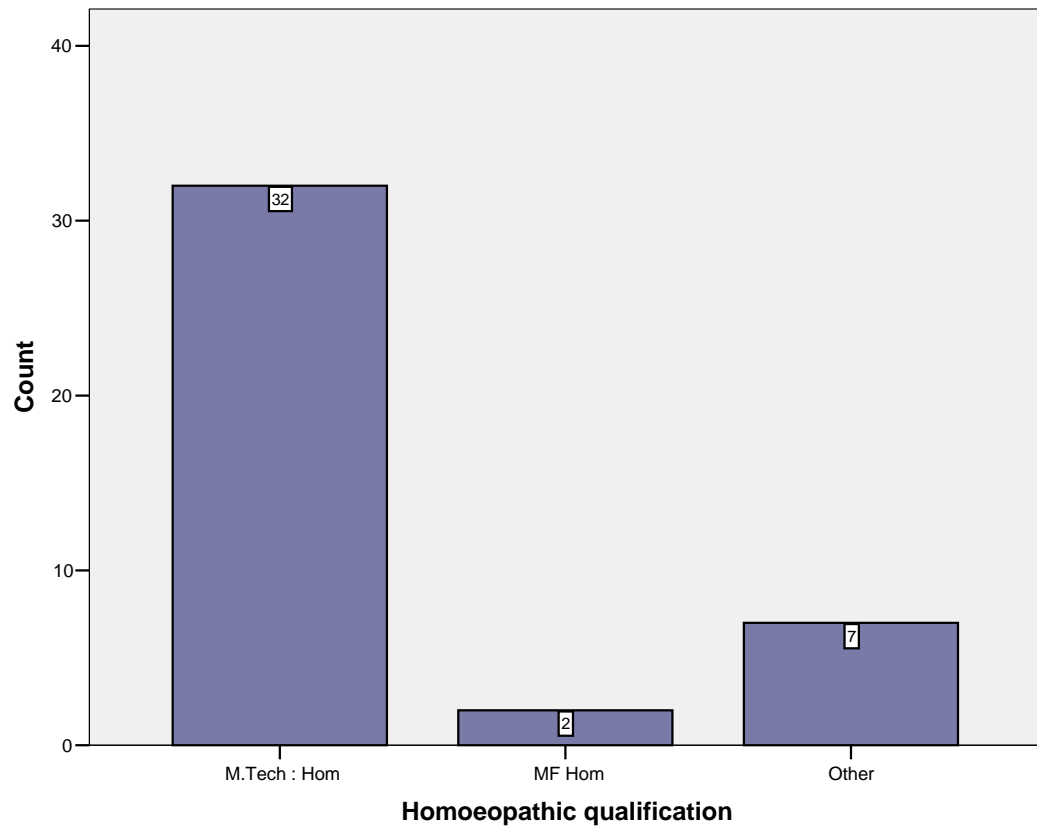


Figure 4.4 shows the distribution of homoeopathic qualifications among participant practitioners.

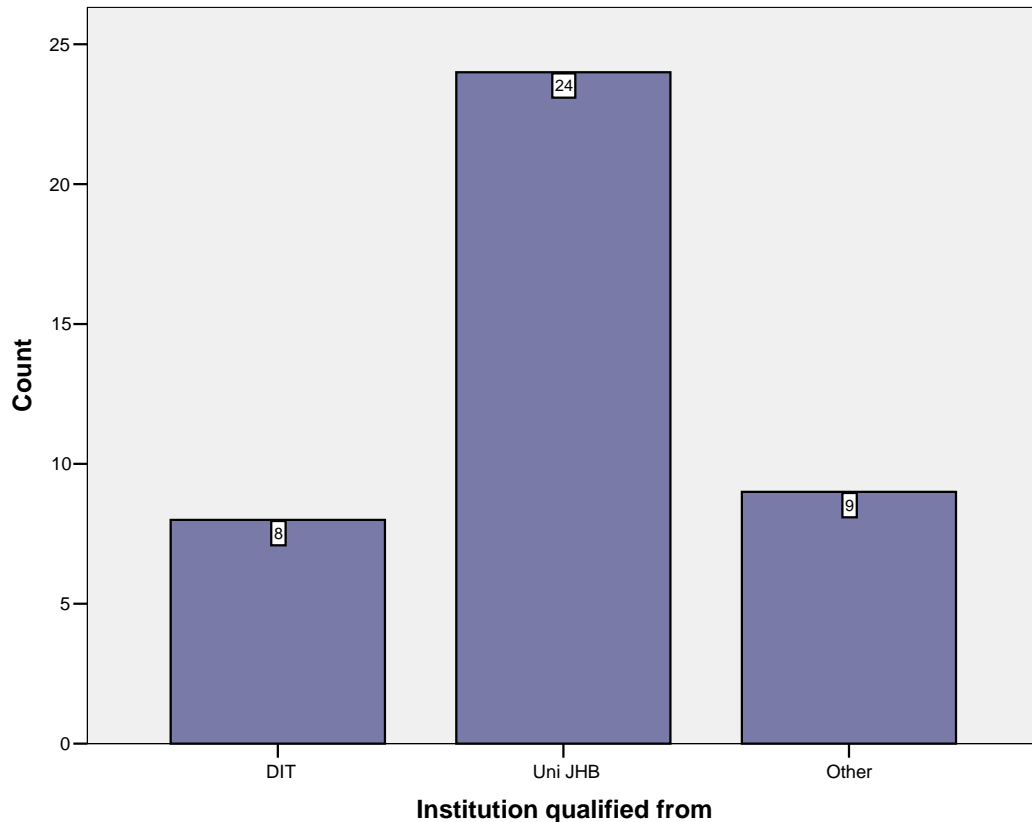


Figure 4.4 Bar graph showing the institution from which the practitioners qualified.

Figure 4.4 shows that 78% (n=32) practitioners have an M.Tech (Hom), and of these 24 practitioners were trained at Uni-Jhb (ex-Technikon Witwatersrand) and practitioners were trained at D.U.T. (ex- D.I.T/ Natal Technikon) seen in Figure 4.5. The remaining 9 practitioners (22%) have another type of homoeopathic qualification.

These are as follows:

M.F.Hom from the British Faculty of Homoeopathy (U.K.): 2 practitioners
D.Hom (Diploma) from the Lindlah College, Johannesburg: 2 practitioners
D. Hom (Diploma) from Department of Health: Homoeopathy (Germany): 1 practitioner

Homoeopath from the London College of Classical Homoeopathy:

1 practitioner

AMB Homoeopathy from the Homoeopathic medical college France:

1 practitioner

BSc (Hons) Homoeopathy from the University of Westminster (U.K.):

1 practitioner

Homoeopath(Germany) from Hein Deeg Institute: 1 practitioner

4.4.5 NUMBER OF YEARS IN PRACTICE

Number of Years in practice	≤ 5 Years	6 – 10 Years	11 – 25 Years	> 25 Years	Total
Count (frequency)	24	12	3	2	41
%	58.54%	29.26%	7.32%	4.88%	100%

Table 4.1 Number of years in practice

Table 4.1 gives a breakdown of the number of years practitioners have been practising homoeopathy.

87.8% (n=36) have been practicing for less than 10 years while only

4.8% (n=2) have been in practice for more than 25 years.

4.4.6 ADDITIONAL MODALITIES UTILISED BY PRACTITIONERS

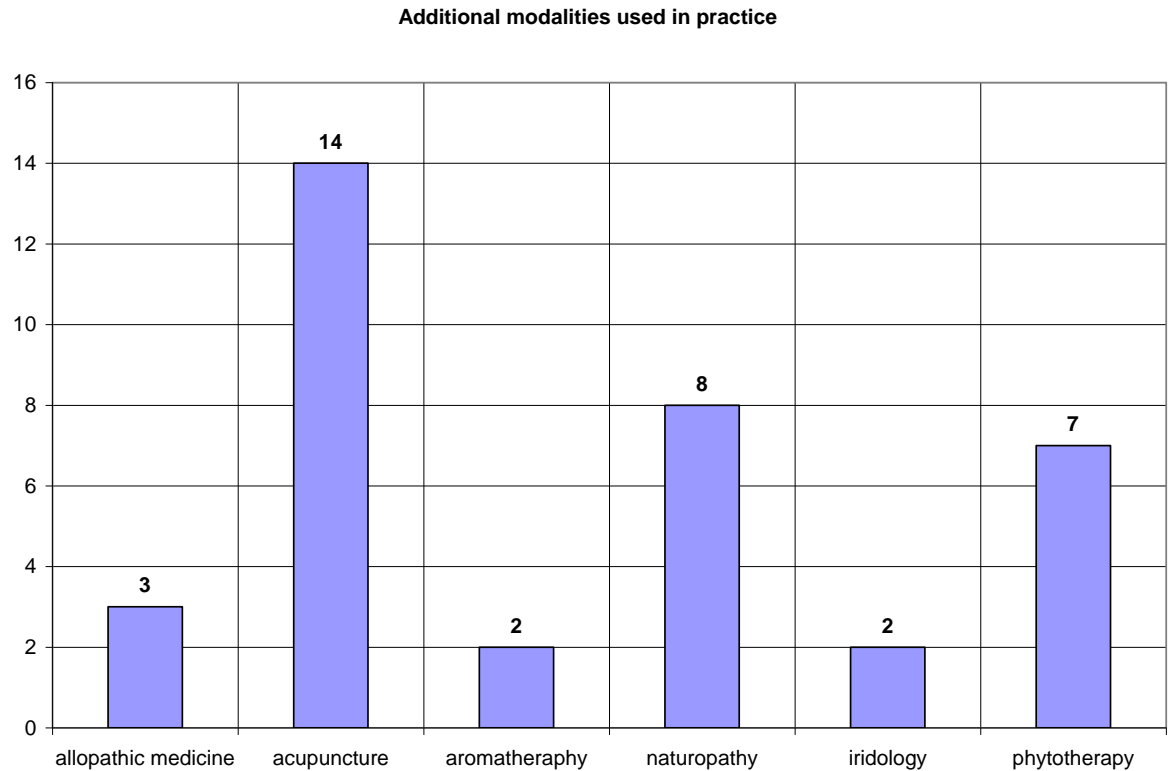


Figure 4.6 Bar graph showing the additional modalities utilized in practice

From Figure 4.6, Phytotherapy, Acupuncture and Naturopathy were the 3 most common additional modalities practiced by the practitioners. Three practitioners also practiced allopathic medicine, two aromatherapy, two iridology and six Chinese medicine.

4.4.7

PERCENTAGE OF PRACTICE THAT IS HOMOEOPATHIC

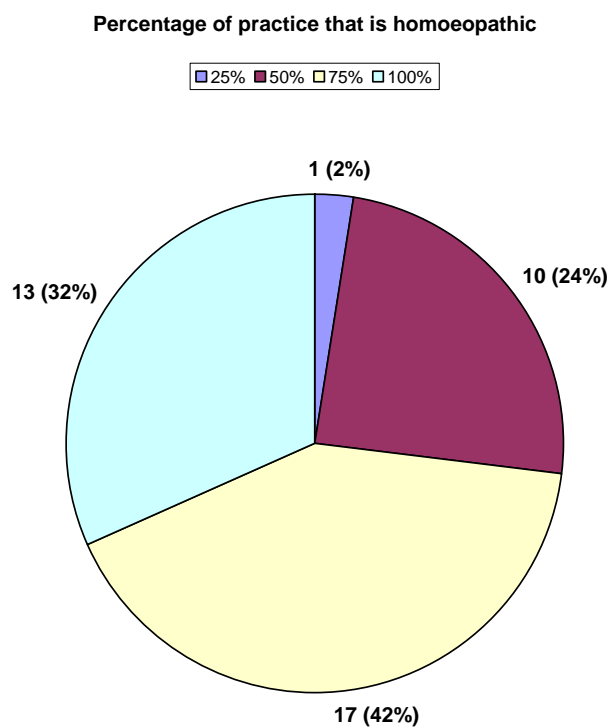


Figure 4.7 Pie chart showing the percentage of practice that is homoeopathic

In Figure 4.7 thirty practitioners (73.2%) indicated that more than 75% of their practice was Homoeopathy, 10 practitioners (24.4%) indicated that 50% of their practice was homoeopathy and only 1 practitioner reported that his practice was 25% homoeopathy.

4.4.8 AREA/LOCATION OF PRACTICE

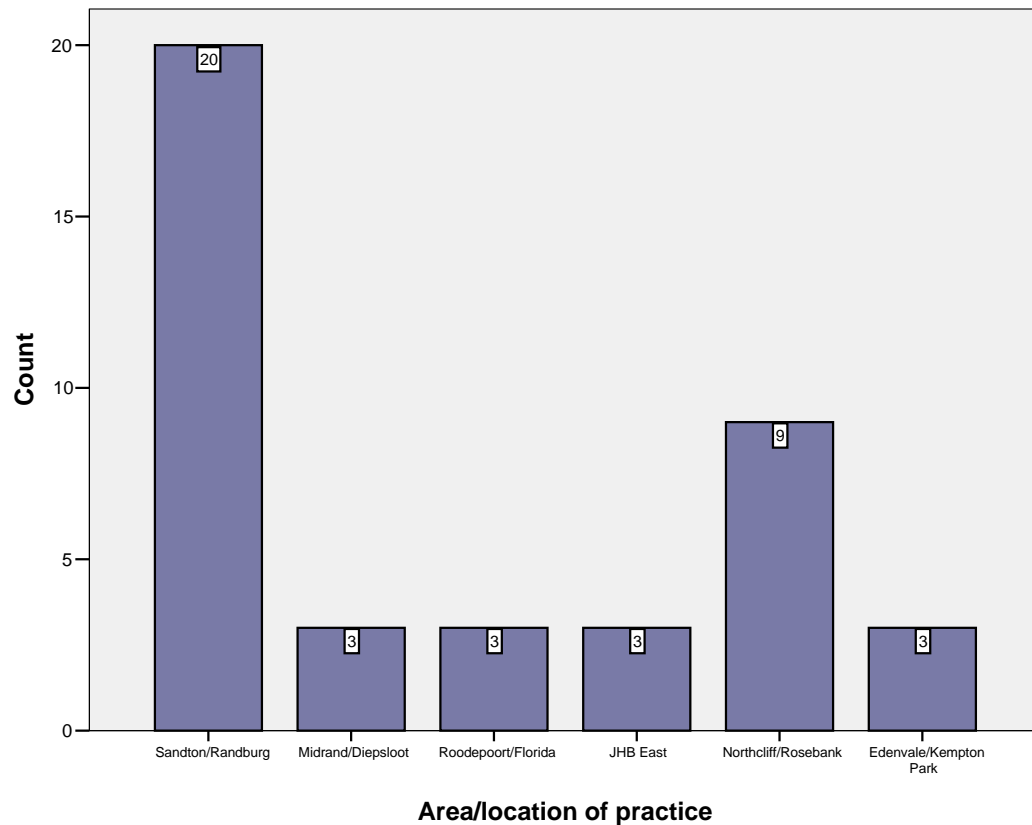


Figure 4.8 Bar graph showing the area distribution of practices in the JHB metropolitan area.

Figure 4.8 shows that the majority of practitioners (n=20, 48.8%) are situated in Sandton/Randburg and 9 (22%) practitioners in the Northcliff/Rosebank area. These are the four most affluent residential areas in the Johannesburg Metropolitan Area.

4.4.9 TYPE OF PRACTICE

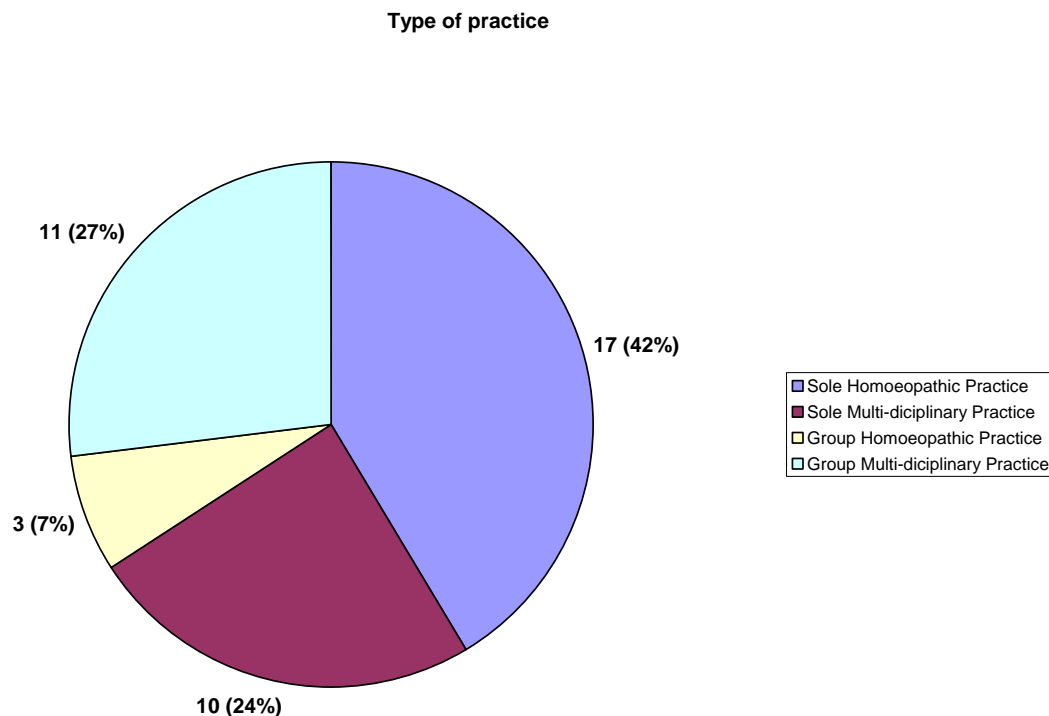


Figure 4.9 Pie chart showing distribution of the types of practices

65.9% of practitioners have a solo practice i.e. they practice alone, 10 (24.4%) have a multidisciplinary practice. 7.3% practice with other homoeopaths. 26.8% were part of a multidisciplinary practice which included other medical and complementary disciplines such as General Practitioner, Psychologists, physiotherapists, chiropractors, aromatherapists, naturopaths, osteopaths and massage therapists.

**4.4.10 NUMBER OF ADD/ADHD PATIENTS BEING TREATED BY
HOMOEOPATHS IN THE LAST 12 MONTHS.**

	Age group of patient					
	<5	5-9	10-14	15-18	>18	
No.	122	410	177	110	86	905
Patients						

Table 4.2 shows the number of ADD/ADHD patients seen by practitioners in the past 12 months.

As can be seen in the above table the greatest number of patients fall between 5 and 14 years of age.

4.4.11 DIAGNOSIS

4.4.11.1 Younger than 5 years: diagnosis

	never	sometimes	often	always
	Count	Count	Count	Count
Diagnosed patient self (younger than 5 years)	30	5	1	1
Colleague diagnosed (younger than 5 years)	29	7	1	
General Practitioner diagnosed (younger than 5 years)	21	6	6	2
Neurologist diagnosed (younger than 5 years)	20	9	5	2
Paediatrician diagnosed (younger than 5 years)	17	10	4	4
Psychologist diagnosed (younger than 5 years)	16	7	8	4
Other diagnosed (younger than 5 years)	17	6	2	

Table 4.3 Frequency table of diagnosis in patients younger than 5 years old

4.4.11.2 5 to 9 years: diagnosis

	never	sometimes	often	always
	Count	Count	Count	Count
Diagnosed patient self (5 to 9 years)	27	7	2	2
Colleague diagnosed (5 to 9 years)	30	7	1	
General Practitioner diagnosed (5 to 9 years)	12	15	8	2
Neurologist diagnosed (5 to 9 years)	13	10	12	3
Paediatrician diagnosed (5 to 9 years)	14	10	10	3
Psychologist diagnosed (5 to 9 years)	9	11	11	6
Other diagnosed (5 to 9 years)	12	3	10	1

Table 4.4 Frequency table of diagnosis in patients 5 – 9 years old

4.4.11.3 10 to 14 years: diagnosis

	never	sometimes	often	always
	Count	Count	Count	Count
Diagnosed patient self (10 to 14 years)	28	4	2	2
Colleague diagnosed (10 to 14 years)	30	6		
General Practitioner diagnosed (10 to 14 years)	15	12	7	1
Neurologist diagnosed (10 to 14 years)	15	9	10	2
Paediatrician diagnosed (10 to 14 years)	19	7	7	2
Psychologist diagnosed (10 to 14 years)	11	11	8	5
Other diagnosed (10 to 14 years)	17	4	4	

Table 4.5 Frequency table of diagnosis in patients 10-14 years old.

4.4.11.4 15 to 18 years: diagnosis

	never	sometimes	often	always
	Count	Count	Count	Count
Diagnosed patient self (15 to 18 years)	27	4	1	3
Colleague diagnosed (15 to 18 years)	29	6		
General Practitioner diagnosed (15 to 18 years)	17	9	5	2
Neurologist diagnosed (15 to 18 years)	15	9	8	2
Paediatrician diagnosed (15 to 18 years)	21	5	5	2
Psychologist diagnosed (15 to 18 years)	12	8	8	4
Other diagnosed (15 to 18 years)	20		3	

Table 4.6 Frequency table of diagnosis of patients 15-18 years old

4.4.11.5. older than 18 years: diagnosis

	never	sometimes	often	always
	Count	Count	Count	Count
Diagnosed patient self (older than 18 years)	30	3	1	2
Colleague diagnosed (older than 18 years)	32	4		
General Practitioner diagnosed (older than 18 years)	21	8	3	2
Neurologist diagnosed (older than 18 years)	18	10	5	2
Paediatrician diagnosed (older than 18 years)	24	4	3	2
Psychologist diagnosed (older than 18 years)	16	8	5	4
Other diagnosed (older than 18 years)	20	1	1	

Table 4.7 Frequency table of diagnosis in patients older than 18 years.

According to these results, Psychologists, Neurologists and Paediatricians most frequently make the diagnosis of ADD/ADHD.

4.4.12 REFERRALS TO OTHER PRACTITIONERS

4.4.12.1 Younger than 5 years: referrals

	never	sometimes	often	always
	Count	Count	Count	Count
Referred to Homoeopath (younger than 5 years)	31	5		
Referred to General Practitioner (younger than 5 years)	32	3		
Referred to Neurologist (younger than 5 years)	26	8	1	1
Referred to Paediatrician (younger than 5 years)	26	7	3	
Referred to Psychologist (younger than 5 years)	21	4	9	2
Referred to other (younger than 5 years)	15	2	2	

Table 4.8 Frequency table showing referrals in patients younger than 5 years old

4.4.12.2 5 to 9 years: referrals

	never	sometimes	often	always
	Count	Count	Count	Count
Referred to Homoeopath (5 to 9 years)	32	4	1	
Referred to General Practitioner (5 to 9 years)	31	5		
Referred to Neurologist (5 to 9 years)	25	8	3	1
Referred to Paediatrician (5 to 9 years)	26	9	2	
Referred to Psychologist (5 to 9 years)	17	7	11	1
Referred to other (5 to 9 years)	10	6	5	1

Table 4.9 Frequency table showing referrals of patients aged 5-9 years

4.4.12.3 10 to 14 years: referrals

	never	sometimes	often	always
	Count	Count	Count	Count
Referred to Homoeopath (10 to 14 years)	33	3		
Referred to General Practitioner (10 to 14 years)	31	4		
Referred to Neurologist (10 to 14 years)	26	7	3	
Referred to Paediatrician (10 to 14 years)	30	5	1	
Referred to Psychologist (10 to 14 years)	17	7	10	2
Referred to other (10 to 14 years)	11	5	1	1

Table 4.10 Frequency table showing referrals of patients 10-14 years old

4.4.12.4 15 to 18 years: referrals

	never	sometimes	often	always	Total
	Count	Count	Count	Count	Count
Referred to Homoeopath (15 to 18 years)	32	2			34
Referred to General Practitioner (15 to 18 years)	30	3			33
Referred to Neurologist (15 to 18 years)	26	6	2		34
Referred to Paediatrician (15 to 18 years)	27	5	1		33
Referred to Psychologist (15 to 18 years)	14	7	11	1	33
Referred to other (15 to 18 years)	13	2	1		16

Table 4.11 Frequency table showing referrals of patients 15-18 years old

4.4.12.5 Older than 18 years: referred

	never	sometimes	often	always
	Count	Count	Count	Count
Referred to Homoeopath (older than 18 years)	33	2		
Referred to General Practitioner (older than 18 years)	31	3		
Referred to Neurologist (older than 18 years)	28	5	1	1
Referred to Paediatrician (older than 18 years)	29	3	1	
Referred to Psychologist (older than 18 years)	19	4	9	1
Referred to other (older than 18 years)	14	1	1	1

Table 4.12 Frequency table showing the referrals of patients older than 18 years.

As can be seen from the above tables, Psychologists were the most frequently referred to practitioner.

4.4.13 TREATMENT

4.4.13.1 Prescribed treatment: younger than 5 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe Simplex treatment (younger than 5 years)	12	7	5	12
Prescribe Complex treatment (younger than 5 years)	16	7	7	5
Prescribe other treatment (younger than 5 years)	10		2	6

Table 4.13 Frequency table of prescribed treatment for patients younger than 5 years old

4.4.13.2 Prescribed treatment: 5 to 9 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe Simplex treatment (5 to 9 years)	3	9	8	18
Prescribe Complex treatment (5 to 9 years)	12	10	8	7
Prescribe other treatment (5 to 9 years)	6	1	3	9

Table 4.14 Frequency table of prescribed treatment for patients 5-9 years old

4.4.13.3 Prescribed treatment: 10 to 14 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe Simplex treatment (10 to 14 years)	6	11	6	13
Prescribe Complex treatment (10 to 14 years)	14	10	5	5
Prescribe other treatment (10 to 14 years)	6		4	9

Table 4.15 Frequency table of prescribed treatment for patients 10-14 years old.

4.4.13.4 Prescribed treatment: 15 to 18 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe Simplex treatment (15 to 18 years)	10	7	6	11
Prescribe Complex treatment (15 to 18 years)	13	10	5	4
Prescribe other treatment (15 to 18 years)	5		3	10

Table 4.16 Frequency table of prescribed treatment for patients 15-18 years old.

4.4.13.5 Prescribed treatment: older than 18 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe Simplex treatment (older than 18 years)	10	6	4	15
Prescribe Complex treatment (older than 18 years)	17	9	3	4
Prescribe other treatment (older than 18 years)	7		3	9

Table 4.17 Frequency table of prescribed treatment for patients older than 18 years.

Simplex treatment was the most frequently prescribed treatment in all the age categories.

4.4.13.6 Simplex Treatment

No. of practitioners (count)	Description
2	Have not treated ADD/ADHD patients
2	Do not use simplexes
4	Similimum

Table 4.18 Simplex Prescribing

No. of practitioners (count)	Name of remedy
1	Acontum napellus
1	Agaricus muscarius
2	Anacardium orientale
1	Apis mellifica
1	Argentum nitricum
1	Arsenicum album
1	Calcera carbonica
1	Calcera phosphoricum
1	Carsinosin
1	Cerebrum 4CH
1	Chamomilla vulgaris
1	Cypredium
8	Datura stramonium
2	Baryta carbonica
1	Hepar sulphuris calcera
2	Ignatia amara
5	Lycopodium clavatum
1	Melissa offinalis
5	Medorrhinum
2	Nux vomica
6	Phosphorus
1	Pulsatilla pratensis
1	Rana bufo
1	Rhus toxicodendron
2	Silica terra
1	Staphysagria
5	Sulphur
6	Tarentula hispanica
8	Tuberculinum bovinum

Table 4.19 Most common simplexes prescribed by practitioners

As seen in the table above, the two most commonly prescribed simplexes are *Datura stramonium* and *Tuberculinum bovinum*.

4.4.13.7 Complex Treatment

No. of practitioners (count)	Description
2	Have not treated patients with ADD/ADHD
8	Do not use complexes
8	Make up own complexes specific for patient

Table 4.20 Complex prescribing

Proprietary Complexes		
Manufacturer	Name of remedy	No. of practitioners (count)
Boiron	Quietude	1
Heel	Calming 30 CH	1
	Ignatia-homaccord	3
	Nervoheel	1
	Selenium-homaccord	1
Pekana	Psystabil	2
Medford	Cogniscript	1
Natura	Cerbo	3
	Ficus carrira (gemmotherapy)	1
	Hypnolix	2
	Nerva	1
	Nervuton	2
	Phospholin	1
	Rescue remedy	1
	Stressless	1
	Tilia tomentosa (gemmotherapy)	1
Reckeweg	R54	1

Table 4.21a Most common proprietary complexes prescribed by practitioners

As can be seen from the above table, the two most commonly prescribed proprietary complexes for patients with ADD/ADHD are Ignatia Homaccord® and Cerbo®.

Complexes compounded by practitioners (non-proprietary)	count
Aethusa cynapium/ Anacardium orientale/ Arsenicum nitricum	1
Arsenicum album/ Gelsemium sempervirens/ Kali phosphoricum/ Lycopodium clavatum	1
Baryta carbonica/ Bryonia alba/ Calcerea carbonica/ Magnesia Phosphorica/ Medorrhinum	1
Hyoscurmus niger/ Ignatia amara/ Rhus toxicodendron/	1
Ignatia amara (15CH)/ Moschus moschiferus (9CH)/ Zincum metallicum (9CH)	1
Kali Phosphoricum (200CH)/ Kava Kava (3XH)	1
Kalium Phosphoricum (9CH)/ Naja tripudians (12CH)/ Zincum metallicum (9CH)	1
Platinum/ Pulsatilla pratensis/ Rhus toxicodendron	1

Table 4.21b Most common complexes used and compounded by practitioners.

4.4.13.8 Groups/Families of remedies prescribed

Group/ Family of remedies	No. of practitioners (count)
Animals	7
Miasmatic remedies/ nosodes	3
Minerals and metals	8
Plants	12
No comment/ have not treated	10

Table 4.22 Most common groups/ families of remedies prescribed.

Plants are seen to be the most common family/ group of remedies prescribed for ADD/ADHD patients (Table 4.22).

4.4.13.9. Miasms

Miasm	No. of practitioners (count)
Cancerinic	6
Psoric	6
Sycotic	17
Syphilitic	6
Tuberulinic	18
No comment/ Have not treated	6

Table 4.23 Most common miasms prescribed by practitioners

The most common miasm was thought to be the Tuberculinic miasm (Table 4.23).

4.4.14 CONVENTIONAL MEDICINE AND HOMOEOPATHY

Practitioners were asked to indicate (for each age group) how often patients were on conventional drug treatment before homoeopathic treatment, and during homoeopathic treatment and whether conventional treatment had interfered with homoeopathic treatment.

4.4.14.1 Drug treatment interference: younger than 5 years

	never	sometimes	often	always
	Count	Count	Count	Count
Patients on drug treatment before Homoeopathic treatment (younger than 5 years)	19	14	2	1
Patients on drug treatment during Homoeopathic treatment (younger than 5 years)	23	9	3	
Conventional drug treatment interfere with Homoeopathic treatment (younger than 5 years)	17	7	4	2

Table 4.24 Frequency table showing drug treatment interference in patients younger than 5 years old.

4.4.14.2 Drug treatment interference: 5 to 9 years

	never	sometimes	often	always
	Count	Count	Count	Count
Patients on drug treatment before Homoeopathic treatment (5 to 9 years)	6	12	18	2
Patients on drug treatment during Homoeopathic treatment (5 to 9 years)	14	16	6	1
Conventional drug treatment interfere with Homoeopathic treatment (5 to 9 years)	9	16	5	3

Table 4.25 Frequency table showing drug interference in patients 5-9 years old.

4.4.14.3 Drug treatment interference: 10 to 14 years

	never	sometimes	often	always
	Count	Count	Count	Count
Patients on drug treatment before Homoeopathic treatment (10 to 14 years)	6	14	11	4
Patients on drug treatment during Homoeopathic treatment (10 to 14 years)	11	16	7	
Conventional drug treatment interfere with Homoeopathic treatment (10 to 14 years)	11	13	3	3

Table 4.26 Frequency table showing drug treatment interference in patients 10-14 years old

4.4.14.4 Drug treatment interference: 15 to 18 years

	never	sometimes	often	always
	Count	Count	Count	Count
Patients on drug treatment before Homoeopathic treatment (15 to 18 years)	9	10	12	2
Patients on drug treatment during Homoeopathic treatment (15 to 18 years)	13	14	5	
Conventional drug treatment interfere with Homoeopathic treatment (15 to 18 years)	10	13	3	3

Table 4.27 Frequency table showing drug treatment interference in patients 15-18 years old

4.4.14.5 Drug treatment interference: older than 18 years

	never	sometimes	often	always
	Count	Count	Count	Count
Patients on drug treatment before Homoeopathic treatment (older than 18 years)	14	9	8	3
Patients on drug treatment during Homoeopathic treatment (older than 18 years)	15	14	4	
Conventional drug treatment interfere with Homoeopathic treatment (older than 18 years)	10	13	3	3

Table 4.28 Frequency table showing drug treatment interference in patients older than 18 years.

For children under 5 years of age:

They were more likely to be on conventional drugs before commencing Homoeopathic treatment but not during homoeopathic treatment. It was thought that conventional treatment interfered with homoeopathic treatment.

For 5-9 year olds; 10-14 years; 15-18 year; older than 18 years:

Results were similar: These patients were more likely to be on conventional treatment before and during homoeopathic treatment. It was also more than likely that conventional treatment interfered with homoeopathic treatment.

4.4.15 OTHER PRESCRIBED TREATMENT

4.4.15.1 Other Prescribed Treatment: younger than 5 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe vitamins (younger than 5 years)	7	5	10	12
Prescribe dietary changes (younger than 5 years)	8	2	5	19
Prescribe herbal remedies (younger than 5 years)	16	8	8	2
Prescribe Bach Flower remedies (younger than 5 years)	19	11	2	1
Prescribe other remedies (younger than 5 years)	6	4	6	2

Table 4.29 Frequency table showing other prescribed treatment for patients younger than 5 years old.

4.4.15.2 Other Prescribed Treatment: 5 to 9 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe vitamins (5 to 9 years)		5	13	19
Prescribe dietary changes (5 to 9 years)	1	3	8	25
Prescribe herbal remedies (5 to 9 years)	9	15	11	2
Prescribe Bach Flower remedies (5 to 9 years)	19	12	4	1
Prescribe other remedies (5 to 9 years)	4	4	8	4

Table 4.30 Frequency table showing other prescribed treatment for patients 5-9 years old

4.4.15.3 Other Prescribed Treatment: 10 to 14 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe vitamins (10 to 14 years)	4	4	13	13
Prescribe dietary changes (10 to 14 years)	4	4	7	19
Prescribe herbal remedies (10 to 14 years)	12	12	8	2
Prescribe Bach Flower remedies (10 to 14 years)	17	12	2	2
Prescribe other remedies (10 to 14 years)	4	3	8	4

Table 4.31 Frequency table showing other prescribed treatment for patients 10-14 years old.

4.4.15.4 Other Prescribed Treatment: 15 to 18 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe vitamins (15 to 18 years)	5	3	11	12
Prescribe dietary changes (15 to 18 years)	7	1	6	17
Prescribe herbal remedies (15 to 18 years)	11	10	8	2
Prescribe Bach Flower remedies (15 to 18 years)	18	10	2	1
Prescribe other remedies (15 to 18 years)	5	3	7	5

Table 4.32 Frequency table showing other prescribed treatment for patients 15-18 years old.

4.4.15.5 Other Prescribed Treatment: older than 18 years

	never	sometimes	often	always
	Count	Count	Count	Count
Prescribe vitamins (older than 18 years)	6	5	9	13
Prescribe dietary changes (older than 18 years)	8	2	6	17
Prescribe herbal remedies (older than 18 years)	13	12	6	2
Prescribe Bach Flower remedies (older than 18 years)	18	11	2	2
Prescribe other remedies (older than 18 years)	7	3	6	4

Table 4.33 Frequency table showing other prescribed treatment for patients older than 18 years old.

Vitamins and dietary changes were the most frequently additional treatments prescribed.

4.4.16 SUCCESS WITH HOMOEOPATHIC TREATMENT

	not successful	little success	moderate success	very successful
	Count	Count	Count	Count
Successful in treating patient with ADD/ADHD (younger than 5 years)	7	2	14	10
Successful in treating patient with ADD/ADHD (5 to 9 years)	1	2	25	9
Successful in treating patient with ADD/ADHD (10 to 14 years)	5	4	15	11
Successful in treating patient with ADD/ADHD (15 to 18 years)	4	2	15	9
Successful in treating patient with ADD/ADHD (older than 18 years)	6	2	16	7

Table 4.34 Frequency table showing the success of practitioners in treating ADD/ADHD

As seen in table 4.34, the majority of the practitioners perceived their treatment to be moderately to very successful in treating patients with ADD/ADHD whatever the patients age.

4.4.17 MISDIAGNOSIS AND OVERDIAGNOSIS

	yes	no	Total
	Count	Count	Count
Do you think ADD/ADHD is misdiagnosed?	38	3	41
Do you think ADD/ADHD is over diagnosed?	39	1	40

Table 4.35 The opinions of practitioners with regard to misdiagnosis/over diagnosis.

According to respondents 92% were of the opinion that ADD/ADHD is misdiagnosed and 97.5% thought that ADD/ADHD is over diagnosed.

4.4.18 DIFFERENCE IN CHILDHOOD AND ADULT ADD/ADHD?

	yes	no	Total
	count	count	count
Do you think there is a difference in behaviour between childhood and adult ADD/ADHD?	22	14	36

Table 4.36 the opinions of practitioners with regard to childhood and adult ADD/ADHD.

According to participants, 61% thought that there is a difference in the behaviour in children and adults with ADD/ADHD.

4.5 MEASURES OF ASSOCIATION BETWEEN VARIABLES

4.5.1 Association between type of homoeopathic qualification and the additional modalities used in practice

The Pearson's Chi-square Test was used to test the relevant hypothesis (3.4.1.1).

Key: Qual = qualification

Cross tabulation									
			Additional modalities						Total
			Allopathic medicine	Acu-puncture	Aroma-Therapy	Naturopathy	Irido-logy	Phyto-therapy	
Qualification	M.Tech (Hom)	Count	1	10	1	8	1	7	28
		% within qual	3.6%	35.7%	3.6%	28.6%	3.6%	25.0%	100.0%
	Other	Count	2	4	1	0	1	0	8
		% within qual	25.0%	50.0%	12.5%	.0%	12.5%	.0%	100.0%
Total		Count	3	14	2	8	2	7	36
		% within qual	8.3%	38.9%	5.6%	22.2%	5.6%	19.4%	100.0%

Table 4.37 shows the cross-tabulation of the type of qualification against the additional modalities practiced

The most commonly utilized additional modality was acupuncture (table 4.37).

There is no statistically significant association between the type of qualification and the additional modalities practiced.

4.5.2 Association between the type of qualification and percentage of practice that is homoeopathic

The Pearson's Chi-squared Test was used to test the relevant hypothesis

(3.4.1.2). Key: Qual = qualification

Cross-tabulation					
			Percentage of practice - homoeopathy		Total
			25%-50%	75%-100%	
qualification	M.Tech (Hom)	Count	7	25	32
		% within qual	21.9%	78.1%	100.0%
	Other	Count	4	5	9
		% within qual	44.4%	55.6%	100.0%
Total		Count	11	30	41
		% within qual	26.8%	73.2%	100.0%

Table 3.38a shows the cross-tabulation of the type of qualification against the percentage of practice that is homoeopathic

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.823	1	.177		
Continuity Correction(a)	.854	1	.355		
Likelihood Ratio	1.701	1	.192		
Fisher's Exact Test				.217	.176
Linear-by-Linear Association	1.778	1	.182		
N of Valid Cases	41				
a Computed only for a 2x2 table					
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.41					

Table 4.38b Chi-Square test for association between qualification and percentage of practice that is homoeopathic

The Chi-Square test (table 4.39) shows that the corrected value to be 0.854, however there is one cell that has an expected count less than 5, so the Fisher's Exact is 0.217 ($p > 0.05$). Therefore there is no statistical association can be made between the type of qualification and percentage of practice that is homoeopathic.

4.5.3 Association between the type of qualification and the number of patients with ADD/ADHD seen in the last 12 months

The Pearson's Chi-square Test was used to test the relevant hypothesis (3.4.1.3). Key : Qual = qualification

Statistics		
Total number of patients		
N	Valid	41
	Missing	0
Mean		21.95
Median		12.00
Mode		3
Std. Deviation		32.979
Minimum		0
Maximum		180

Table 4.39a Measures of central tendency: total number of patients

Cross-tabulation					
			Total number of patients		Total
			0-10 patients	11 or more patients	
Qualification	M.Tech (Hom)	Count	15	17	32
		Expected count	14.8	17.2	32
		% within qual	46.9%	53.1%	100.0%
	Other	Count	4	5	9
		Expected count	4.2	4.8	9
		% within qual	44.4%	55.6%	100.0%
Total		Count	19	22	41
		Expected count	19	22	41
		% within qual	46.3%	53.7%	100.0%

Table 4.39b shows the cross-tabulation of the type of qualification against the number of patients with ADD/ADHD

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.017(b)	1	.897		
Continuity Correction(a)	.000	1	1.000		
Likelihood Ratio	.017	1	.897		
Fisher's Exact Test				1.000	.600
Linear-by-Linear Association	.016	1	.898		
N of Valid Cases	41				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 4.17					

Table 4.39c Chi-Square test for the association between qualification and total number of patients.

The corrected value is < 0.001 . As there are 2 cells that have an expected count less than 5, the Fishers Exact is 1.000 ($p > 0.05$). Therefore no statistical association can be made between the type of qualification and number of patients .

4.5.4 Association between type of qualification and treatment

The Pearson's Chi-square test was used to test the relevant hypotheses (3.4.1.4). The Chi-square test tables have not been included if there was no significant result. This is mainly because there was one or more cells with expected counts less than 5.

4.5.4.1 Simplex treatment

a) Younger than 5 Years old:

Cross-tabulation					
			Prescribe Simplex treatment (younger than 5 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	11	17	28
		Expected Count	9.3	18.7	28.0
		% within qualification	39.3%	60.7%	100.0%
	Other	Count	1	7	8
		Expected Count	2.7	5.3	8.0
		% within qualification	12.5%	87.5%	100.0%
Total		Count	12	24	36
		Expected Count	12.0	24.0	36.0
		% within qualification	33.3%	66.7%	100.0%

Table 4.40 shows the cross-tabulation of the type of Homoeopathic qualification and simplex treatment for children younger than 5 years old

b) 5– 9 Year olds

			Prescribe Simplex treatment (5 to 9 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	3	27	30
		Expected Count	2.4	27.6	30.0
		% within qualification	10.0%	90.0%	100.0%
	Other	Count	0	8	8
		Expected Count	.6	7.4	8.0
		% within qualification	.0%	100.0%	100.0%
Total		Count	3	35	38
		Expected Count	3.0	35.0	38.0
		% within qualification	7.9%	92.1%	100.0%

Table 4.41 shows the cross tabulation of the type of homoeopathic qualification and simplex treatment

c) 10– 14 Year olds:

			Prescribe Simplex treatment (10 to 14 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	6	22	28
		Expected Count	4.7	23.3	28.0
		% within qualification	21.4%	78.6%	100.0%
	Other	Count	0	8	8
		Expected Count	1.3	6.7	8.0
		% within qualification	.0%	100.0%	100.0%
Total		Count	6	30	36
		Expected Count	6.0	30.0	36.0
		% within qualification	16.7%	83.3%	100.0%

Table 4.42 shows the cross tabulation of the type of Homoeopathic qualification against simplex treatment for 10-14 year olds.

d) 15 – 18 Year olds:

			Prescribe Simplex treatment (15 to 18 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	8	18	26
		Expected Count	7.6	18.4	26.0
		% within qualification	30.8%	69.2%	100.0%
	Other	Count	2	6	8
		Expected Count	2.4	5.6	8.0
		% within qualification	25.0%	75.0%	100.0%
Total		Count	10	24	34
		Expected Count	10.0	24.0	34.0
		% within qualification	29.4%	70.6%	100.0%

Table 4.43 shows the cross tabulation of the type of homoeopathic qualification against simplex treatment for 15-18 year olds

e) Older than 18 years old::

			Prescribe Simplex treatment (older than 18 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	8	19	27
		Expected Count	7.7	19.3	27.0
		% within qualification	29.6%	70.4%	100.0%
	Other	Count	2	6	8
		Expected Count	2.3	5.7	8.0
		% within qualification	25.0%	75.0%	100.0%
Total		Count	10	25	35
		Expected Count	10.0	25.0	35.0
		% within qualification	28.6%	71.4%	100.0%

Table 4.44 shows the cross-tabulation of the type of homoeopathic qualification against simplex treatmentfor patients older than 18 years old.

No statistically significant association can be made between the type of qualification of the practitioner and how often simplex treatment is prescribed. Regardless of qualification simplex treatment was prescribed more frequently than not.

4.5.4.2 Complex treatment

The Pearson's Chi-square test was conducted for each age group

a) Younger than 5 years old:

			Prescribe Complex treatment (younger than 5 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	11	16	27
		% within qualification	40.7%	59.3%	100.0%
	Other	Count	5	3	8
		% within qualification	62.5%	37.5%	100.0%
Total		Count	16	19	35
		% within qualification	45.7%	54.3%	100.0%

Table 4.45 shows the cross-tabulation of homoeopathic qualification against complex treatment for children younger than 5 years old.

b) 5– 9 years old:

			Prescribe Complex treatment (5 to 9 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	8	21	29
		% within qualification	27.6%	72.4%	100.0%
	Other	Count	4	4	8
		% within qualification	50.0%	50.0%	100.0%
Total		Count	12	25	37
		% within qualification	32.4%	67.6%	100.0%

Table 4.46 shows the cross-tabulation of the type of homoeopathic qualification against complex treatment for 5-9 year olds

c) 10-14 Years old:

			Prescribe Complex treatment (10 to 14 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	10	16	26
		% within qualification	38.5%	61.5%	100.0%
	Other	Count	4	4	8
		% within qualification	50.0%	50.0%	100.0%
Total		Count	14	20	34
		% within qual	41.2%	58.8%	100.0%

Table 4.47 shows the cross-tabulation of the type of homoeopathic qualification against complex treatment for 10-14 year olds

d) 15 –18 Years Old:

			Prescribe Complex treatment (15 to 18 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	9	15	24
		% within qualification	37.5%	62.5%	100.0%
	Other	Count	4	4	8
		% within qualification	50.0%	50.0%	100.0%
Total		Count	13	19	32
		% within qualification	40.6%	59.4%	100.0%

Table 4.48 shows the cross-tabulation of the type of homoeopathic qualification against complex treatment for 15-18 year olds.

e) 18 Years and older:

			Prescribe Complex treatment (older than 18 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	12	13	25
		% within qualification	48.0%	52.0%	100.0%
	Other	Count	5	3	8
		% within qualification	62.5%	37.5%	100.0%
Total		Count	17	16	33
		% within qualification	51.5%	48.5%	100.0%

Table 4.49 shows the cross-tabulation of the type of homoeopathic qualification against complex treatment for patients older than 18 years old.

No statistically significant association can be made between the type of qualification and how often complex treatment is prescribed.

4.5.4.3 Vitamins

The Pearson's Chi-square test was conducted for each age group

a) Younger than 5 Years old:

			Prescribe vitamins (younger than 5 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	6	20	26
		% within qualification	23.1%	76.9%	100.0%
	Other	Count	1	7	8
		% within qualification	12.5%	87.5%	100.0%
Total		Count	7	27	34
		% within qualification	20.6%	79.4%	100.0%

Table 4.50 shows the cross-tabulation of the type of homoeopathic qualification against vitamins prescribed for children younger than 5 years old

b) 5 – 9 Years old:

			Prescribe vitamins (5 to 9 years)	Total
			at least once	
Qualification	M.Tech (Hom)	Count	29	29
		% within qualification	100.0%	100.0%
	Other	Count	8	8
		% within qualification	100.0%	100.0%
Total		Count	37	37
		% within qualification	100.0%	100.0%

Table 4.51 shows the cross-tabulation of the type of homoeopathic qualification against prescription of vitamins for 5-9 year old.

c) 10 – 14 Years old:

			Prescribe vitamins (10 to 14 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	3	23	26
		% within qualification	11.5%	88.5%	100.0%
	Other	Count	1	7	8
		% within qualification	12.5%	87.5%	100.0%
Total		Count	4	30	34
		% within qualification	11.8%	88.2%	100.0%

Table 4.52 shows the cross-tabulation of the type of homoeopathic qualification against the prescription of vitamins for 10-14 year olds.

d) 15 – 18 Years old:

			Prescribe vitamins (15 to 18 years)		Total
			never	at least once	
qual	M.Tech (Hom)	Count	3	20	23
		% within qual	13.0%	87.0%	100.0%
	Other	Count	2	6	8
		% within qual	25.0%	75.0%	100.0%
Total		Count	5	26	31
		% within qual	16.1%	83.9%	100.0%

Table 4.53 shows the cross-tabulation of the type of homoeopathic qualification against vitamins prescribed for 15-18 year olds.

e) Older than 18 years old:

			Prescribe vitamins (older than 18 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	4	21	25
		% within qualification	16.0%	84.0%	100.0%
	Other	Count	2	6	8
		% within qualification	25.0%	75.0%	100.0%
Total		Count	6	27	33
		% within qualification	18.2%	81.8%	100.0%

Table 4.54 shows the cross-tabulation of the homoeopathic qualification against vitamins prescribed for patients older than 18 years old.

No statistically significant association can be made between the type of qualification and how often vitamins are prescribed. In table 4.51 shows that all practitioners regardless of qualification prescribed vitamins at least once for 5 to 9 year olds.

4.5.4.4 Dietary changes

The Pearson's Chi-square test was conducted for each age group.

a) Younger than 5 Years:

			Prescribe dietary changes (younger than 5 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	7	19	26
		% within qualification	26.9%	73.1%	100.0%
	Other	Count	1	7	8
		% within qualification	12.5%	87.5%	100.0%
Total		Count	8	26	34
		% within qualification	23.5%	76.5%	100.0%

Table 4.55 shows the cross-tabulation of the type of qualification against dietary changes for children younger than 5 years old.

b) 5 – 9 Years old:

			Prescribe dietary changes (5 to 9 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	1	28	29
		% within qualification	3.4%	96.6%	100.0%
	Other	Count	0	8	8
		% within qualification	.0%	100.0%	100.0%
Total		Count	1	36	37
		% within qualification	2.7%	97.3%	100.0%

Table 4.56 shows the cross-tabulation of the type of homoeopathic qualification against dietary changes for 5-9 year olds

c) 10 – 14 Years old:

			Prescribe dietary changes (10 to 14 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	4	22	26
		% within qualification	15.4%	84.6%	100.0%
	Other	Count	0	8	8
		% within qualification	.0%	100.0%	100.0%
Total		Count	4	30	34
		% within qualification	11.8%	88.2%	100.0%

Table 4.57 shows the cross-tabulation of the type of homoeopathic qualification against dietary changes for 10-14 year olds

d) 15 – 18 Years old:

			Prescribe dietary changes (15 to 18 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	4	19	23
		% within qualification	17.4%	82.6%	100.0%
	Other	Count	3	5	8
		% within qualification	37.5%	62.5%	100.0%
Total		Count	7	24	31
		% within qualification	22.6%	77.4%	100.0%

Table 4.58 shows the cross-tabulation of the type of homoeopathic qualification against dietary changes for 15-18 year olds.

e) Older than 18 years old:

			Prescribe dietary changes (older than 18 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	5	20	25
		% within qualification	20.0%	80.0%	100.0%
	Other	Count	3	5	8
		% within qualification	37.5%	62.5%	100.0%
Total	Count		8	25	33
	% within qualification		24.2%	75.8%	100.0%

Table 4.59 shows the cross-tabulation of the type of homoeopathic qualification against dietary changes for patients older than 18 years old.

No statistically significant association can be made between the type of qualification and prescribing dietary changes. However, it can be seen that a greater number of practitioners prescribed dietary changes for their patients.

4.5.4.5 Herbal Remedies

The Pearson's Chi-square was conducted for each group

a) Younger than 5 years old:

			Prescribe herbal remedies (younger than 5 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	12	14	26
		% within qualification	46.2%	53.8%	100.0%
	Other	Count	4	4	8
		% within qualification	50.0%	50.0%	100.0%
Total		Count	16	18	34
		% within qualification	47.1%	52.9%	100.0%

Table 4.60 shows the cross-tabulation of the type of homoeopathic qualification against herbal remedies for children younger than 5 years old

b) 5 – 9 Years old:

			Prescribe herbal remedies (5 to 9 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	6	23	29
		% within qualification	20.7%	79.3%	100.0%
	Other	Count	3	5	8
		% within qualification	37.5%	62.5%	100.0%
Total		Count	9	28	37
		% within qualification	24.3%	75.7%	100.0%

Table 4.61 shows the cross-tabulation of the type of homoeopathic qualification against herbal remedies.

c) 10 – 14 Years old:

			Prescribe herbal remedies (10 to 14 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	9	17	26
		% within qualification	34.6%	65.4%	100.0%
	Other	Count	3	5	8
		% within qualification	37.5%	62.5%	100.0%
Total		Count	12	22	34
		% within qualification	35.3%	64.7%	100.0%

Table 4.62 shows the cross-tabulation of the type of homoeopathic qualification against herbal remedies prescribed for 10-14 year olds

d) 15 – 18 Years old:

			Prescribe herbal remedies (15 to 18 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	8	15	23
		% within qualification	34.8%	65.2%	100.0%
	Other	Count	3	5	8
		% within qualification	37.5%	62.5%	100.0%
Total		Count	11	20	31
		% within qualification	35.5%	64.5%	100.0%

Table 4.63 shows the cross-tabulation of the type of homoeopathic qualification against herbal remedies prescribed for 15-18 year olds.

e) Older than 18 years old:

			Prescribe herbal remedies (older than 18 years)		Total
			never	at least once	
qualification	M.Tech (Hom)	Count	10	15	25
		% within qualification	40.0%	60.0%	100.0%
	Other	Count	3	5	8
		% within qualification	37.5%	62.5%	100.0%
Total		Count	13	20	33
		% within qualification	39.4%	60.6%	100.0%

Table 4.64 shows the cross-tabulation of the type of homoeopathic qualification against herbal remedies prescribed for patients older than 18 years old.

No statistically significant association can be made between the type of homoeopathic qualification and the prescription of herbal remedies. Regardless of qualification a greater number of homoeopaths prescribe herbal remedies for their patients.

4.5.4.6 Bach Flower Remedies

The Pearson's Chi-square test was conducted for each age group

a) Younger than 5 Years old:

			Prescribe Bach Flower remedies (younger than 5 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	15	11	26
		% within qualification	57.7%	42.3%	100.0%
	Other	Count	4	3	7
		% within qualification	57.1%	42.9%	100.0%
Total		Count	19	14	33
		% within qualification	57.6%	42.4%	100.0%

Table 4.65 shows the cross-tabulation of the type of homoeopathic qualification against Bach remedies prescribed for children younger than 5 years old

b) 5 –9 Years old:

			Prescribe Bach Flower remedies (5 to 9 years)		Total
			never	at least once	
qualification	M.Tech (Hom)	Count	15	14	29
		% within qualification	51.7%	48.3%	100.0%
	Other	Count	4	3	7
		% within qualification	57.1%	42.9%	100.0%
Total		Count	19	17	36
		% within qualification	52.8%	47.2%	100.0%

Table 4.66 shows the cross-tabulation of the type of homoeopathic qualification against Bach remedies prescribed for 5-9 year olds.

c) 10 – 14 Years old:

			Prescribe Bach Flower remedies (10 to 14 years)		Total
			never	at least once	
qualification	M.Tech (Hom)	Count	13	13	26
		% within qualification	50.0%	50.0%	100.0%
	Other	Count	4	3	7
		% within qualification	57.1%	42.9%	100.0%
Total		Count	17	16	33
		% within qualification	51.5%	48.5%	100.0%

Table 4.67 shows the cross-tabulation of the type of homoeopathic qualification against Bach remedies prescribed for 10-14 year olds.

d) 15 – 18 Years old:

			Prescribe Bach Flower remedies (15 to 18 years)		Total
			never	at least once	
qualification	M.Tech (Hom)	Count	13	10	23
		% within qualification	56.5%	43.5%	100.0%
	Other	Count	5	3	8
		% within qualification	62.5%	37.5%	100.0%
Total		Count	18	13	31
		% within qualification	58.1%	41.9%	100.0%

Table 4.68 shows the cross-tabulation of the type of homoeopathic qualification against Bach remedies prescribed for 15-18 year olds

e) Older than 18 years old:

			Prescribe Bach Flower remedies (older than 18 years)		Total
			never	at least once	
Qualification	M.Tech (Hom)	Count	13	12	25
		% within qualification	52.0%	48.0%	100.0%
	Other	Count	5	3	8
		% within qualification	62.5%	37.5%	100.0%
Total		Count	18	15	33
		% within qualification	54.5%	45.5%	100.0%

Table 4.69 shows the cross-tabulation of the type of homoeopathic qualification against Bach remedies prescribed for patients older than 18 years old

No statistically significant association can be made between the type of qualification and the prescription of Bach remedies. It can be noted that Bach Flower remedies are prescribed less frequently by these homoeopaths.

4.5.5 Association between type of qualification and success rate

The Pearson's Chi-squared test was used to test the relevant hypothesis

(3.4.1.5).

Key: Qual = qualification

4.5.5.1 Younger than 5 years old:

Cross-tabulation					
			Younger than 5 years		Total
			no to little success	moderate to very successful	
qual	M.Tech (Hom)	Count	9	17	26
		% within qual	34.6%	65.4%	100.0%
	Other	Count	0	7	7
		% within qual	.0%	100.0%	100.0%
Total		Count	9	24	33
		% within qual	27.3%	72.7%	100.0%

Table 4.70a shows the cross-tabulation of the type of qualification against the success rate for children younger than 5 year old

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.332(b)	1	.068		
Continuity Correction(a)	1.815	1	.178		
Likelihood Ratio	5.131	1	.024		
Fisher's Exact Test				.149	.081
Linear-by-Linear Association	3.231	1	.072		
N of Valid Cases	33				
a Computed only for a 2x2 table					
b 1 cell (25.0%) has expected count less than 5. The minimum expected count is 1.91.					

Table 4.70b Chi-Square test for association of qualification and success rate (< 5 years)

The corrected value is 1.815, but as there is one cell with an expected count less than 5, the Fisher's Exact is 0.149 ($p > 0.05$). Therefore no statistically

significant association can be made between the type of qualification and success rate for children under 5 years old.

4.5.5.2 5 – 9 Years old:

Cross-tabulation					
			5-9 year olds		Total
			no to little success	moderate to very successful	
qual	M.Tech (Hom)	Count	3	26	29
		% within qual	10.3%	89.7%	100.0%
	Other	Count	0	8	8
		% within qual	.0%	100.0%	100.0%
Total		Count	3	34	37
		% within qual	8.1%	91.9%	100.0%

Table 4.71a shows the cross-tabulation of the type of qualification against the success rate for 5 - 9 year old.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.901(b)	1	.343		
Continuity Correction(a)	.047	1	.828		
Likelihood Ratio	1.533	1	.216		
Fisher's Exact Test				1.000	.470
Linear-by-Linear Association	.876	1	.349		
N of Valid Cases	37				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is .65.					

Table 4.71b Chi-Square test for the association between qualification and success rate (5-9 years).

The corrected value is 0.47, but there are two cells with an expected count less than 5 so the Fisher's Exact is 1.000 ($p > 0.05$). Therefore no statistically

significant association can be made between the type of qualification and success rate for 5 to 9 year olds.

4.5.5.3 10- 14 Years old:

Cross-tabulation					
			10-14 year olds		Total
			no to little success	moderate to very successful	
qual	M.Tech (Hom)	Count	8	19	27
		% within qual	29.6%	70.4%	100.0%
	Other	Count	1	7	8
		% within qual	12.5%	87.5%	100.0%
Total		Count	9	26	35
		% within qual	25.7%	74.3%	100.0%

Table 4.72a shows the cross-tabulation of type of qualification against the success rate for 10-14 year olds.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.948(b)	1	.330		
Continuity Correction(a)	.263	1	.608		
Likelihood Ratio	1.060	1	.303		
Fisher's Exact Test				.648	.318
Linear-by-Linear Association	.921	1	.337		
N of Valid Cases	35				
a Computed only for a 2x2 table					
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.06.					

Table 4.72b Chi-square test for association between qualification and success rate (10-14 years).

The corrected value is 0.263, but there is one cell with an expected count less than 5, so the Fisher's Exact is 0.648 ($p > 0.05$). Therefore no statistically

significant association can be made between the type of qualification and success rate in 10 to 14 year olds.

4.5.5.4 15-18 Years old:

Cross-tabulation					
			15-18 year olds		Total
			no to little success	moderate to very successful	
qual	M.Tech (Hom)	Count	5	19	24
		% within qua	20.8%	79.2%	100.0%
	Other	Count	1	5	6
		% within qual	16.7%	83.3%	100.0%
Total		Count	6	24	30
		% within qual	20.0%	80.0%	100.0%

Table 4.73a shows the cross-tabulation of the type of qualification against the success rate for 15 and 18 year olds

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.052(b)	1	.819		
Continuity Correction(a)	.000	1	1.000		
Likelihood Ratio	.054	1	.816		
Fisher's Exact Test				1.000	.656
Linear-by-Linear Association	.050	1	.822		
N of Valid Cases	30				
a Computed only for a 2x2 table					
b 3 cells (75.0%) have expected count less than 5. The minimum expected count is 1.20.					

Table 4.73b Chi-square tests for association between qualification and success rate (15-18 years)

The corrected value is < 0.001 , but there are three cells with an expected count less than 5, so Fisher's Exact is 1.000 ($p > 0.05$). Therefore no statistically

significant association can be made between the type of qualification and success rate in 15-18 year olds.

4.5.5.5 Older than 18 years old:

Cross-tabulation					
			Older than 18 years		Total
			no to little success	moderate to very successful	
qual	M.Tech (Hom)	Count	7	19	26
		% within qual	26.9%	73.1%	100.0%
	Other	Count	1	5	6
		% within qual	16.7%	83.3%	100.0%
Total		Count	8	24	32
		% within qual	25.0%	75.0%	100.0%

Table 4.74a shows the cross-tabulation of the type of qualification against the success rate of patients older than 18 years old.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.274(b)	1	.601		
Continuity Correction(a)	.000	1	1.000		
Likelihood Ratio	.293	1	.588		
Fisher's Exact Test				1.000	.524
Linear-by-Linear Association	.265	1	.607		
N of Valid Cases	32				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.50.					

Table 4.74b Chi-square test for association between qualification and success rate (> 18 years)

The corrected value is < 0.001, but there are two cells with an expected count less than 5, so the Fisher's Exact is 1.000. Therefore no statistically significant

association can be made between the type of qualification and success rate in patients older than 18 years.

No statistically significant association can be made between the type of homoeopathic qualification and the success rate with treating ADD/ADHD.

Regardless of qualification, majority of the homoeopaths in this study report that they are moderately to very successful.

4.5.6 Association between the Institution from which practitioner qualified and additional modalities

The Pearson's Chi-squared test was used to test the relevant hypothesis (3.4.1.6).

Cross-tabulation									
			Additional modalities					Total	
			allopathic medicine	Acu-puncture	Aroma-therapy	Naturo-pathy	Irid-ology	Phyto-therapy	
institution	DIT	Count	0	4	0	2	0	2	8
		% within institution	.0%	50.0%	.0%	25.0%	.0%	25.0%	100.0%
		% within add modalities	.0%	40.0%	.0%	25.0%	.0%	28.6%	28.6%
	Uni JHB	Count	1	6	1	6	1	5	20
		% within institution	5.0%	30.0%	5.0%	30.0%	5.0%	25.0%	100.0%
		% within add modalities	100.0%	60.0%	100.0%	75.0%	100.0%	71.4%	71.4%
Total		Count	1	10	1	8	1	7	28
		% within institution	3.6%	35.7%	3.6%	28.6%	3.6%	25.0%	100.0%
		% within add modalities	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 4.75 shows the cross-tabulation of the institution from which practitioners qualified against the additional modalities practiced

No statistically significant association between the institution from which the practitioner qualified and the type of additional modalities practiced.

4.5.7 Institution and percentage of practice that is homoeopathic

The Pearson's Chi-squared test was used to test the relevant hypothesis

(3.4.1.7).

Cross-tabulation							
			Percentage homoeopathy practiced				Total
			25%	50%	75%	100%	
institution	UNI JHB (Old TWR)	Count	0	6	12	6	24
		% within institution	.0%	25.0%	50.0%	25.0%	100.0%
	Other (incl DIT)	Count	1	4	5	7	17
		% within institution	5.9%	23.5%	29.4%	41.2%	100.0%
Total		Count	1	10	17	13	41
		% within institution	2.4%	24.4%	41.5%	31.7%	100.0%

Table 4.76a shows the cross-tabulation of the institution from which a practitioner qualified against the percentage of homoeopathy practiced

Cross-tabulation					
			Percentage homoeopathy practiced		Total
			25%-50%	75%-100%	
institution	UNI JHB (Old TWR)	Count	6	18	24
		% within institution	25.0%	75.0%	100.0%
	Other (incl DIT)	Count	5	12	17
		% within institution	29.4%	70.6%	100.0%
Total		Count	11	30	41
		% within institution	26.8%	73.2%	100.0%

Table 4.76 b shows the cross-tabulation (2x2) of the institution from which the practitioner qualified against percentage of homoeopathy practiced.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.099(b)	1	.753		
Continuity Correction(a)	.000	1	1.000		
Likelihood Ratio	.098	1	.754		
Fisher's Exact Test				1.000	.513
Linear-by-Linear Association	.096	1	.756		
N of Valid Cases	41				
a Computed only for a 2x2 table					
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.56.					

Table 4.76c Chi-square test for association between institution at which homoeopath qualified and percentage of homoeopathy practiced.

The corrected value is < 0.001 , with an associated significance of 1.000. As there is one cell with an expected count of less than 5, the Fisher's Exact is 1.000 ($p > 0.05$). Therefore there is no statistically significant association between the institution and percentage of homoeopathy practiced.

4.5.8 Institution and Total Number of patients

The Pearson's Chi-squared test was used to test the relevant hypothesis

(3.4.1.8).

Crosstab					
			Total number of patients		Total
			0-10 patients	11 or more patients	
institution	Durban Institute of Technology	Count	3	5	8
		% within institution	37.5%	62.5%	100.0%
	Uni JHB	Count	12	12	24
		% within institution	50.0%	50.0%	100.0%
Total		Count	15	17	32
		% within institution	46.9%	53.1%	100.0%

Table 4.77a shows the cross-tabulation of the institution from which the practitioner qualified against the number of patients with ADD/ADHD seen in the last 12 months.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.312(b)	1	.577		
Continuity Correction(a)	.058	1	.810		
Likelihood Ratio	.312	1	.576		
Fisher's Exact Test				.752	.406
Linear-by-Linear Association	.304	1	.581		
N of Valid Cases	41				

a Computed only for a 2x2 table

b 0 cells (25.0%) have expected count less than 5. The minimum expected count is 7.88.

Table 4.77b Chi-square test for association between the institution from which the practitioner qualified and number of patients seen in the last 12 months.

The corrected value is 0.058 ($p > 0.05$), with an associated significance of 0.810).

Therefore no statistically significant association can be made between the two variables

4.5.9 Institution from which qualified and treatment

The Pearson's Chi-squared test was used to test the relevant hypotheses (3.4.1.9).

The Chi-square test tables have not been included in this section unless there was a significant result.

4.5.9.1 Simplex

The test was conducted for each age group.

a) Younger than 5 Years old:

Cross-tabulation					
			Prescribe Simplex treatment (younger than 5 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	1	5	6
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Uni JHB	Count	10	12	22
		% within Institution at which you qualified as Homoeopath	45.5%	54.5%	100.0%
	Other	Count	1	7	8
		% within institution at which you qualified as Homoeopath	12.5%	87.5%	100%
Total	Count		12	24	36
	% within Institution at which you qualified as Homoeopath		33.3%	66.7%	100.0%

Table 4.78 shows the cross-tabulation of the institution from which the practitioner qualified against simplex treatment for children younger than 5 years olds.

b) 5-9 Years old:

Cross-tabulation					
			Prescribe Simplex treatment (5 to 9 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	0	8	8
		% within Institution at which you qualified as Homoeopath	.0%	100.0%	100.0%
	Uni JHB	Count	3	19	22
		% within Institution at which you qualified as Homoeopath	13.6%	86.4%	100.0%
	Other	Count	0	8	8
		% within Institution at which you qualified as homoeopath	0%	100%	100%
Total		Count	3	35	38
		% within Institution at which you qualified as Homoeopath	7.9%	92.1%	100.0%

Table 4.79 shows the cross-tabulation of the institution from which the practitioner qualified against simplex treatment for 5 –9 Years olds.

c) 10-14 years old:

Cross-tabulation					
			Prescribe Simplex treatment (10 to 14 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	1	5	6
		% within institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Uni JHB	Count	5	17	22
		% within Institution at which you qualified as Homoeopath	22.7%	77.3%	100.0%
	Other	Count	0	8	8
		% within Institution at which you qualified as homoeopath	0%	100%	100%
Total		Count	6	30	36
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%

Table 4.80 shows the cross-tabulation of the institution from which the practitioner qualified against simplex treatment for 10 – 14 Years olds

d) 15-18 Year olds:

Crosstabulation					
			Prescribe Simplex treatment (15 to 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	1	5	6
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Uni JHB	Count	7	13	20
		% within Institution at which you qualified as Homoeopath	35.0%	65.0%	100.0%
	Other	Count	2	6	8
		% within Institution at which at you qualified as Homoeopath	25%	75%	100%
Total	Count		10	24	34
	% within Institution at which you qualified as Homoeopath		29.4%	70.6%	100.0%

Table 4.81 shows the cross-tabulation of the institution from which the practitioner qualified against simplex treatment for 15 – 18 years old.

e) Older than 18 years:

Crosstabulation					
			Prescribe Simplex treatment (older than 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	2	5	7
		% within Institution at which you qualified as Homoeopath	28.6%	71.4%	100.0%
	Uni JHB	Count	6	14	20
		% within Institution at which you qualified as Homoeopath	30.0%	70.0%	100.0%
	Other	Count	2	6	8
		% within Institution at which you qualified as homoeopath	25%	75%	100%
Total		Count	10	25	35
		% within Institution at which you qualified as Homoeopath	29.6%	70.4%	100.0%

Table 4.82 shows the cross-tabulation of the institution from which the practitioner qualified against simplex treatment for patients older than 18 years

No statistically significant association can be made between the Institution from which the practitioner qualified and how frequently simplex treatment was prescribed. However, it can be seen that the majority of practitioners prescribed a simplex at least once.

4.5.9.2 Complex

The test was conducted for each age group

a) Younger than 5 years old:

Cross-tabulation					
			Prescribe Complex treatment (younger than 5 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	3	3	6
		% within Institution at which you qualified as Homoeopath	50.0%	50.0%	100.0%
	Uni JHB	Count	8	13	21
		% within Institution at which you qualified as Homoeopath	38.1%	61.9%	100.0%
	Other	Count	5	3	8
		% within Institution at which you qualified as Homoeopath	62.5%	37.5%	100%
Total	Count		16	19	35
	% within institution Institution at which you qualified as Homoeopath		45.7%	54.3%	100.0%

Table 4.83 shows the cross-tabulation of the institution from which the practitioner qualified

against complex treatment for younger than 5 year olds.

b) 5-9 Year olds:

Cross-tabulation					
			Prescribe Complex treatment (5 to 9 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	5	3	8
		% within Institution at which you qualified as Homoeopath	62.5%	37.5%	100.0%
	Uni JHB	Count	3	18	21
		% within Institution at which you qualified as Homoeopath	14.3%	85.7%	100.0%
	Other	Count	4	4	8
			50%	50%	100%
Total		Count	12	25	37
		% within Institution at which you qualified as Homoeopath	32.4%	67.6%	100.0%

Table 4.84a shows the cross-tabulation of the institution from which the practitioners qualified against complex treatment for 5 – 9 year olds.

b) 5 – 9 year olds:

Crosstab					
			Prescribe Complex treatment (5 to 9 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	UNI JHB (Old TWR)	Count	3	18	21
		% within Institution at which you qualified as Homoeopath	14.3%	85.7%	100.0%
	Other (incl DIT)	Count	9	7	16
		% within Institution at which you qualified as Homoeopath	56.3%	43.8%	100.0%
Total	Count		12	25	37
	% within Institution at which you qualified as Homoeopath		32.4%	67.6%	100.0%

Table 4.84b Shows the cross-tabulation between the institution from which the practitioner qualified (Uni-Jhb vs other incl DIT) and complex treatment for 5-9 year olds

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.298(b)	1	.007		
Continuity Correction(a)	5.508	1	.019		
Likelihood Ratio	7.471	1	.006		
Fisher's Exact Test				.012	.009
Linear-by-Linear Association	7.100	1	.008		
N of Valid Cases	37				
a Computed only for a 2x2 table					
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.19.					

Table 4.84c Chi-square test for association between institution and complex treatment prescribed for 5-9 year olds.

The corrected value is 5.508, $p > 0.05$ and an associated significance of 0.007.

Therefore no statistically significant association can be made. However it can be seen that the homoeopaths trained at Uni-Jhb prescribed complexes more frequently.

c) 10-14 Years old:

Cross-tabulation					
			Prescribe Complex treatment (10 to 14 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	4	2	6
		% within Institution at which you qualified as Homoeopath	66.7%	33.3%	100.0%
	Uni JHB	Count	6	14	20
		% within Institution at which you qualified as Homoeopath	30.0%	70.0%	100.0%
	Other	Count	4	4	8
		% within Institution at which you qualified as Homoeopath	50%	50%	100%
Total		Count	14	20	34
		% within Institution at which you qualified as Homoeopath	41.1%	58.9%	100.0%

Table 4.85 shows the cross-tabulation of the institution from which the practitioners qualified against complex treatment for 10 – 14 year olds.

d) 15-18 Year olds:

Cross-tabulation					
			Prescribe Complex treatment (15 to 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	4	2	6
		% within Institution at which you qualified as Homoeopath	66.7%	33.3%	100.0%
	Uni JHB	Count	5	13	18
		% within Institution at which you qualified as Homoeopath	27.8%	72.2%	100.0%
	Other	Count	4	4	8
		% within Institution at which you qualified as Homoeopath	50%	50%	100%
Total	Count		13	19	32
	% within Institution at which you qualified as Homoeopath		40.6%	59.4%	100.0%

Table 4.86 shows the cross-tabulation of the institution from which the practitioners qualified against complex treatment for 15 – 18 year olds.

e) Older than 18 years:

Cross-tabulation					
			Prescribe Complex treatment (older than 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	5	2	7
		% within Institution at which you qualified as Homoeopath	71.4%	28.6%	100.0%
	Uni JHB	Count	7	11	18
		% within Institution at which you qualified as Homoeopath	38.9%	61.1%	100.0%
	Other	Count	5	3	8
		% within Institution at which you qualified as Homoeopath	62.5%	37.5%	100%
Total	Count		17	16	33
	% within Institution at which you qualified as Homoeopath		51.5%	48.5%	100.0%

Table 4.87 shows the cross-tabulation of the institution from which the practitioners qualified against complex treatment for patients older than 18 years.

There is no statistically significant association between the institution from which the practitioner qualified and complex treatment prescribed. However, it can be seen that the homoeopaths that most frequently prescribed complexes were from Uni-Jhb, most notable, 85% of practitioners from Uni-Jhb prescribed complexes for 5-9 year olds (table 4.84b & c).

4.5.9.3 Vitamins

The test was conducted for each age group

a) Younger than 5 years old:

Cross-tabulation					
			Prescribe vitamins (younger than 5 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	1	5	6
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Uni JHB	Count	5	15	20
		% within Institution at which you qualified as Homoeopath	25.0%	75.0%	100.0%
	Other	Count	1	7	8
		% within Institution at which you qualified as Homoeopath	12.5%	87.5%	100%
Total		Count	7	27	34
		% within Institution at which you qualified as Homoeopath	20.6%	79.4%	100.0%

Table 4.88 shows the cross-tabulation of the institution from which the practitioner qualified against vitamins prescribed for children younger than 5 Years old.

b) 5-9 Year olds:

Cross-tabulation				
			Prescribe vitamins (5 to 9 years)	Total
			at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	8	8
		% within Institution at which you qualified as Homoeopath	100.0%	100.0%
	Uni JHB	Count	21	21
		% within Institution at which you qualified as Homoeopath	100.0%	100.0%
	Other	Count	8	8
		% within Institution at which you qualified as Homoeopath	100%	100%
Total			Count	29
			% within Institution at which you qualified as Homoeopath	100.0%

Table 4.89 shows the cross-tabulation of the institution from which the practitioner qualified against vitamins prescribed for children 5 – 9 years old.

c) 10-14 Year olds:

Cross-tabulation					
			Prescribe vitamins (10 to 14 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	1	5	6
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Uni JHB	Count	2	18	20
		% within Institution at which you qualified as Homoeopath	10.0%	90.0%	100.0%
	Other	Count	1	7	8
		% within Institution at which you qualified as Homoeopath	12.5%	87.5%	100%
Total		Count	4	30	34
		% within Institution at which you qualified as Homoeopath	11.8%	88.2%	100.0%

Table 4.90 shows the cross-tabulation of the institution from which practitioners qualified against vitamins prescribed for 10 – 14 year olds.

d) 15-18 Year olds:

Cross-tabulation					
			Prescribe vitamins (15 to 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	1	5	6
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Uni JHB	Count	2	15	17
		% within Institution at which you qualified as Homoeopath	11.8%	88.2%	100.0%
	Other	Count	2	6	8
		% within Institution at which you qualified asHomoeopath	25%	75%	100%
Total		Count	5	26	31
		% within Institution at which you qualified as Homoeopath	16.1%	83.9%	100.0%

Table 4.91 shows the cross tabulation of the institution from which the practitioner qualified against vitamins prescribed for 15 – 18 year olds.

e) Older than 18 years::

Cross-tabulation					
			Prescribe vitamins (older than 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	2	5	7
		% within Institution at which you qualified as Homoeopath	28.6%	71.4%	100.0%
	Uni JHB	Count	2	16	18
		% within Institution at which you qualified as Homoeopath	11.1%	88.9%	100.0%
	Other	Count	2	6	8
		% within Institution at which you qualified as Homoeopath	25%	75%	100%
Total	Count		6	27	33
	% within Institution at which you qualified as Homoeopath		18.1%	81.9%	100.0%

Table 4.92 shows the cross-tabulation of the institution from which the practitioner qualified against vitamins prescribed for patients older than 18 years.

The majority (71.4% - 100%) of these practitioners prescribed vitamins at least once. All practitioners (regardless of where they were trained) prescribed vitamins to children aged 5-9 years old (table 4.89).

There is no statistically significant association between the institution from which the practitioner qualified and the prescribing of vitamins.

4.5.9.4 Dietary changes

The test was conducted for each age group

a) Younger than 5 Years old:

Cross-tabulation					
			Prescribe dietary changes (younger than 5 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	1	5	6
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Uni JHB	Count	6	14	20
		% within Institution at which you qualified as Homoeopath	30.0%	70.0%	100.0%
	Other	Count	1	7	8
		% within institution at which you qualified as Homoeopath	12.5%	87.5%	100%
Total	Count		7	19	26
	% within Institution at which you qualified as Homoeopath		26.9%	73.1%	100.0%

Table 4.93 shows the cross-tabulation of the institution from which the practitioner qualified against the dietary changes for children younger than 5 Years old:

b) 5-9 Year olds:

Cross-tabulation					
			Prescribe dietary changes (5 to 9 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	0	8	8
		% within Institution at which you qualified as Homoeopath	.0%	100.0%	100.0%
	Uni JHB	Count	1	20	21
		% within Institution at which you qualified as Homoeopath	4.8%	95.2%	100.0%
	Other	Count	0	8	8
		% within Institution at which you qualified as Homoeopath	0%	100%	100%
Total	Count		1	36	37
	% within Institution at which you qualified as Homoeopath		2.7%	97.3%	100.0%

Table 4.94 shows the cross-tabulation of the institution from which the practitioner qualified against the dietary changes for 5– 9 year olds.

c) 10-14 Year olds:

Cross-tabulation					
			Prescribe dietary changes (10 to 14 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	1	5	6
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Uni JHB	Count	3	17	20
		% Within Institution at which you qualified as Homoeopath	15.0%	85.0%	100.0%
	Other	Count	0	8	8
		% within Institution at which you qualified as Homoeopath	0%	100%	100%
Total	Count		4	30	34
	% within Institution at which you qualified as Homoeopath		11.8%	88.2%	100.0%

Table 4.95 shows the cross-tabulation of the institution from which the practitioner qualified against the dietary changes for 10– 14 Year olds.

d) 15-18 Year olds:

Cross-tabulation					
			Prescribe dietary changes (15 to 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	1	5	6
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Uni JHB	Count	3	14	17
		% within Institution at which you qualified as Homoeopath	17.6%	82.4%	100.0%
	Other	Count	3	5	8
		% within Institution at which you qualified as Homoeopath	37.5%	62.5%	100%
Total	Count		7	25	33
	% within Institution at which you qualified as Homoeopath		22.6%	77.4%	100.0%

Table 4.96 shows the cross-tabulation of the institution from which the practitioner qualified against the dietary changes for 15- 18 year olds.

e) Older than 18 years:

Cross-tabulation					
			Prescribe dietary changes (older than 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	2	5	7
		% within Institution at which you qualified as Homoeopath	28.6%	71.4%	100.0%
	Uni JHB	Count	3	15	18
		% within Institution at which you qualified as Homoeopath	16.7%	83.3%	100.0%
	Other	Count	3	5	8
		% within Institution at which you qualified as Homoeopath	37.5%	62.5%	100%
Total	Count		8	25	33
	% within Institution at which you qualified as Homoeopath		24.2%	75.8%	100.0%

Table 4.97 shows the cross-tabulation of the institution from which the practitioner qualified against the dietary changes for patients older than 18 years.

Dietary changes are prescribed the majority of practitioners (regardless of where they were trained), all the homoeopaths except one prescribed dietary changes to children 5-9 years old.

There is no statistically significant association between the institution from which the practitioner qualified and the prescribing of dietary changes.

4.5.9.5 Herbal Remedies

The test was conducted for each age group

a) Younger than 5 years old:

Cross-tabulation					
			Prescribe herbal remedies (younger than 5 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	3	3	6
		% within Institution at which you qualified as Homoeopath	50.0%	50.0%	100.0%
	Uni JHB	Count	9	11	20
		% within Institution at which you qualified as Homoeopath	45.0%	55.0%	100.0%
	Other	Count	4	4	8
		% within Institution at which you qualified as Homoeopath	50%	50%	100%
Total	Count		16	18	34
	% within Institution at which you qualified as Homoeopath		47.1%	52.9%	100.0%

Table 4.98 shows the cross-tabulation of the institution from which the practitioner qualified against herbal remedies prescribed for children younger than 5 Years.

b) 5-9 year olds:

Cross-tabulation					
			Prescribe herbal remedies (5 to 9 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	2	6	8
		% within Institution at which you qualified as Homoeopath	25.0%	75.0%	100.0%
	Uni JHB	Count	4	17	21
		% within Institution at which you qualified as Homoeopath	19.0%	81.0%	100.0%
	Other	Count	3	5	8
		% within Institution at which you qualified as Homoeopath	37.5%	62.5%	100%
Total	Count		9	28	37
	% within Institution at which you qualified as Homoeopath		24.3%	75.7%	100.0%

Table 4.99 shows the cross-tabulation of the institution from which the practitioner qualified against the herbal remedies prescribed for 5- 9 Year olds.

c) 10-14 year olds:

Cross-tabulation					
			Prescribe herbal remedies (10 to 14 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	3	3	6
		% within Institution at which you qualified as Homoeopath	50.0%	50.0%	100.0%
	Uni JHB	Count	6	14	20
		% within Institution at which you qualified as Homoeopath	30.0%	70.0%	100.0%
	Other	Count	3	5	8
		% within Institution at which you qualified as Homoeopath	37.5%	62.5%	100%
Total		Count	12	22	34
		% within Institution at which you qualified as Homoeopath	35.3%	64.7%	100.0%

Table 4.100 shows the cross-tabulation of the institution from which the practitioner qualified against herbal remedies prescribed for 10- 14 Year olds.

d) 15-18 year olds:

Cross-tabulation					
			Prescribe herbal remedies (15 to 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	3	3	6
		% within Institution at which you qualified as Homoeopath	50.0%	50.0%	100.0%
	Uni JHB	Count	5	12	17
		% within Institution at which you qualified as Homoeopath	29.4%	70.6%	100.0%
	Other	Count	3	5	8
		% within Institution at which you qualified as Homoeopath	37.5%	62.5%	100%
Total	Count		11	20	31
	% within Institution at which you qualified as Homoeopath		35.5%	64.5%	100.0%

Table 4.101 shows the cross-tabulation of the institution from which the practitioners qualified against herbal remedies prescribed for 15- 18 Years old.

e) Older than 18 years:

Cross-tabulation					
			Prescribe herbal remedies (older than 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	4	3	7
		% within Institution at which you qualified as Homoeopath	57.1%	42.9%	100.0%
	Uni JHB	Count	6	12	18
		% within Institution at which you qualified as Homoeopath	33.3%	66.7%	100.0%
	Other	Count	3	5	8
		% within Institution at which you qualified as Homoeopath	37.5%	62.5%	100%
Total	Count		13	20	33
	% within Institution at which you qualified as Homoeopath		39.4%	60.6%	100.0%

Table 4102 shows the cross-tabulation of the institution from which the practitioners qualified against herbal remedies prescribed for patients older than 18 years old.

There is no statistically significant association between the institution from which the practitioner qualified and prescribing of herbal remedies. Regardless of where they were trained, herbal remedies are prescribed more frequently than not. A higher percentage of practitioners trained at Uni-Jhb seem to prescribe herbal remedies more frequently.

4.5.9.6 Bach Flower Remedies

The test was conducted for each age group

a) Younger than 5 Years old:

Cross-tabulation					
			Prescribe Bach Flower remedies (younger than 5 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	3	3	6
		% within Institution at which you qualified as Homoeopath	50.0%	50.0%	100.0%
	Uni JHB	Count	12	8	20
		% within Institution at which you qualified as Homoeopath	60.0%	40.0%	100.0%
	Other	Count	4	3	7
		% within Institution at which you qualified as Homoeopath	57.1%	42.9%	100%
Total	Count		19	14	33
	% within Institution at which you qualified as Homoeopath		57.6%	42.4%	100.0%

Table 4.103 Shows the cross-tabulation of the institution from which the practitioners qualified against Bach remedies prescribed for children younger than 5 years old.

b) 5- 9 Years old:

Cross-tabulation					
			Prescribe Bach Flower remedies (5 to 9 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	2	6	8
		% within Institution at which you qualified as Homoeopath	25.0%	75.0%	100.0%
	Uni JHB	Count	13	8	21
		% within Institution at which you qualified as Homoeopath	61.9%	38.1%	100.0%
	Other	Count	4	3	7
		% within Institution at which you qualified as Homoeopath	57.1%	42.9%	100%
Total	Count		19	17	36
	% within Institution at which you qualified as Homoeopath		52.8%	47.2%	100.0%

Table 4.104 shows the cross-tabulation of the institution from which practitioners qualified against Bach flower remedies prescribed for 5 – 9 year olds.

c) 10- 14 Years old:

Cross-tabulation					
			Prescribe Bach Flower remedies (10 to 14 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	3	3	6
		% within Institution at which you qualified as Homoeopath	50.0%	50.0%	100.0%
	Uni JHB	Count	10	10	20
		% within Institution at which you qualified as Homoeopath	50.0%	50.0%	100.0%
	Other	Count	4	3	7
		% within Institution at which you qualified as Homoeopath	57.1%	42.9%	100%
Total	Count		17	16	33
	% within Institution at which you qualified as Homoeopath		51.5%	48.5%	100.0%

Table 4.105 shows the cross-tabulation of the institution from which practitioners qualified against Bach remedies prescribed for 10-14 year olds.

d) 15- 18 Years old:

Cross-tabulation					
			Prescribe Bach Flower remedies (15 to 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	3	3	6
		% within Institution at which you qualified as Homoeopath	50.0%	50.0%	100.0%
	Uni JHB	Count	10	7	17
		% within Institution at which you qualified as Homoeopath	58.8%	41.2%	100.0%
	Other	Count	5	3	8
		% within Institution at which you qualified as Homoeopath	62.5%	37.5%	100%
Total	Count		18	13	31
	% within Institution at which you qualified as Homoeopath		58.1%	41.9%	100.0%

Table 4.106 shows the cross-tabulation of the institution from which practitioners qualified against Bach remedies prescribed for 15-18 year olds.

e) Older than 18 years:

Cross-tabulation					
			Prescribe Bach Flower remedies (older than 18 years)		Total
			never	at least once	
Institution at which you qualified as Homoeopath	Durban Institute of Technology	Count	4	3	7
		% within Institution at which you qualified as Homoeopath	57.1%	42.9%	100.0%
	Uni JHB	Count	9	9	18
		% within Institution at which you qualified as Homoeopath	50.0%	50.0%	100.0%
	Other	Count	5	3	8
		% within Institution at which you qualified as Homoeopath	67.5%	32.5%	100%
Total	Count		18	15	33
	% within Institution at which you qualified as Homoeopath		54.5%	45.5%	100.0%

Table 4.107 shows the cross-tabulation of the institution from which practitioners qualified against Bach remedies prescribed for patients older than 18 years.

There is no statistically significant association between the institution from which the practitioner qualified and prescribing of Bach flower remedies.

Bach flower remedies seem to be most frequently prescribed by those homoeopaths trained at DIT.

4.5.10 Institution and Success Rate

The Pearson's Chi-squared test was used to test the relevant hypothesis (3.4.10).

This test was conducted for each age group

4.5.10.1 Younger than 5 year old: Cross-tabulation

			Patients under 5 years old		Total
			no to little success	moderate to very successful	
institution	UNI JHB (Old TWR)	Count	8	12	20
		% within institution	40.0%	60.0%	100.0%
	Other (incl DIT)	Count	1	12	13
		% within institution	7.7%	92.3%	100.0%
Total	Count		9	24	33
	% within institution		27.3%	72.7%	100.0%

Table 4.108a shows the cross-tabulation between the institution from which the practitioners qualified against the success rate of treatment of children younger than 5 years old.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.146(b)	1	.042		
Continuity Correction(a)	2.677	1	.102		
Likelihood Ratio	4.701	1	.030		
Fisher's Exact Test				.056	.047
Linear-by-Linear Association	4.021	1	.045		
N of Valid Cases	33				
a Computed only for a 2x2 table					
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.55.					

Table 4.108b Chi-square test for association between institution and success rate (< 5 years old).

Symmetric Measures			
		Value	Approx. Sig.
Nominal by Nominal	Phi	.354	.042
	Cramer's V	.354	.042
N of Valid Cases		33	
a Not assuming the null hypothesis.			
b Using the asymptotic standard error assuming the null hypothesis.			

Table 4.108c Effect size

The corrected value is 2.677 (with an associated significance of 0.102). As there is one cell with an expected count of less than 5, the Fisher's Exact is 0.056 > 0.05, < 0.01. There is no association between the two variables at a 5% level of significance, but if the level of significance were 10% then there would be moderate significance ($\Phi = 0.042$).

4.5.10.2 5 – 9 Year olds: Cross-tabulation

			5-9 year olds		Total
			no to little success	moderate to very successful	
institution	UNI JHB (Old TWR)	Count	2	19	21
		% within institution	9.5%	90.5%	100.0%
	Other (incl DIT)	Count	1	15	16
		% within institution	6.3%	93.8%	100.0%
Total		Count	3	34	37
		% within institution	8.1%	91.9%	100.0%

Table 4.109a Shows Cross-tabulation of the institution at which the practitioners qualified against success rate of treatment for 5-9 years old.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.131(b)	1	.718		
Continuity Correction(a)	.000	1	.715		
Likelihood Ratio	.134	1	.715		
Fisher's Exact Test				1.000	.604
Linear-by-Linear Association	.127	1	.721		
N of Valid Cases	37				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.30.					

Table 4.109b Chi-squared test for association between institution and success rate (5-9 years)

The corrected value is 0.000 (0.001). As there are two cells with an expected count less than 5, the Fisher's Exact is 1.000 ($p > 0.05$). Therefore there is no statistically significant association between these two variables.

4.5.10.3 10 - 14 Year olds: Cross-tabulation

			10-14 year olds		Total
			no to little success	moderate to very successful	
institution	UNI JHB (Old TWR)	Count	6	15	21
		% within institution	28.6%	71.4%	100.0%
	Other (incl DIT)	Count	3	11	14
		% within institution	21.4%	78.6%	100.0%
Total		Count	9	26	35
		% within institution	25.7%	74.3%	100.0%

Table 4.110a Shows the cross-tabulation of the institution at which the practitioners qualified against success rate of treatment for 10-14 year olds.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.224(b)	1	.636		
Continuity Correction(a)	.006	1	.937		
Likelihood Ratio	.228	1	.633		
Fisher's Exact Test				.712	.474
Linear-by-Linear Association	.218	1	.641		
N of Valid Cases	35				
a Computed only for a 2x2 table					
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.60.					

Table 4.110b Chi-square test for association between institution and success rate (10-14 years).

The corrected value is 0.006. As there is one cell with an expected count less than 5, the Fisher's Exact is 0.712 ($p > 0.05$). Therefore there is no statistically significant association between these two variables.

4.5.10.4 15 – 18 Year olds: Cross-tabulation

			15-18 years old		Total
			no to little success	moderate to very successful	
institution	UNI JHB (Old TWR)	Count	4	14	18
		% within institution	22.2%	77.8%	100.0%
	Other (incl DIT)	Count	2	10	12
		% within institution	16.7%	83.3%	100.0%
Total		Count	6	24	30
		% within institution	20.0%	80.0%	100.0%

Table 4.111a Shows the cross-tabulation of the institution from which the practitioners qualified against the success rate of treatment for 15-18 year olds.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.139(b)	1	.709		
Continuity Correction(a)	.000	1	1.000		
Likelihood Ratio	.141	1	.707		
Fisher's Exact Test				1.000	.545
Linear-by-Linear Association	.134	1	.714		
N of Valid Cases	30				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.40.					

Table 4.111b Chi-square test for association between institution and success rate (15-18 years)

The corrected value is 0.000 (0.001). The Fisher's Exact is 1.000 ($p > 0.05$). Therefore there is no statistically significant association between these two variables

4.5.10.5 18 Year and older: Cross-tabulation

			Older than 18 years		Total
			no to little success	moderate to very successful	
institution	UNI JHB (Old TWR)	Count	5	14	19
		% within institution	26.3%	73.7%	100.0%
	Other (incl DIT)	Count	3	10	13
		% within institution	23.1%	76.9%	100.0%
Total	Count		8	24	32
	% within institution		25.0%	75.0%	100.0%

Table 4.112a Shows the cross-tabulation of the institution from which practitioners qualified against the success rate of treatment for patients older than 18 years old.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.043(b)	1	.835		
Continuity Correction(a)	.000	1	1.000		
Likelihood Ratio	.043	1	.835		
Fisher's Exact Test				1.000	.587
Linear-by-Linear Association	.042	1	.838		
N of Valid Cases	32				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.25					

Table 4.112b Chi-square test for association between institution and success rate (>18 years).

The corrected value is >0.001. As there are two cells with an expected count less than 5, the Fisher's Exact is 1.000 ($p > 0.05$). Therefore there is no statistically significant association between these two variables.

No statistically significant association can be made between the institution and success rate of treatment. However, the majority of practitioners reported being moderately to very successful in treating ADD/ADHD in all age groups and practitioners that qualified from DIT and other institutions were significantly more successful in treating children younger than 5 years old.

4.5.11 Association between Number of years in practice and the number of patients seen.

The Pearson's Chi-squared test was used to test the relevant hypothesis (3.4.1.11).

			Total number of patients		Total
			0-10 patients	11 or more patients	
Years in practice	1 - 5 years	Count	13	11	24
		% within years in practice	54.2%	45.8%	100.0%
	6 or more years	Count	6	11	17
		% within years in practice	35.3%	64.7%	100.0%
Total		Count	19	22	41
		% within years in practice	46.3%	53.7%	100.0%

Table 4.113a shows the cross-tabulation of the number of years the homoeopaths have been in practice against the number of patients with ADD/ADHD seen in the last 12 months.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.425(b)	1	.233		
Continuity Correction(a)	.767	1	.381		
Likelihood Ratio	1.440	1	.230		
Fisher's Exact Test				.342	.191
Linear-by-Linear Association	1.391	1	.238		
N of Valid Cases	41				
a Computed only for a 2x2 table					
b 0 cells (50.0%) have expected count less than 5. The minimum expected count is 7.88.					

Table 4.113b Chi-square test for association between the number of years in practice against the number of patients seen in the last 12 months.

The corrected value is 0.767 (with an associated significance of 0.381) $p > 0.05$, therefore there is no statistically significant association between the number of years in practice and the number of patients seen in the last 12 months.

4.5.12 Association between the number of years in practice and Treatment

The Pearson's Chi-squared test was used to test the relevant hypothesis (3.4.1.12). The Chi-square test tables have not been included if there was no significant result.

4.5.12.1 Simplex

The test was conducted for each age group

a) Younger than 5 years old:

			Prescribe Simplex treatment (younger than 5 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	9	11	20
		Expected Count	6.7	13.3	20.0
		% within Years in Homoeopathic practice	45.0%	55.0%	100.0%
	6 or more years	Count	3	13	16
		Expected Count	5.3	10.7	16.0
		% within Years in Homoeopathic practice	18.8%	81.3%	100.0%
Total		Count	12	24	36
		Expected Count	12.0	24.0	36.0
		% within Years in Homoeopathic practice	33.3%	66.7%	100.0%

Table 4.114 shows the cross-tabulation of the number of years in practice against simplex treatment for children younger than 5 years old

b) 5-9 year olds:

			Prescribe Simplex treatment (5 to 9 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	2	21	23
		Expected Count	1.8	21.2	23.0
		% within Years in Homoeopathic practice	8.7%	91.3%	100.0%
	6 or more years	Count	1	14	15
		Expected Count	1.2	13.8	15.0
		% within Years in Homoeopathic practice	6.7%	93.3%	100.0%
Total		Count	3	35	38
		Expected Count	3.0	35.0	38.0
		% within Years in Homoeopathic practice	7.9%	92.1%	100.0%

Table 4.115 shows the cross-tabulation of the number of years in practice against simplex treatment for 5-9 year olds.

c) 10-14 Year olds:

			Prescribe Simplex treatment (10 to 14 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	6	14	20
		Expected Count	3.3	16.7	20.0
		% within Years in Homoeopathic practice	30.0%	70.0%	100.0%
	6 or more years	Count	0	16	16
		Expected Count	2.7	13.3	16.0
		% within Years in Homoeopathic practice	.0%	100.0%	100.0%
Total	Count		6	30	36
	Expected Count		6.0	30.0	36.0
	% within Years in Homoeopathic practice		16.7%	83.3%	100.0%

Table 4.116a shows the cross-tabulation for the number of years in practice against simplex treatment for 10-14 year olds.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.760(b)	1	.016		
Continuity Correction(a)	3.803	1	.051		
Likelihood Ratio	8.006	1	.005		
Fisher's Exact Test				.024	.020
Linear-by-Linear Association	5.600	1	.018		
N of Valid Cases	36				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.67.					

Table 4.116b Chi-square test for association between the number of years in practice and simplex treatment (10-14 years)

Symmetric Measures			
		Value	Approx. Sig.
Nominal by Nominal	Phi	.400	.016
	Cramer's V	.400	.016
N of Valid Cases		36	
a Not assuming the null hypothesis.			
b Using the asymptotic standard error assuming the null hypothesis.			

Table 4.116c Effect size

The corrected value is 3.803. As two cells have an expected count of less than 5, the Fisher's Exact is 0.024 which is < 0.05 therefore there is a statistically significant association between the number of years practiced and simplex treatment for 10-14 year olds. The effect size (Φ) is 0.4 which indicates a moderate practical significance (effect).

d) **15-18 year olds:**

Cross tabulation					
			Prescribe Simplex treatment (15 to 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	9	10	19
		Expected Count	5.6	13.4	19.0
		% within Years in Homoeopathic practice	47.4%	52.6%	100.0%
	6 or more years	Count	1	14	15
		Expected Count	4.4	10.6	15.0
		% within Years in Homoeopathic practice	6.7%	93.3%	100.0%
Total		Count	10	24	34
		Expected Count	10.0	24.0	34.0
		% within Years in Homoeopathic practice	29.4%	70.6%	100.0%

Table 4.117a shows the cross-tabulation for the number of years in practice against simplex treatment for 15 – 18 year olds

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.689(b)	1	.010		
Continuity Correction(a)	4.872	1	.027		
Likelihood Ratio	7.559	1	.006		
Fisher's Exact Test				.020	.011
Linear-by-Linear Association	6.492	1	.011		
N of Valid Cases	34				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.41.

Table 4.117b Chi-square test for association between the number of years in practice and simplex treatment (15-18 years)

Symmetric Measures			
		Value	Approx. Sig.
Nominal by Nominal	Phi	.444	.010
	Cramer's V	.444	.010
N of Valid Cases		34	
a Not assuming the null hypothesis.			
b Using the asymptotic standard error assuming the null hypothesis.			

Table 4.117c Effect size

The corrected value is 4.872. As there is one cell with an expected count of less than 5, the Fisher's Exact is 0.020 ($p < 0.05$) therefore there is a statistically significant association between the number of years in practice and prescribing simplex treatment for 15-18 year olds. The effect size (Φ) is 0.444 which indicates a moderate practical significance (effect).

e) Older than 18 years old:

Cross tabulation					
			Prescribe Simplex treatment (older than 18 years)		Total
			1never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	9	11	20
		Expected Count	5.7	14.3	20.0
		% within Years in Homoeopathic practice	45.0%	55.0%	100.0%
	6 or more years	Count	1	14	15
		Expected Count	4.3	10.7	15.0
		% within Years in Homoeopathic practice	6.7%	93.3%	100.0%
Total		Count	10	25	35
		Expected Count	10.0	25.0	35.0
		% within Years in Homoeopathic practice	28.6%	71.4%	100.0%

Table 4.118a shows the cross-tabulation for the number of years in practice against simplex treatment for patients older than 18 years.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.172(b)	1	.013		
Continuity Correction(a)	4.436	1	.035		
Likelihood Ratio	7.005	1	.008		
Fisher's Exact Test				.022	.015
Linear-by-Linear Association	5.995	1	.014		
N of Valid Cases	35				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.29.

Table 4.118b Chi-square test for association between the number of years in practice and simplex treatment (>18 years)

Symmetric Measures			
		Value	Approx. Sig.
Nominal by Nominal	Phi	.420	.013
	Cramer's V	.420	.013
N of Valid Cases		35	
a Not assuming the null hypothesis.			
b Using the asymptotic standard error assuming the null hypothesis.			

Table 4.118c Effect size

As there is one cell with an expected count of less than 5, the Fisher's Exact is 0.022 ($p < 0.05$), therefore there is a statistically significant association between the number of years in practice and prescribing simplex treatment for patients older than 18 years old. The effect size (Φ) is 0.420, which indicates a moderate practical significance (effect).

The association between the number of years practiced and prescribing of simplexes is moderately significant for the following age groups: 10-14 years old, 15-18 years old and patients older than 18 years old. The more experience a practitioner has, the more frequently they prescribe simplexes.

4.5.12.2 Complex Treatment

The test was conducted for each age group

a) Under 5 years old:

Cross-tabulation					
			Prescribe Complex treatment (younger than 5 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	10	9	19
		% within Years in Homoeopathic practice	52.6%	47.4%	100.0%
	6 or more years	Count	6	10	16
		% within Years in Homoeopathic practice	37.5%	62.5%	100.0%
Total	Count		16	19	35
	% within Years in Homoeopathic practice		45.7%	54.3%	100.0%

Table 4.119 shows the cross-tabulation of the number of years in practice against complex treatment for children younger than 5 years old.

b) 5-9 Years old:

Cross-tabulation					
			Prescribe Complex treatment (5 to 9 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	8	14	22
		% within Years in Homoeopathic practice	36.4%	63.6%	100.0%
	6 or more years	Count	4	11	15
		% within Years in Homoeopathic practice	26.7%	73.3%	100.0%
Total		Count	12	25	37
		% within Years in Homoeopathic practice	32.4%	67.6%	100.0%

Table 4.120 shows the cross-tabulation of the number of years in practice against complex treatment for 5-9 year olds.

c) 10-14 Year olds:

Cross-tabulation					
			Prescribe Complex treatment (10 to 14 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	9	9	18
		% within Years in Homoeopathic practice	50.0%	50.0%	100.0%
	6 or more years	Count	5	11	16
		% within Years in Homoeopathic practice	31.3%	68.8%	100.0%
Total		Count	14	20	34
		% within Years in Homoeopathic practice	41.2%	58.8%	100.0%

Table 4.121 shows the cross-tabulation for the number of years in practice against complex treatment for 10-14 year olds.

d) 15-18 Year olds:

Cross tabulation					
			Prescribe Complex treatment (15 to 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	8	9	17
		% within Years in Homoeopathic practice	47.1%	52.9%	100.0%
	6 or more years	Count	5	10	15
		% within Years in Homoeopathic practice	33.3%	66.7%	100.0%
Total		Count	13	19	32
		% within Years in Homoeopathic practice	40.6%	59.4%	100.0%

Table 4.122 shows the cross-tabulation of the number of years in practice against complex treatment for 15-18 year olds.

e) Older than 18 years

Cross tabulation					
			Prescribe Complex treatment (older than 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	11	7	18
		% within Years in Homoeopathic practice	61.1%	38.9%	100.0%
	6 or more years	Count	6	9	15
		% within Years in Homoeopathic practice	40.0%	60.0%	100.0%
Total		Count	17	16	33
		% within Years in Homoeopathic practice	51.5%	48.5%	100.0%

Table 4.123 shows the cross-tabulation of the number of years in practice against complex treatment for patients older than 18 years old.

No statistically significant association can be made between the number of years in practice and the prescribing of complexes.

4.5.12.3 Vitamins

The test was conducted for each age group

a) Under 5 years old:

Cross tabulation					
			Prescribe vitamins (younger than 5 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	6	13	19
		% within Years in Homoeopathic practice	31.6%	68.4%	100.0%
	6 or more years	Count	1	14	15
		% within Years in Homoeopathic practice	6.7%	93.3%	100.0%
Total		Count	7	27	34
		% within Years in Homoeopathic practice	20.6%	79.4%	100.0%

Table 4.124 shows the cross-tabulation of the number of years in practice against vitamins prescribed for children younger than 5 years old.

b) 5-9 Years old:

Cross-tabulation				
			Prescribe vitamins (5 to 9 years)	Total
			at least once	
Years in Homoeopathic practice	1 - 5 years	Count	23	23
		% within Years in Homoeopathic practice	100.0%	100.0%
	6 or more years	Count	14	14
		% within Years in Homoeopathic practice	100.0%	100.0%
Total		Count	37	37
		% within Years in Homoeopathic practice	100.0%	10

Table 4.125 shows the cross-tabulation of the number of years in practice against vitamins prescribed for 5-9 year olds.

There is no statistically significant association for this age group, but it can be noted that all practitioners regardless of how many years in practice they had, prescribed vitamins at least once to 5-9 year olds.

c) 10-14 Years old:

Cross-tabulation					
			Prescribe vitamins (10 to 14 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	4	14	18
		% within Years in Homoeopathic practice	22.2%	77.8%	100.0%
	6 or more years	Count	0	16	16
		% within Years in Homoeopathic practice	.0%	100.0%	100.0%
Total		Count	4	30	34
		% within Years in Homoeopathic practice	11.8%	88.2%	100.0%

Table 4.126 shows the cross-tabulation of the number of years in practice against vitamins prescribed for 10-14 year olds.

d) 15-18 Years old:

Cross-tabulation					
			Prescribe vitamins (15 to 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	5	12	17
		% within Years in Homoeopathic practice	29.4%	70.6%	100.0%
	6 or more years	Count	0	14	14
		% within Years in Homoeopathic practice	.0%	100.0%	100.0%
Total		Count	5	26	31
		% within Years in Homoeopathic practice	16.1%	83.9%	100.0%

Table 4.127a shows the cross-tabulation of the number of years in practice against vitamins prescribed for 15-18 year olds.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.910(b)	1	.027		
Continuity Correction(a)	2.976	1	.085		
Likelihood Ratio	6.795	1	.009		
Fisher's Exact Test				.048	.036
Linear-by-Linear Association	4.751	1	.029		
N of Valid Cases	31				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.26.					

Table 4.127b Chi-square test for association between the number of years in practice and vitamins prescribed (15-18 years)

Symmetric Measures			
		Value	Approx. Sig.
Nominal by Nominal	Phi	.398	.027
	Cramer's V	.398	.027
N of Valid Cases		31	
a Not assuming the null hypothesis.			
b Using the asymptotic standard error assuming the null hypothesis.			

Table 4.127c Effect size

As there are two cells with an expected count of less than 5, the Fisher's Exact is 0.048 ($p < 0.05$), therefore there is a statistically significant association between the number of years in practice and vitamins prescribed for 15-18 year olds. The effect size (Φ) is 0.398 which indicates a moderate practical significance (effect).

e) Older than 18 years old:

Cross-tabulation					
			Prescribe vitamins (older than 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	5	13	18
		% within Years in Homoeopathic practice	27.8%	72.2%	100.0%
	6 or more years	Count	1	14	15
		% within Years in Homoeopathic practice	6.7%	93.3%	100.0%
Total		Count	6	27	33
		% within Years in Homoeopathic practice	18.2%	81.8%	100.0

Table 4.128 shows the cross-tabulation of the number of years in practice against vitamins prescribed for patients older than 18 years.

Table 4.125 shows that all practitioners regardless of how much experience they had, prescribed vitamins at least once to children 5-9 years old.

Tables 4.127 a, b and c shows a statistically significant result.

4.5.12.4 Dietary Changes

The test was conducted for each age group

a) Under 5 Years old

Cross-tabulation					
			Prescribe dietary changes (younger than 5 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	7	12	19
		% within Years in Homoeopathic practice	36.8%	63.2%	100.0%
	6 or more years	Count	1	14	15
		% within Years in Homoeopathic practice	6.7%	93.3%	100.0%
Total		Count	8	26	34
		% within Years in Homoeopathic practice	23.5%	76.5%	100.0%

Table 4.129a shows the cross-tabulation of the number of years in practice against dietary changes for children younger than 5 years old.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2- sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)
Pearson Chi-Square	4.242(b)	1	.039		
Continuity Correction(a)	2.731	1	.098		
Likelihood Ratio	4.744	1	.029		
Fisher's Exact Test				.053	.046
Linear-by-Linear Association	4.117	1	.042		
N of Valid Cases	34				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.53.					

Table 4.129b Chi-square test for association between the number of years in practice and dietary changes

Symmetric Measures			
		Value	Approx. Sig.
Nominal by Nominal	Phi	.353	.039
	Cramer's V	.353	.039
N of Valid Cases		34	
a Not assuming the null hypothesis.			
b Using the asymptotic standard error assuming the null hypothesis.			

Table 4.129c Effect size

The corrected value is 2.731. As there are two cells with an expected count of less than 5, the Fisher's Exact is 0.053 ($p > 0.05$). Therefore no statistically significant result at 5% significance level, however if the level of significance had been 10% there would have been a statistically significant association.

b) 5-9 Years old:

Cross-tabulation					
			Prescribe dietary changes (5 to 9 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	1	22	23
		% within Years in Homoeopathic practice	4.3%	95.7%	100.0%
	6 or more years	Count	0	14	14
		% within Years in Homoeopathic practice	.0%	100.0%	100.0%
Total		Count	1	36	37
		% within Years in Homoeopathic practice	2.7%	97.3%	100.0%

Table 4.130 shows the cross-tabulation for the number of years in practice against dietary changes for 5-9 year olds.

c) 10-14 Years old:

Cross-tabulation					
			Prescribe dietary changes (10 to 14 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	4	14	18
		% within Years in Homoeopathic practice	22.2%	77.8%	100.0%
	6 or more years	Count	0	16	16
		% within Years in Homoeopathic practice	.0%	100.0%	100.0%
Total		Count	4	30	34
		% within Years in Homoeopathic practice	11.8%	88.2%	100.0%

Table 4.131 shows the cross-tabulation of the number of years in practice against dietary changes for 10-14 year olds.

d) 15-18 Years old:

Cross-tabulation					
			Prescribe dietary changes (15 to 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	6	11	17
		% within Years in Homoeopathic practice	35.3%	64.7%	100.0%
	6 or more years	Count	1	13	14
		% within Years in Homoeopathic practice	7.1%	92.9%	100.0%
Total		Count	7	24	31
		% within Years in Homoeopathic practice	22.6%	77.4%	100.0%

Table 4.132 shows the cross-tabulation of the number of years in practice against dietary changes for 15-18 year olds.

e) Older than 18 years old:

Crosstab					
			Prescribe dietary changes (older than 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	6	12	18
		% within Years in Homoeopathic practice	33.3%	66.7%	100.0%
	6 or more years	Count	2	13	15
		% within Years in Homoeopathic practice	13.3%	86.7%	100.0%
Total		Count	8	25	33
		% within Years in Homoeopathic practice	24.2%	75.8%	100.0%

Table 4.133 shows the cross-tabulation of the number of years in practice against dietary changes for patients older than 18 years

There is no statistically significant association between the number of years in practice and the prescribing of dietary changes.

4.5.12.5 Herbal Remedies

The test was conducted on each age group

a) Younger than 5 years old:

Cross-tabulation					
			Prescribe herbal remedies (younger than 5 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	11	8	19
		% within Years in Homoeopathic practice	57.9%	42.1%	100.0%
	6 or more years	Count	5	10	15
		% within Years in Homoeopathic practice	33.3%	66.7%	100.0%
Total		Count	16	18	34
		% within Years in Homoeopathic practice	47.1%	52.9%	100.0%

Table 4.134 shows the cross-tabulation of the number of year in practice against the herbal remedies prescribed for children younger than 5 years old

b) 5-9 Years old:

			Prescribe herbal remedies (5 to 9 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	6	17	23
		% within Years in Homoeopathic practice	26.1%	73.9%	100.0%
	6 or more years	Count	3	11	14
		% within Years in Homoeopathic practice	21.4%	78.6%	100.0%
Total		Count	9	28	37
		% within Years in Homoeopathic practice	24.3%	75.7%	100.0%

Table 4.135 shows the cross-tabulation of the number of years in practice against the herbal remedies prescribed for 5-9 year olds.

c) 10-14 Years old:

Cross-tabulation					
			Prescribe herbal remedies (10 to 14 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	8	10	18
		% within Years in Homoeopathic practice	44.4%	55.6%	100.0%
	6 or more years	Count	4	12	16
		% within Years in Homoeopathic practice	25.0%	75.0%	100.0%
Total		Count	12	22	34
		% within Years in Homoeopathic practice	35.3%	64.7%	100.0%

Table 4.136 shows the cross-tabulation of the number of years in practice against the herbal remedies prescribed for 10-14 year olds.

d) 15-18 Years old:

Cross-tabulation					
			Prescribe herbal remedies (15 to 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	8	9	17
		% within Years in Homoeopathic practice	47.1%	52.9%	100.0%
	6 or more years	Count	3	11	14
		% within Years in Homoeopathic practice	21.4%	78.6%	100.0%
Total		Count	11	20	31
		% within Years in Homoeopathic practice	35.5%	64.5%	100.0%

Table 4.137 shows the cross-tabulation of the number of years in practice against the herbal remedies prescribed for 15-18 year olds.

e) Older than 18 years old:

Cross-tabulation					
			Prescribe herbal remedies (older than 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	8	10	18
		% within Years in Homoeopathic practice	44.4%	55.6%	100.0%
	6 or more years	Count	5	10	15
		% within Years in Homoeopathic practice	33.3%	66.7%	100.0%
Total		Count	13	20	33
		% within Years in Homoeopathic practice	39.4%	60.6%	100.0%

Table 4.138 shows the cross-tabulation of the number of years in practice against the herbal remedies prescribed for patients older than 18 years.

There is no statistically significant association between the number of years in practice and the prescribing of herbal remedies.

4.5.12.6 Bach Flower Remedies

The test was conducted for each age group

a) Younger than 5 years old:

Cross-tabulation					
			Prescribe Bach Flower remedies (younger than 5 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	11	7	18
		% within Years in Homoeopathic practice	61.1%	38.9%	100.0%
	6 or more years	Count	8	7	15
		% within Years in Homoeopathic practice	53.3%	46.7%	100.0%
Total		Count	19	14	33
		% within Years in Homoeopathic practice	57.6%	42.4%	100.0%

Table 4.139 shows the cross-tabulation of the number of years in practice against the Bach remedies prescribed for children younger than 5 years old

b) 5-9 Years old:

Cross-tabulation					
			Prescribe Bach Flower remedies (5 to 9 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	12	10	22
		% within Years in Homoeopathic practice	54.5%	45.5%	100.0%
	6 or more years	Count	7	7	14
		% within Years in Homoeopathic practice	50.0%	50.0%	100.0%
Total		Count	19	17	36
		% within Years in Homoeopathic practice	52.8%	47.2%	100.0%

Table 4140 shows the cross-tabulation of the number of years in practice against Bach remedies prescribed for 5-9 year olds.

c) 10-14 Years old:

Cross-tabulation					
			Prescribe Bach Flower remedies (10 to 14 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	10	7	17
		% within Years in Homoeopathic practice	58.8%	41.2%	100.0%
	6 or more years	Count	7	9	16
		% within Years in Homoeopathic practice	43.8%	56.3%	100.0%
Total		Count	17	16	33
		% within Years in Homoeopathic practice	51.5%	48.5%	100.0%

Table 4.141 shows the cross-tabulation of the number of years in practice against Bach remedies prescribed for 10-14 year olds.

d) 15-18 Year olds:

Cross-tabulation					
			Prescribe Bach Flower remedies (15 to 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	11	6	17
		% within Years in Homoeopathic practice	64.7%	35.3%	100.0%
	6 or more years	Count	7	7	14
		% within Years in Homoeopathic practice	50.0%	50.0%	100.0%
Total		Count	18	13	31
		% within Years in Homoeopathic practice	58.1%	41.9%	100.0%

Table 4.142 shows the cross-tabulation of the number of years in practice against Bach remedies for 15-18 year olds.

e) Older than 18 years old:

Cross-tabulation					
			Prescribe Bach Flower remedies (older than 18 years)		Total
			never	at least once	
Years in Homoeopathic practice	1 - 5 years	Count	11	7	18
		% within Years in Homoeopathic practice	61.1%	38.9%	100.0%
	6 or more years	Count	7	8	15
		% within Years in Homoeopathic practice	46.7%	53.3%	100.0%
Total		Count	18	15	33
		% within Years in Homoeopathic practice	54.5%	45.5%	100.0%

Table 4.143 shows the cross-tabulation of the number of years in practice against Bach remedies for patients older than 18 years old.

There is no statistically significant association between the number of years in practice and the prescribing of Bach remedies.

4.5.13 Association between the Number of years in practice and Success Rate

The Pearson's Chi-square test was used to test the relevant hypothesis (3.4.1.13).

The test was conducted for each age group.

4.5.13.1 Younger than 5 Years old:

Cross-tabulation					
			Younger than 5 years		Total
			no to little success	moderate to very successful	
Years in practice	1 - 5 years	Count	8	10	18
		% within years in practice	44.4%	55.6%	100.0%
	6 or more years	Count	1	14	15
		% within years in practice	6.7%	93.3%	100.0%
Total		Count	9	24	33
		% within years in practice	27.3%	72.7%	100.0%

Table 4.144a shows the cross-tabulation of the number of years in practice against success rate of treatment of children younger than 5 years old.

Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.887(b)	1	.015		
Continuity Correction(a)	4.136	1	.042		
Likelihood Ratio	6.594	1	.010		
Fisher's Exact Test				.021	.018
Linear-by-Linear Association	5.709	1	.017		
N of Valid Cases	33				
a Computed only for a 2x2 table					
b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 4.09.					

Table 4.144b Chi square test for association between the number of years in practice and success rate (< 5 years)

Symmetric Measures			
		Value	Approx. Sig.
Nominal by Nominal	Phi	.422	.015
	Cramer's V	.422	.015
N of Valid Cases		33	
a Not assuming the null hypothesis.			
b Using the asymptotic standard error assuming the null hypothesis.			

Table 4.144c Effect size

The corrected value is 4.136. As there are two cells with an expected count of less than 5, the Fisher's exact is 0.021 ($p < 0.05$), therefore there is a statistically significant association between the number of years in practice and the success rate in treating children < 5 years. The Effect size (Φ) is 0.4 which indicates a moderate practical significance (effect).

4.5.13.2 5-9 Years old:

Cross-tabulation					
			5-9 Year olds		Total
			no to little success	moderate to very successful	
Years in practice	1 - 5 years	Count	2	21	23
		% within years in practice	8.7%	91.3%	100.0%
	6 or more years	Count	1	13	14
		% within years in practice	7.1%	92.9%	100.0%
Total		Count	3	34	37
		% within years in practice	8.1%	91.9%	100.0%

Table 4.145 shows the cross-tabulation of the number of years in practice against the success rate of treating children 5 and 9 years old.

4.5.13.3 10-14 Years old:

Cross-tabulation					
			10-14 year olds		Total
			no to little success	moderate to very successful	
Years in practice	1 - 5 years	Count	6	13	19
		% within years in practice	31.6%	68.4%	100.0%
	6 or more years	Count	3	13	16
		% within years in practice	18.8%	81.3%	100.0%
Total		Count	9	26	35
		% within years in practice	25.7%	74.3%	100.0%

Table 4.146 shows the cross-tabulation of the number of years in practice against the success rate of treating children 10 and 14 years old.

4.5.13.4 15-18 Years old:

Cross-tabulation					
			15-18 Year olds		Total
			no to little success	moderate to very successful	
Years in practice	1 - 5 years	Count	5	11	16
		% within years in practice	31.3%	68.8%	100.0%
	6 or more years	Count	1	13	14
		% within years in practice	7.1%	92.9%	100.0%
Total		Count	6	24	30
		% within years in practice	20.0%	80.0%	100.0%

Table 4.147 Shows the cross tabulation of the number of years in practice against the success rate of treating 15-18 years old.

4.5.13.5 Older than 18 years old:

Cross-tabulation					
			18 years and older		Total
			no to little success	moderate to very successful	
Years in practice	1 - 5 years	Count	6	11	17
		% within years in practice	35.3%	64.7%	100.0%
	6 or more years	Count	2	13	15
		% within years in practice	13.3%	86.7%	100.0%
Total		Count	8	24	32
		% within years in practice	25.0%	75.0%	100.0%

Table 4.148 shows the cross-tabulation of the number of years in practice against the success rate of treating patients older than 18 years.

There is a statistically significant association between the number of years in practice and success rate in children < 5 years but no statistically significant association between the number of years in practice and success rate in the other age group.

4.5.14 Association between Location and Number of Patients

The Pearson's Chi-square test was used to test the relevant hypothesis (3.4.1.14).

Cross-tabulation					
			Total number of patients		Total
			0-10 patients	11 or more patients	
location	Sandton/Randburg	Count	7	13	20
		% within location	35.0%	65.0%	100.0%
		% within total number of patients	36.8%	59.1%	48.8%
	Midrand/Diepsloot	Count	3	0	3
		% within location	100.0%	.0%	100.0%
		% within total number of patients	15.8%	.0%	7.3%
	Roodepoort/Florida	Count	2	1	3
		% within location	66.7%	33.3%	100.0%
		% within total number of patients	10.5%	4.5%	7.3%
	Johannesburg East	Count	0	3	3
		% within location	.0%	100.0%	100.0%
		% within total number of patients	.0%	13.6%	7.3%
	Northcliff/Rosebank	Count	5	4	9
		% within location	55.6%	44.4%	100.0%
		% within total number of patients	26.3%	18.2%	22.0%
	Edenvale/Kempton Park	Count	2	1	3
		% within location	66.7%	33.3%	100.0%
		% within total number of patients	10.5%	4.5%	7.3%
Total	Count		19	22	41
	% within location		46.3%	53.7%	100.0%
	% within total number of patients		100.0%	100.0%	100.0%

Table 4.149 shows the cross-tabulation of area/location of the practitioner's practice against the number of patients with ADD/ADHD, seen in the last 12 months.

There is no statistically significant association between the location/area of practice and number of patients seen in the past 12 months. However, it can be seen that the majority of patients were seen in the Sandton/Randburg area.

4.5.15 Association between Location and Type of Practice

The Pearson's Chi-square test was used to test the relevant hypothesis (3.4.1.15).

Cross-tabulation							
			Type of practice				Total
			Sole Homoeopathic practice	Sole Multi-disciplinary practice	Group Homoeopathic practice	Group Multi-disciplinary practice	
Location/area	Sandton/ Randburg	Count	7	5	1	7	20
		% within location	35.0%	25.0%	5.0%	35.0%	100.0%
		% within type of practice	41.2%	50.0%	33.3%	63.6%	48.8%
	Midrand/ Diepsloot	Count	1	1	0	1	3
		% within location	33.3%	33.3%	.0%	33.3%	100.0%
		% within type of practice	5.9%	10.0%	.0%	9.1%	7.3%
	Roode-poort/ Florida	Count	3	0	0	0	3
		% within location	100.0%	.0%	.0%	.0%	100.0%
		% within type of practice	17.6%	.0%	.0%	.0%	7.3%
	Jhb East	Count	0	2	0	1	3
		% within location	.0%	66.7%	.0%	33.3%	100.0%
		% within type of practice	.0%	20.0%	.0%	9.1%	7.3%
	Northcliff/ Rosebank	Count	5	2	0	2	9
		% within location	55.6%	22.2%	.0%	22.2%	100.0%
		% within type of practice	29.4%	20.0%	.0%	18.2%	22.0%
	Edenvale/ Kempton Park	Count	1	0	2	0	3
		% within location	33.3%	.0%	66.7%	.0%	100.0%
		% within type of practice	5.9%	.0%	66.7%	.0%	7.3%
Total	Count		17	10	3	11	41
	% within location		41.5%	24.4%	7.3%	26.8%	100.0%
	% within type of practice		100.0%	100.0%	100.0%	100.0%	100.0%

Table 4.150 shows the cross-tabulation of area/location of the practitioner's practice against the type of practice.

There is no statistically significant association between the two variables. However, by visual analysis the predominant type of practice is a sole homoeopathic practice (41.5%).

CHAPTER 5

5. DISCUSSION

5.1 Introduction

As was the case with Verhoogt's research (2003), the initial challenge of the research survey was in contacting participants and encouraging them to participate in the research. Seventy-two homoeopaths are registered with the Allied Health Professions Council of South Africa within the selected geographic area according to the list supplied by the council on the 5th May 2005. This list was incomplete and not up to date as there were homoeopaths that the researcher was aware of (who were registered with the council) whose names did not reflect on the list supplied, there were also practitioners listed that had moved out of the area or had stopped practising. A total of 98 practitioners were contacted. 63 practitioners initially agreed to participate and the questionnaires were sent to these practitioners. Of the 63, only 41 completed the questionnaire and form the study sample (n=41), i.e. an overall response rate of 42%. Two of the 41 practitioners had not treated any ADD/ADHD patients but did however agree to complete Section A (demographics) and Section C (open ended questions relating to ADD/ADHD). This is a fairly good response rate as compared to Maharajh (2005), whose response rate of General practitioners and pharmacists was only 32.2%. In this survey the improved response rate was due to the personalized delivery, collection and interview as opposed to postal delivery, which Maharjkh proved to an ineffective method of acquiring responses. There was a seemingly high drop out rate (22 practitioners), which made the

response rate lower than it could have been. Although initially thought that 41 practitioners was a sufficient sample, the resulting number of non statistically significant results could be due to there not being enough respondents.

The following reasons were given for non-participation: retired; died; maternity leave, not practicing, moved out of the Johannesburg metropolitan area, did not have enough experience or did not have patients with ADD/ADHD.

Some of those who initially agreed to participate but did not / were not able to complete the questionnaire said they were “just too busy” or they did not complete the questionnaire in the time frame given, despite an extension of time being allowed. Retired practitioners and those registered but not practicing were excluded from the study, as were those practitioners who had moved out of the Johannesburg metropolitan area. Homoeopaths from Johannesburg South were not included in this study as most of them could not be contacted, two did not complete the research in time and some were lecturers from University of Johannesburg.

5.3 Practitioner demographics and practice characteristics

5.3.1 Practitioner demographics

The following demographic information was measured: age; gender; home language; type of practice; institution from which they qualified; number of years in practice; additional modalities used in practice.

The study sample, comprising 41 registered practicing homoeopaths, was compared to the study conducted by Verhoogt (2003) in Kwazulu Natal (KZN), in which there were 30 registered practicing homoeopaths.

5.3.1.1 Age

The majority of the practitioners were in the 25 – 30 and 31 – 35 categories (39% and 31% respectively), therefore cumulatively 70% of the participants in this study were 25-35 years of age. A similar trend was found in KZN (Verhoogt, 2003), in that the majority (60%) of participants were 20-35 years of age. A different trend was found in an two overseas studies in which homoeopathic practitioner demographics in 5 European countries (Germany, The Netherlands, Norway, Russia and the Ukraine) was surveyed, the largest group was found to be between 40 and 49 years, with 30% between 30 and 39 years old and the smallest groups were in the 20 –29 years old group (6.7%) and those aged more than 60 years at 5% (Verhoogt, 2003). In this study, there was 1 practitioner

over 60 years old that was in practice and was prepared to participate in this research. The reason for the differences in results between South Africa and Europe, is that in order to study homoeopathy , a medical degree is a pre-requisite.

5.3.1.2 Gender

More than half (58.5%) the participants were female (n=24) and 41.5% were male (n=17). This differs from the KZN study (Verhoogt, 2003), in that there were more male (60% n= 35) Homoeopaths practicing in KZN. The trend in the Johannesburg Metropolitan Area seems to follow the European studies, i.e. 70 % were female. Male practitioners may have been under-represented in this study as females may have had more sympathy with the researcher and made the time to complete the questionnaire. As mentioned in Verhoogt's research (2003), the likelihood of there being more female practitioners now and in the future is strong because there are on average more female homoeopaths graduating from Durban University of Technology and University of Johannesburg than males (Verhoogt, 2003).

5.3.1.3 Home Language

Homoeopaths registered in the poorer socio-economic areas could not be contacted and so did not participate in the study, making it difficult to get a true indication of this demographic variable because some of these practitioners are likely to have spoken one of the other indigenous/ ethnic languages.

78% of the participants had English as their home language, 9.8% said Afrikaans was their home language and 12.2% indicated that their mother tongue was different from those listed (3 German, 1 French and 1 Bulgarian).

5.3.1.4 Homoeopathic Qualification

Seventy eight percent (n=32) of the homoeopaths held a Master's degree of Technology: Homoeopathy (M.Tech: Hom), of which 19.5% (n=8) qualified from DIT and 58.5% (n=24) qualified from Uni-Jhb. The remaining 22% (n= 9) qualified elsewhere: Three have a D.Hom (two of which qualified from the Lindlah College); one is qualified as a homoeopath from the London College of Classical Homoeopathy; one is qualified as a Homoeopath from the Department of Health (Germany); one has an AMB Homoeopathy from France; One has a BSc (Hons) Homoeopathy from the British faculty of Homoeopathy and two have an M.F.Hom. In the KZN study 66.7% of the homoeopaths held a Master's degree of Technology: Homoeopathy from Technikon Natal (Verhoogt, 2003). It can be therefore generalized that homoeopathic graduates (M.Tech:Hom) tend to practice in the province in which they graduated.

5.3.1.5 Years in Practice

The average number of years in practice is 7 years whereas in KZN, the average was 9 years (Verhoogt, 2003). In this study 58% (n=24) had been in practice less than 5 years, 29% (n=12) for six to ten years, and 9.8% (n=4) had been practicing between 12 and 26 years and none of the homoeopaths had more than 26 years of experience except 1 practitioner who had 47 years of experience. In the KZN, it was found that 43% (n=13) had less than 5 years of experience, 30% (n=9) had between 6 and 10 years of experience, 11% (n=3) had between 11 and 20 years of experience, 16.7% (n=5) had between 21 and 30 years of experience and none of the participants had more than 30 years of experience (Verhoogt, 2003). In both regions the majority of homeopaths participating in the studies have less than 10 years of experience this is due to the fact that the first M.Tech : Hom graduates were only produced in 1994 (Technikon Natal) and 1998 (Technikon Witwatersrand) respectively and that these formed the bulk of the sample group (78%).

5.3.1.6 Additional modalities used in practice and the percentage of Homoeopathic practice

In this study the three most common disciplines practiced were: Phytotherapy (87.8%, n=36): Acupuncture (38.9%, n=14) and Naturopathy (9.5%, n=8). These were also the most common practiced disciplines in KZN i.e. phytotherapy

was the most frequently practiced additional modality (70% n=21) in KZN but not used to the degree as seen in the current study. In KZN Acupuncture was used by 53% (n=16) of practitioners and Naturopathy by 60% (n=18), (Verhoogt, 2003). Acupuncture is practiced by more practitioners in KZN than in Johannesburg. In this study three practitioners indicated they also practiced allopathic medicine (8.3%), in KZN only one practitioner was trained as a medical doctor and one a laboratory nurse (Verhoogt, 2003). In this study, other modalities utilized by practitioners were aromatherapy (n=2); iridology (n=2); Traditional Chinese Medicine (n=6), Bach Flower Remedies (n=1), Allergy testing (n=1), Darkfield Microscopy (n=1), Electromagnetic machines (n=1), neuro-feedback (n=1), osteopathy (n=1), body alignment (n=1), ozone therapy (n=1), and metabolic typing (n=1).

Over all it can be stated that acupuncture and phytotherapy are the major additional modalities used by homoeopaths (both in KZN and Johannesburg) this is most likely because these modalities are studied as auxiliary modalities in the M.Tech : Hom qualification (78% of participants).

Thirty homoeopaths (73.2%) indicated that they practiced homoeopathy more than 75% of the time, and just over half (n=17) of these reported that they practiced homoeopathy 100% of the time. In KZN twenty participants (66.7%) indicated that they practiced homoeopathy more than 75% of the time of these ten reported that they practice homoeopathy 100% of the time. The Jacobs *et al.* study (1998) as cited by Verhoogt (2003), which was conducted in the USA found that 85% of practitioners surveyed practiced homoeopathy more than 85%

of the time. Therefore a similar trend occurs in Kwa-Zulu Natal and in Johannesburg but this is still a lower percentage, as compared to the USA, of practitioners practicing homoeopathy. Perhaps a reason for this is that practitioners have found that they need to diversify into practicing other modalities to sustain their practice and/or be able to offer other therapies to the client without having to refer them to another practitioner.

5.3.1.7 Location of practice

The majority of the homoeopaths that participated in this study came from the “Northern Suburbs” of Johannesburg i.e. Sandton/Randburg (48.8%, n=20) and Northcliff/Rosebank (22.2%, n=9). None of the respondents came from Johannesburg South – these included lecturers from Uni-Jhb (excluded) and homoeopaths practicing the poorer socio-economic areas, which were not able to be contacted or were not interested in participating and so, were not included in the study. There was an even spread of practitioners (7.3%, n=3) from Midrand, Roodepoort/Florida, Johannesburg East and Edenvale/Kempton Park. Since no data could be collected from practitioners from the southern parts of Johannesburg, this may have impacted on some other data collected.

5.3.1.8 Type of Practice

The majority of the homoeopaths (41.5%, n=17) have a sole Homoeopathic practice. Three (7.3%) have a group homoeopathic practice (i.e. practise with

other homoeopaths) while 26.8% (n=11) are part of a multidisciplinary practice (practice with other practitioners of other disciplines) and 24.4% (n=10) have a sole multidisciplinary practice (i.e. they practice on their own, practising homoeopathy as well as other disciplines). These figures reflect a similar trend to that in KZN i.e. the majority of the homoeopaths have there own practice i.e. 40% of practitioners (n=12) were in a sole practice, 36.7% (n=11) were part of a multidisciplinary practice and 23.3% (n=7) practiced with other homoeopaths (Verhoogt, 2003).

5.4 **Management and Opinions of ADD/ADHD**

5.4.1 Patients being treated by homoeopaths.

Participants were asked the number of patients they had who presented with ADD/ADHD symptoms within the last 12 months. Nine hundred and five patients with symptoms of ADD/ADHD were seen by 39 practitioners in the last 12 months. The majority of patients were between the ages of 5 and 14 years old (school going age group). This corresponds to the fact that children are generally first diagnosed during the primary school years (Janssen-Cilag, 2005).

5.4.2.1 Diagnosis.

Across all age groups the trend was fairly similar. The majority of the homoeopathic practitioners did not make the diagnosis themselves (tables: 4.4.11.1 – 4.4.11.5). The reason for this is possibly because the children had already been diagnosed by another professional and were coming to the homoeopath in search of an alternative to conventional medicine or as a last resort, having tried all the other options. It was more likely that a general practitioner, paediatrician, neurologist or psychologist had made the diagnosis. Participants also stated that teachers were sometimes responsible for making the diagnosis. The temptation to label the students' behaviour is understandable when there are 35 students in a class and one of them is not co-operating. Many teachers tend to mislabel children as having ADD/ADHD because they

don't have the time or resources to develop real expertise in diagnosis (Lawlis, 2005).

5.4.2.2 Misdiagnosis and over-diagnosis?

Ninety three percent of the homoeopaths stated that they think ADD/ADHD is misdiagnosed and 97.5% stated that they think that ADD/ADHD is over-diagnosed.

The following were the comments were made by practitioners with regard to misdiagnosis and over diagnosis:

Ten of the participants agreed that teachers and schools are making the diagnosis (incorrectly) as they have difficulty in controlling and or coping with the large classes of today, so diagnosing and therefore medicating the children is an easy way out. This is in keeping with the findings of Sax *et al.* (2003), which state that teachers were most likely to suggest a diagnosis of ADHD in the Washington DC area.

Although teachers are not qualified to diagnose these children, they are able to identify "problem" behaviour as they are in contact with the children for a considerable portion of the day. In general, the diagnosis is given far too easily, and without proper assessment. These children often have a learning disability, which makes it difficult to keep up with tasks given to them, other mental/emotional difficulties (e.g. anxiety and/or depression) and/or another

medical condition may also present as ADD/ADHD. Many conditions can mask/mimic the symptoms associated with ADD/ADHD, so this is why it is so important for a child presenting with the symptoms of ADD/ADHD to have a thorough medical examination to rule out any other possible cause. Many normal children are misdiagnosed just because they have a lot of energy, are inquisitive or have an active imagination and differ slightly from the rest of the class (temperament). These children may be highly intelligent so they “act out” or behave in a particular manner because they are bored.

Some of the homoeopaths in this study questioned whether ADD/ADHD might just be a fad (fashionable diagnosis), drawing a comparison to all the “Chronic Fatigue” sufferers who were diagnosed in the past. ADD/ADHD as a condition seems to have been blown out of proportion.

Some other comments made were:

- “ It is an attention focus problem rather than attention deficit – attention is scattered and not channeled in the right place. (E.g. some children can play video games for hours)”.
- “ The criteria for diagnosis is too vague or rigid and the diagnosis is based on the wrong criteria.”
- “ In making the diagnosis, professionals might not take into account the home/personal situation (family dynamics).”

Diller (1999), points out that there are some troublesome aspects of how ADD is currently framed in official psychiatry, this reflects what the homoeopaths reported:

1. The process of establishing an objective diagnostic standards for ADD has itself been quite subjective.
2. Official guidelines for evaluating ADD symptoms are vague and open to interpretation (yet the evaluator has to make an all-or-nothing diagnosis – no recognition of “mild” or “near” ADD/ADHD).
3. The diagnosis has no definitive medical or psychological marker, so it is often made on the basis of a patient’s history alone. Circumstances and biases of those evaluating a child’s behaviour are seldom taken into account.
4. The diagnosis (DSM) is overly focused on the individual and does not take sufficient account of family systems and other environmental factors.
5. ADD seems to have become too inclusive. It has lost relevance to the age-related, developmental nature of some core problems.
6. ADD/ADHD as officially described can look a lot like other conditions/disorders, and many children meet some criteria, but not all of the symptoms of several different conditions.

Homoeopaths can and do formulate a diagnosis but classically do not allow the diagnosis to dictate the medicine prescribed i.e. the medicine prescribed according to the totality of symptoms presented by the specific patient. In the majority of cases, patients come to a homoeopath pre-diagnosed, but when this

has not occurred homoeopaths refer patients to specialists (neurologists, specialist paediatricians, and psychologists) for diagnosis. A homoeopath will base a “diagnosis” on case history and physical examination and some will also make use of the DSM IV, which is the standard diagnostic method.

5.4.3 Referrals

A similar trend was found throughout the age groups (tables 4.4.12.1 – 4.4.12.5). The homoeopaths in this study hardly ever referred their patients to other homoeopaths although patients might be referred if the practitioner does not treat children or feels that the case is beyond their scope of practice, or they may consult with another practitioner for input. Practitioners are more likely to refer patients to a neurologist, paediatrician, psychologist or other specialists namely Kinesiologist (n=4), Occupational Therapist (n=3), Dietician (n=2), and less commonly Cranial sacral osteopath (n=1), therapist specialising in Neurofeedback (n=1), remedial teacher (n=1), physiotherapist (n=1), Radionics (n=1), Voll practitioner (n=1), Astrologer (n=1), Numerologist (n=1). The professional/practitioner referred to will depending on the child’s problems and needs.

5.4.4 Homoeopathic Treatment

5.4.4.1 General approach

The majority of practitioners say they try to find the root cause (core issues) of the problems experienced by the patient. They investigate what motivates the behaviour, they assess school, home and family environments; a full case history is taken (including the family history). The totality of symptoms is assessed, especially symptoms seemingly unrelated to ADD/ADHD, and the best indicated remedy is given (simplex/constitutional/complex). Three practitioners specifically mentioned that they exclude viral, bacterial, parasitic or fungal infections and any other illness or pathology. One practitioner uses the Conner's scale and checking task, which is used by psychologists. Assessment is also made for deficiencies in vitamins and minerals (especially the essential fatty acids).

5.4.4.2 Simplexes and Complexes

The majority of practitioners (90.24%) prescribe a simplex (similimum) whereas only twenty-three practitioners (51.22%) prescribe complexes.

In this study the two most commonly prescribed simplexes were *Datura stramonium* (20.5% n=8) and *Tuberculinum* (20.5% n=8) (description of these to follow). Others, in descending order were: *Phosphorus*, *Tarentula hispanica*, *Sulphur*, *Medorrhinum*, and *Lycopodium clavatum*. This has some correlation

with the study conducted by Lamont (1997) i.e. the remedies found to be the most successful in treating ADD/ADHD were *Stramonium*, *Cina* and *Hyoscymus niger* as well *Veratrum album* and *Tarentula hispanica* which were found useful to a lesser degree. In another study (Jacobs *et al*, 2005) the most frequently prescribed remedies (in descending order) were *Medorrhinum* (4), *Saccharum officinalis* (4), *Calcarea carbonica* (3), *Calcarea phosphorica* (3), *China officinalis* (3) and *Stramonium* (3).

(i) *Stamonium*: a child needing this remedy may display a mixture of fear and violence, with rapid changes in emotion (from sadness to joy). These children are afraid of the dark and do not want to be left alone. Other fears include: wild animals (they fear these animals will attack them); violent death; evil and water. They often have nightmares and night terrors, waking scared (“wild stareing gaze”) and shrieking. Violence and rage (bite, kick, strike) are common responses with stammering, cursing, talkativeness and jealousy also being common behaviours. A frightening or traumatic event (i.e. being chased by a dog, violent abuse, birth trauma or head injury) may be the causative factor for their behaviour (Herscu, 1991). The frequent prescribing of this remedy could possibly be linked to the high incidence of violence and therefore fear that currently exists in this country as well as in the television programmes (even in cartoons).

(ii) *Tuberculinum*: This remedy would mainly be prescribed for the hyperactive type. They are never satisfied and have a constant desire for movement and change (restless), they hate restriction. These children love to travel. They are afraid of animals (dogs and cats – they can also be mean to them and are often allergic to them), have delusions that they can fly, that someone is following him/her. They are irritable and can be mean and nasty to other children; break things (even their parents' favourite things just to be spiteful); are generally destructive, throw tantrums, are precocious and are often malicious. These children can be sensitive (physically and mentally), artistic and intelligent. They are prone to respiratory complaints (allergies, asthma and pneumonia) and very susceptible to change in the weather (Herscu, 1991).

The homoeopaths in this study recommended that the remedies would mostly be prescribed in 200CH potency or in ascending potencies (30CH, 200CH and 1M).

It was found that the most common complexes prescribed are: Ignatia-Homaccord® (Heel), 13% (n=3); Cerbo® (Natura), 13% (n=3) and Nervuton® (Natura), 8.7% (n=2). Some practitioners prefer to make up their own complex, which would be patient specific.

The most commonly prescribed, Ignatia Homacord is composed of: *Ignatia amara* 4X; *Ignatia amara* 10X; *Ignatia amara* 30X; *Ignatia amara* 200X; *Moschus moschiferus* 6X and *Moschus moschiferus* 30X. *Ignatia amara* is indicated for patients who have a tendency to weep, exogenous depression, hysteria,

changes in mood and irrational symptoms. *Moschus* is indicated for persons who are fearful and may suffer from hysteria, nervous excitability, and restlessness accompanied by trembling, and/or anxiety with palpitations. There was some correlation between complex prescribed and the training received.

5.4.4.3 Groups/Families of Remedies

The research shows that plants (specifically mentioned were the Solanaceae and Liliflora) were the highest ranked group of remedies prescribed. A person classified as a “plant” type could be seen as sensitive, artistic and easily influenced, symptoms would be described randomly and not completely; and the patient’s history would show emotional or physical hurt/shock/strain (Sankaran, 1994 & 1997). As the main theme for plants is sensitivity, it corresponds to the idea that many ADD/ADHD patients suffer from what is termed sensory defensiveness (Allen and Harrison, 2004).

Minerals and Metals can be combined into one group, which means then this group comes a close second. Specifically mentioned were the carbonic and sulphuric groups. A “mineral” type person would have a structured and strong nature; be very organized; have a systematic approach - would present his/her symptoms with exactness (everything would be written down). Causative factors would be a break in structure or relationship or failure in performance (Sankaran, 1994 & 1997).

The nature of an “animal” type person would be competitive, even aggressive and would have problems with attractiveness and competitiveness. They would be the attention seekers. Causative factors could be neglect, rejection, failure in competition/defense/love (Sankaran, 1994 & 1997). The most likely “animal” would be a spider (especially *Tarentula hispanica*). They are hypersensitive to their environment (vibrations: music/ noise, touch, light and cold sensitive). Any small stimulus will produce an exaggerated and uncontrolled response (e.g. biting/kicking) yet they love music and rhythm can control their hyper response. They can be cunning, mischievous and sneaky (tease and hide). Restless, always on the move, hurried (fast) movement, and may have problems with coordination. They don’t have much of an appetite, have a preference for a liquid diet, they are usually thin/ “stringy” (long limbs look out of proportion to the rest of the body). Their behaviour maybe as a rebellion against a restrictive society, such as a dominating mother (Ross, 2003).

Nosodes (miasmatic remedies) would be prescribed for one or more of the following reasons: symptom similarity (best indicated remedy); well-selected remedies have failed to act (active miasm needs to be treated); response to other remedies has been short-lived (symptom picture becomes altered after each prescription); acute diseases fail to resolve (patient lacks vitality to recover completely); miasm obscures the symptom picture (Couchman, 2002).

5.4.4.4 Miasms

Miasm is defined as a “defilement/pollution”, inherited characteristics or disease tendencies leading to a recognizable pattern of illness (Couchman, 2002; Gaier,1991).

The dominant Miasm (in any person) can be identified by the patients’ family history (certain diseases/ disease tendencies that have occurred though the generations), personal history (illnesses from childhood until presenting complaint), remedies that have acted well in the past and any genetic diseases (Couchman, 2002). In this study it was found that in cases where ADD/ADHD is suspected, 51.4% of participants reported that the Tuberculinic miasm was the most common.

The Tuberculinic miasm would be indicated where there is a history of respiratory tract infections/conditions (allergic type person/family-asthma especially); hypersensitivity; restlessness, hyperactivity; lymph gland affections. The person feels worse change of season, sea air, cold and damp; and would feel better in the fresh air or being in the mountains. They are sociable, experimental with a love for travel, but are prone to anger outbursts (Ross, 2003).

The Sycotic miasm, second most common in this study (48.6%), is indicated for persons with a personal or family history of conditions affecting the mucous membranes and inflammatory conditions (joints-arthritis, ovaries/testes/kidneys, discharges having a fishy smell, post nasal catarrh), such people have a

tendency for extremes: hyper and hypo energy fluctuations, hormone imbalances, overgrowths: cysts/warts, emotional (mood) fluctuations. They are the adrenaline junkies; are manipulative, and distrustful but dependant and needy for support and company (fear being alone). Their mind is confused; they have a poor memory, they must read things over, blank off during conversation; and are daydreamers. They may have an addictive personality. They are usually worse in the mornings, during the daytime and in damp weather; and are better at night (night owls); in sea air; and when lying on their abdomen (Ross, 2003).

Both these miasms can be reflective and influenced by today's society. In a person with a tuberculinic predisposition, they tend to always be in a hurry, moving from place to place, never satisfied with life and the over-stimulation of the sympathetic nervous system this can eventually lead to burnout, a pattern that is becoming more and more prevalent in today's highly competitive society. The high prevalence of the sycotic miasm in today's society could be as a result of suppression of disease (eg. Vaccination) and a lifestyle of excess (on demand).

5.4.5 Adjunctive therapies and treatment

In this study it was reported that homoeopaths have a holistic approach and advise patients on treatments specific to each case, encompassing whatever is required to obtain optimal well being. They will also recommend vitamins or supplements, especially when a deficiency has been identified: Essential Fatty

Acids (EFA's) are the most commonly prescribed for ADD/ADHD followed by Vitamin B Complexes, Multivitamins and Magnesium.

Some practitioners go so far as to recommend specialty products such as:

Eye Q®; Melatone syrup®; ADDvantage® and Foodstate supplements (those containing EFA's, B group vitamins, Zinc, Calcium and Magnesium). The homoeopath's dietary advice given to patients would be to reduce allergens (elimination diet); reduce or remove sugar; and decrease or remove food containing colourants, preservatives and additives (especially MSG) this correlates with literature concerning dietary changes.

In addition to the remedy given, practitioners may also recommend Electrolyoids and/or mineraloids; Chinese medicine or Tissue Salts. Refer to Appendix 7 for a complete list of specialized supplements and Homoeopathic preparations manufactured for ADD/ADHD.

In order to address the psychological aspects of the case, in addition to the remedy given, counselling (coaching) is done either by the practitioners themselves or by referral to someone specializing in behaviour modification (ADD/ADHD).

5.4.6 Conventional treatment and Homoeopathy? (Tables 4.4.14.1 – 4.4.14.5)

71.4% to 96.3% of practitioners stated that patients were already on some kind of conventional medication before seeking Homoeopathic treatment.

Most of the participants (64.7% to 77.8%) prescribe homoeopathic treatment concurrently with the existing conventional drug treatment. As the patient shows improvement, the homoeopath will gradually wean the patient off conventional treatment. The weaning process can take two to three months. These homoeopaths use different methods of treatment and ideas when weaning a patient off allopathic treatment.

The treatment and “protocol” practitioners utilize to wean a patient off allopathic drug treatment is as follows:

- Adjust dosage and potency of remedy on each follow up visit.
- Homoeopathic remedy(s) should be taken 1 hour apart from conventional treatment.
- Methylphenidate: halve the dose every 2 weeks for 2 months (when the child is responding well to homoeopathic treatment). It is important that there is communication with the allopathic (prescribing) doctor, informing them that the patient is being weaned off the drug and is continuing with homoeopathic treatment.
- If withdrawal is a concern: Prescription of Ritalin 30CH once daily for 2 weeks.
- It is recommended that the child continue conventional treatment during the school term and take a “drug holiday” during school holidays.
- Some practitioners say their approach depends on the parents and their feelings and attitudes, so practitioners educate them on the side effects and long-term effects of conventional treatment. Practitioners also discuss

different scenarios and give the parents all the options available and then let the parent decide what course of action to take.

- Some practitioners (n=3) do not treat a patient on conventional drugs concurrently with Homoeopathic remedies. These practitioners wean the child off the conventional treatment first and only then start treating with homoeopathic remedies. These practitioners believed strongly that conventional treatment interferes with homoeopathic treatment.

Homoeopaths recommend changes in diet and/or supplementation, as it is an important aspect of treatment. In assessment of the patients, core issues are addressed such as: social pressure to perform (from school and parents), and issues of personality or dysfunction. A comment made by one practitioner was that: “the patient is not suffering from a Ritalin® deficiency, so why prescribe it”.

76.7% to 85.7% of the homoeopaths say that conventional drug treatment interferes with Homoeopathic treatment. Their assessment of whether conventional treatment is/has interfered with homoeopathic treatment is based on the following:

- Practitioners assess before and after each treatment (i.e. each prescription) at every consultation, by asking parents and teachers for their observations as to any changes in the child’s behaviour.
- Interference can be seen if there is no change in behaviour/symptoms.
- Remedies well indicated do not act; or there is a poor response; or there is a short-lived improvement followed by a relapse.

- Symptoms experienced by the child are actually side effects of the Methylphenidate (i.e. the drug is masking the symptoms or causing them).
- Practitioners did say that it is difficult to assess in many cases, as there are too many factors (obstacles to cure), so they typically base treatment on the totality of symptoms and address each case individually.

Problems encountered when managing a case where the patient is on both homoeopathic and conventional treatment concurrently include:

- Twelve of the practitioners said that it is difficult to get a clear symptom picture if the patient is on both conventional and homoeopathic medication. They stated that it is difficult to assess the efficacy of the homoeopathic remedy as they can't be sure which medication is responsible for which symptoms (improvements and aggravations/side effects). Symptoms noted include: mental dullness, lack of spark previously in child/part of child's behaviour.
- Eight practitioners noted that compliance is a major problem. Diet and/or homoeopathic treatment are usually neglected while the patient is still on conventional treatment. Patients are not willing to reduce or come off conventional treatment as they have become reliant on those drugs (been taking them for years, so are nervous to stop taking them). Some patients are less serious about stopping the conventional treatment and so they are less likely to change and follow a healthy (holistic) program.
- Parents and patients are sometimes skeptical of the homoeopathy.
- Parents (and patients) have high expectations and are impatient for results.

This is why it is so important for a homoeopathic practitioner to explain that homoeopathic treatment will take time before changes can be seen. This is one of the biggest challenges homoeopaths face in general as our society dictates quick fix solutions.

- Parents are influenced by teachers, friends and other medical professionals. Medical practitioners do not always accept a homoeopath's professional opinion, so it becomes difficult to become part of the "treatment team" for patients with ADD/ADHD.

The actions taken by the participants when there is reported pressure from teachers and or the school to medicate:

- Communication and education of parents, teachers and even doctors is of prime importance. They need to understand the alternatives (and adjunctive treatment) to Methylphenidate and the other conventional drugs used in treating ADD/ADHD, including diet, psychological intervention and homoeopathy.
- Practitioners should explain the protocol/procedure of homoeopathic treatment to patient/parents. There needs to be a fair trial period. A change in symptoms (behaviour) can take several weeks to months depending on the individual child as well as the remedy given. A practitioner recommended a period of one and half terms (if homoeopathic treatment is started at the beginning of the year) but only one term if homoeopathic treatment commenced near the end of the year.
- Parent and teachers should be informed of successful cases.

- Eleven practitioners said that the decision should be up to the parents as to what medication/treatment to give the child and the school or teacher should not pressurize them into making decisions. Teachers are not qualified to make a diagnosis but they do have a strong influence on parents; so should only inform the parent of a child's behaviour and then leave it up to the parents to decide on the course of action to take. The problem is that teachers are unable to cope with large classes so, to make their lives easier, they suggest the prescription of methylphenidate as a first resort.
- Some homoeopaths even suggest that teachers should not be told that the child is on homoeopathic medication and has stopped taking Methylphenidate (if that is the case). Merely stating that the child is on treatment should be sufficient information.
- The worst-case scenario would be for the child to change school, a less drastic measure would be to change classes (teacher) if possible.

5.4.7 Contributing Factors

According to the homoeopaths in this study the following factors were found to be the contributing factors (in their experience) to the development of ADD/ADHD symptoms:

Family dynamics are a contributing factor in up to 80% of cases and are the causative factor in about 20% of cases. Single parent families are as a result of divorce as well as the absence of one parent due to death or work. The rise in

divorce rates, single parenting and abuse creates a general sense of a lack of commitment, security and discipline in today's society. In particular, divorce (custody battles) causes a child's self concept to be damaged (develop a poor self image/esteem).

Another aspect of family dynamics is that of "parental neglect"; which arises from the pressures of modern society: both parents having to work; away from home for long hours and an emphasis on materialism. There is a lack of quality family time and the limited time actually spent with children is not used in a positive/productive manner. Time is not spent on discipline, creating boundaries and structuring activities (e.g. developing a routine of eating, sleeping, home work etc.). When children are left to their own devices, there is no discipline, and they have not learnt social skills from their parents, they will not be able to adapt/cope in the school environment (where they have to obey certain rules). Parents that have no control or, at the opposite end of the spectrum are over-protective or over controlling, create behavioural problems in a child. Alternatively parents might have inadequate coping skills and do not know how to handle their children. From the child's perspective: They may have misunderstood values, which leads to frustration and can manifest as the behaviour associated with ADD/ADHD. Children are under immense pressure to perform and to fit into society's norms: this comes from their peers, parents, the schools and society as a whole. Generally speaking, individual expression is frowned upon. ADD/ADHD children are usually not academically minded, rather, they are more practically inclined, and there are some of those who are highly intelligent.

Schools are aimed at the average rather than accommodating the extremes. The school system does not support individualism – it's a fit in or fall out scenario, because teachers and schools in general are not flexible.

Psychological problems (disorders) can co-exist or mimic the behaviour of ADD/ADHD, which is why careful diagnosis is important. Psychological problems mentioned by the homoeopaths include: unresolved emotional trauma and other emotions, fatigue and stress, depression or depressive tendencies, bullying at school or home.

Environment: over stimulation and distractions such as television, music, computers and other noise make it difficult to concentrate. Lack of exercise, outside activity and insufficient creative stimulation can also contribute.

History: A family history of this condition or similar can predispose a child to developing the characteristics of ADD/ADHD (Miasmatic influences). Birth trauma (forceps delivery); physical and emotional states of the mother and nutrition during pregnancy and even at conception; breast-feeding and parental drug abuse or stimulant intake can affect a child's physical and mental development. This substantiates the evidence that ADD/ADHD has a genetic/familial aspect and confirms ideas that complications during antenatal and postnatal periods could contribute to the development of ADD/ADHD (Bryam, 1998; Allan, 2004).

Vaccinations especially whooping cough (DPT: Diphtheria, Pertussis, Tetanus) – vaccinations can suppress childhood diseases. Repeated antibiotics or any type of allopathic medication given in repeated doses can affect (suppress) a child's immune system

Diet: 90% of practitioners agree that diet is the major cause in some cases whilst it aggravates the symptoms in most cases. Incorrect eating habits (which begins with pregnancy and breast feeding) are as follows: Vitamin, mineral, amino acid and EFA deficiencies, diabetes or insulin resistance or glucose intolerance, eating of refined foods (carbohydrates) and allergens: additives, preservatives and colourants as well as environmental allergens and heavy metals. Dietary influences are well documented as contributing factors and that with a few simple changes in a person's diet, symptoms (e.g. concentration) improve.

5.4.8 Homoeopathic knowledge influences the approach to a patient

The practitioner's homoeopathic knowledge (through their training) enables them to have a holistic view and approach to the condition and the patient. This holistic approach allows the homoeopath to address physical, mental and emotional issues and also to restore and create balance to these states, with the aim of improving overall functioning of the patient.

Their knowledge also helps the homoeopath to look past the diagnosis and to understand the patient (who they are and where they are). This enables the practitioner to treat each case individually. A homoeopaths' approach is based

on the principle that any symptom is a dynamic derangement of the vital force and to find the root cause of the symptoms and to consider the miasmatic influences in the patient (labelling people does not lead us to the cause of the problem). A homoeopath's approach can be likened to a psychologist using the Ecosystemic approach.

Three practitioners commented that there are children who do need allopathic medication but this should only be prescribed after all the alternatives have been explored. Parents need to take a more active role in treatment and need to be educated with regard to the treatments available.

5.4.9.1 Adult and Childhood ADD/ADHD – Is there a difference?

Sixty one percent (n=22) of the practitioners said there is difference between adults and children who present with ADD/ADHD, the remaining 39% (n=19) said there was no difference between adults and children. The participant homoeopaths reported the following with regards to differences in adult and childhood ADD/ADHD:

Adults and children present differently. Most adults have learnt to compensate: they have developed coping skills because they have probably had the condition their whole life (even though they have not realized they had symptoms of ADD/ADHD).

In many cases, it is only when their child is diagnosed with ADD/ADHD that adults come to realize they have, or are diagnosed with ADD/ADHD (Hallowell and Rately, 1996).

Adults tend to demonstrate restlessness by changing jobs and changing their minds frequently, rather than by being physically restless as displayed by children. The “behavioural symptoms” are probably more noticeable in children; they also are more likely to have learning and concentration difficulties, which is noticed by the teachers at school.

An adult is more likely to understand the condition than a child, which is not able to rationalize in the manner that an adult can.

Adults tend to develop depression (as well as mood or anxiety “disorders”), usually as a result of low self-esteem. It is important that an early, correct “diagnosis” is made and more importantly that treatment be initiated. It has been noticed in practice that adults that were on Methylphenidate, as children and/or as adolescents, have become recreational drug addicts.

5.4.9.2 Differences in treatment

As Homoeopaths each patient is treated as an individual, according to homoeopathic principles and is given the similimum remedy.

Adults are able to express themselves and explain how they feel, so it is much easier for a homoeopathic practitioner to determine the similimum (constitutional remedy). They also have an entire childhood and adolescent history, which the

practitioner is able to assess. Children are treated more by “observation” as they are likely to be more reserved (in consultations) and are not always able to express themselves in the manner that adults are able to do, so it is more difficult to find the similimum. The potencies and frequencies of the remedies given will differ. The use of Mother tinctures are used more in adults than children. The herbs used will also differ as will the nutritional advice given, because the recommend daily allowances (RDA's) for children and adults are different.

In adults the emphasis is on the psychological intervention (n=9): they are taught coping skills, given “coaching”, they need to be taught to take responsibility for actions and to think about their life. Stress management, meditation and yoga may also be suggested. This may either be implemented either by the practitioners themselves, or patients may be referred to someone specializing in this type of therapy. In children the emphasis is on behaviour modification: by teaching them routines, structuring time, exercise, planning and setting of goals. Parental involvement is important in the efficacy of a child’s treatment: they need to be held responsible and to encourage their children. Communication with parents, teachers and other practitioners form an important part of the treatment program.

5.4.10 Success in treating ADD/ADHD with homoeopathic treatment

Most of the participants rated the degree of success achieved as being very successful (79.4%), while only a small percent reported no or little success (10.6%).

In Europe, a study was conducted to obtain scientific evidence of the effectiveness of homoeopathic treatment in ADHD. The results showed that homoeopathy is effective in treating ADHD, particularly in areas of behavioural and cognitive functions (European Journal of Peaditrics [online], 2005).

Practitioners measure their success objectively. Objective changes can be seen in the patient at the follow up consultations. Patients report that they are feeling better: in other words, their energy levels have improved, they are calmer, they have improved concentration and co-operation, their physical health and sense of well being has also improved. Any concomitant (co-existing) physical symptoms that improve are a good indicator that treatment is being successful (the correct remedy was chosen) and evidence of Herring's Law of cure may further be indicative of progress made.

At follow-up consultations an assessment is made of school performance (teacher feedback) by means of report cards and or Conner's scale; differences in behaviour noticed by the parent and the practitioners themselves as well as feedback from other therapists. Some practitioners will do psychometric testing.

For the younger children, parent and teacher feedback is the most reliable and the most important source of information.

Placebo-controlled studies are the best method of showing that homoeopathy can be an effective treatment for ADD/ADHD. The following homoeopathic studies have been conducted in South Africa, all of which have shown some degree of effectiveness in the management/treatment of ADD/ADHD:

Strauss, 1998, Muller, 1996, Smith, 2001, Middleborough, 2003, Lottering, 2005.

Lamont, 1997 conducted a study in which children afflicted with ADHD were given either homoeopathic treatment or a placebo for ten days, and then parents/caregivers rated the children on the amount of ADHD behaviour they displayed. Those receiving homeopathic medicines showed significantly less ADHD behaviour than those given placebo. When evaluated in a follow up interview two months after the study ended, 57% of those children who showed improvement with homoeopathy had continued to improve, even though they had discontinued the homoeopathic medicine, 24% relapsed by the time of the follow-up and the remaining 19% continued to show positive results, but only while taking the homoeopathic medicines.

5.4.11 Comparisons: Cross tabulations and Chi square tests

Most of the comparisons produced a non-statistically significant result. One of the main reasons for this was that there were not enough practitioners participating in the study. Practitioners may have indicated “never “ as a response either because they actually did not prescribe that treatment/disagrees with the statement or they had not seen a patient in that age group, therefore did not prescribe that treatment.

5.4.11.1 Type of Qualification vs additional modalities used

Twenty-eight practitioners had qualified with an M.Tech (Hom), of which 10 (35.7%) practiced acupuncture; 1 (3.6%) practiced aromatherapy; 8 (28.6%) practiced naturopathy; 1 practiced iridology; 7 (25%) practiced phytotherapy and 1 practiced allopathic medicine. Those practitioners who had an M.F. Hom only practiced allopathic medicine in addition to homoeopathy. Of the 6 practitioners that had other qualifications, 4 also practiced acupuncture; 1 practiced aromatherapy and 1 practiced iridology. Homoeopaths with an M.Tech (Hom) have been introduced to acupuncture in the course, so this may be a reason for more homoeopaths with this qualification practicing acupuncture.

No statistically significant association could be made between the qualification and type of additional modalities prescribed.

5.4.11.2 Type of qualification vs percentage of practice that is homoeopathic.

Fifteen practitioners with an M.Tech (Hom) said that their practice was 75% homoeopathy whereas those with an M.F (Hom) reported that their practice was made up of only 25-50% homoeopathy which could mean that these practitioners are only using homoeopathy as an adjunct rather than their main focus of practice. This can be expected as those with an M.F (Hom) are qualified doctors that have studied homoeopathy.

No statistically significant association could be made between the type of qualification and the percentage of practice that is homoeopathic.

5.4.11.2 Type of qualification vs number of patients

No statistically significant association could be made between type of qualification and number of patients with ADD/ADHD.

5.4.11.3 Type of qualification vs treatments

More than 60 % of the homoeopaths prescribed simplex treatment to patients with ADD/ADHD, but no statistically significant association can be made between the type of qualification and prescribing of simplexes. Practitioners with an M.Tech seem to prescribe complexes more frequently than those practitioners with other qualifications, this could be because a large proportion of the M.Tech practitioners are from Uni-Jhb, which teaches complex prescribing. No

statistically significant association can be made between type of qualification and prescribing of complexes.

Qualification has no statistically significant association with prescribing vitamins – more than 75% of practitioners prescribe vitamins and all practitioners regardless of qualification prescribed vitamins at least once to children 5-9 years. At least 62% of practitioners prescribed dietary changes but no statistically significant association can be made between qualification and prescribing dietary changes. Herbal remedies are prescribed more by those with an M.Tech than by practitioners with another qualification (no statistical significance). Regardless of qualification, Bach Flower remedies are prescribed less frequently by these homoeopaths – no statistically significant association could be made between qualification and Bach flower remedies.

5.4.11.5 Type of qualification vs Success rate

Regardless of qualification, majority of practitioners reported being moderately to very successful in treating ADD/ADHD.

No statistically significant association can be made between qualification and success rate.

5.4.11.6 Institution from which practitioner qualified vs additional modalities used in practice

The most practiced additional modality, by both DIT AND Uni-Jhb, was acupuncture. This is possibly because acupuncture is introduced to students during their studies. No statistically significant association can be made between institutions and the additional modalities practiced.

5.4.11.7 Institution vs percentage of practice that is homoeopathic

Regardless from which institution the homoeopath qualified, the majority (73%) have a practice that is 75-100% homoeopathic, but more homoeopaths for DIT seen to have a purely homoeopathic practice than those trained at Uni-Jhb and from other institutions. This may be due to the fact that the training given at DIT is of a more classical approach than at other institutions.

No statistically significant association can be made between institution and percentage of homoeopathy practiced.

5.4.11.8 Institution vs number of patients

A higher percentage (62%) of Homoeopaths trained at DIT had more than 11 patients against only 50% of those trained at Uni-Jhb. No statistically significant association can be made between the institution from which the practitioner qualified and the number of patients seen in the last 12 months.

5.4.11.9 Institution from which the practitioner qualified vs treatments

It was found that complexes were more frequently prescribed by Uni-Jhb trained Homoeopaths than D.I.T Homoeopaths. Simplexes were prescribed more frequently by DIT Homoeopaths and other homoeopaths than by Uni-Jhb practitioners (which prescribed simplexes the least). Complexes were prescribed most frequently by those practitioners that qualified from Uni-Jhb and a statistically significant result was produced in the 5-9 year old group for complex treatment and showed a moderate practical significance. By visual analysis there were 2 practitioners that always only prescribe complexes. The possible reason for the difference in prescribing techniques is that Uni-Jhb teaches complex prescribing whereas DIT focuses on similimum prescribing (simplexes). All practitioners prescribed vitamins at least once for children 5-9 years old and 71-100% of practitioners prescribed vitamins at least once. All but one practitioner prescribed dietary changes at least once to children 5-9 years old. Herbal treatment was prescribed by more frequently by homoeopaths trained at Uni-Jhb than at DIT and other institutions, even though Herbal remedies are taught at both DIT and Uni-Jhb. Bach flower remedies were prescribed most frequently by the homoeopaths trained at DIT, these remedies are taught and used in the Clinic at DIT. No statistically significant association can be made between the institution from which the homoeopath qualified and the prescribing of vitamins, dietary changes, herbal remedies and Bach flower remedies.

5.4.11.10 Institution vs success rate

More Uni-Jhb trained practitioners (than those trained elsewhere) reported a moderate to very successful treatment of ADD/ADHD in the 5 – 9, 10 - 14 and 18 and older age groups.

No statistically significant association between the institution at which the practitioner trained and the success rate (there would have been a moderately significant association for the under 5 year age group, had the level of significance been 90% and not 95%).

5.4.11.11 Number of years in practice vs number of patients

It was found that that more in years in practice (the more experience) the practitioner had the more patients the practitioner had, which is to be expected but no statistically significant association can be made between the number of years practiced and the number of patients.

5.4.11.12 Number of years in practice vs treatments

The number of years in practice and the prescribing of simplexes seems to have some significance (moderate practical significance) for 10-15 year olds; 15-18 year olds and 18 years and older. The more years in practice the more the practitioner prescribed a complex but there is no statistically significant association between the number of years in practice and the prescribing of complexes.

The more years in practice, the more likely practitioners would prescribe vitamins; a statistically significant result was found for the 15-18 year olds.

The more experience a practitioner has the more likely they would give dietary changes, a statistically significant result was found for the younger than 5 years age group.

The more experience (number of years in practice) the more likely they will prescribe herbal and Bach remedies, but no statistically significant association was found.

5.4.11.13 Number of years in practice vs success rate

as can be expected, the more experience a practitioner has, the higher the success rate will be, a statistically significant result was found for the younger than 5 year age group.

5.4.11.14 Location of practice vs number of patients

It was found that most practitioners had between 1-10 patients presenting with ADD/ADHD, except in Johannesburg east where all the practitioners interviewed there had more than 21 patients.

5.4.11.15 Location vs Type of practice

The trend is that most practitioners in the Johannesburg metropolitan area (except Johannesburg East) have sole Homoeopathic practices.

CHAPTER 6

6. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSION

The purpose of this study was to investigate the management and treatment of ADD/ADHD by Homoeopathic practitioners (in the Johannesburg metropolitan area). A 3-part questionnaire was sent out to the practitioners to complete. Section A of the questionnaire focused on the demographics of the practitioners, Section B looked at how children and adults were diagnosed, referred, treated and the success rate of the practitioner, as well as interference of conventional treatment with homoeopathic treatment. Section C was open-ended questions, which were related to questions in Section B.

The majority of practitioners that participated in this study were from the more affluent, “northern suburbs”, had studied at Wits Technikon (which could be expected), were female and were between the ages of 25-30 years old.

The study reflects a bias to the white (predominantly English speaking), younger practitioners and those practicing in the northern suburbs, so the data may not be a true reflection of how Homoeopaths are managing and treating ADD/ADHD in Johannesburg or in South Africa as a whole. We also can't be sure of the numbers of ADD/ADHD patients (if any) who are being treated in the poorer (low socio-economic) areas in Johannesburg and if the treatment is any different from that found in this study. This was because of

the difficulty in contacting practitioners. We can state that there are a large number of patients consulting with homoeopaths for ADD/ADHD. It can be generalized that the M.Tech: Hom graduates tend to practice in the province in which they graduated.

The diagnosis of ADD/ADHD is most often made by psychologists, neurologists or paediatricians. Although homoeopaths are trained in diagnosis, the prescription does not rely on a formal diagnosis of ADD/ADHD. Homoeopaths are also most likely to refer to neurologists, paediatricians and psychologists if they feel it is required. The other most common practitioners referred to are: occupational therapists, kinesiologists and dieticians.

The participants in this study were in strong agreement that ADD/ADHD is misdiagnosed and overdiagnosed (92.3% thought it is misdiagnosed and 97.5% thought it to be overdiagnosed). A practitioners training enables them to look beyond the diagnosis and to focus on the physical, mental and emotional issues in that patient. Based on a patient's totality of symptoms, a remedy(s) would be prescribed.

It was found that acupuncture and phytotherapy were the major additional modalities utilized by homoeopaths in both KZN and the Johannesburg metropolitan area. As far as treatment was concerned, simplex (simillimum) prescribing is the preferred choice. Homoeopaths trained at DIT seem to prescribe simplexes more frequently than those trained at Uni-Jhb and complexes seem to be prescribed more frequently by those that were trained

at Uni-Jhb, so therefore it can be concluded that training has an influence on prescribing style (which is to be expected), but no statistically significant association was found. The two most commonly prescribed simplexes were *Datura stramonium* and *Tuberculinum bovinum*. The two most commonly prescribed complexes were Ignatia-Homaccord® and Cerbo® which are both proprietary medicines. The “plant” group/family of remedies seem to show a close reflection of ADD/ADHD behaviour. Tuberculinum seems to be the most common miasm found by the homoeopaths in this study. Diet and supplementation form a very important part of treatment and this is reflected by the fact that most homoeopaths prescribe these in addition to the remedy given. They also prescribed Herbal remedies, Bach flower remedies and other adjunctive therapies to a lesser degree. This is partly due the training received and experience of the homoeopath. Participants felt that conventional medicines interfere with the homoeopathic remedies and will gradually wean the patient off the conventional medicines while the patient is concurrently taking homoeopathic medicine. Only 3 of the participants wean the patient off conventional medicine before starting homoeopathic treatment.

Sixty-one percent of participants thought that there is a difference between adult and childhood ADD/ADHD, one of the main reasons being that adults develop coping mechanisms. So as a result treatment will differ but the principle remains the same: treating each patient as an individual.

According to practitioners family dynamics and diet were the major contributing factors to developing the symptoms associated with ADD/ADHD. An important point was made that parents need to be more involved with their children, in their daily life as well as the treatment program.

Majority of the homoeopaths reported that they are moderately to very successful in the treatment and management of ADD/ADHD. As is to be expected the more experience a practitioner had, the more likely they were to prescribe other treatments and report a greater success rate.

As mentioned above the homoeopaths interviewed reported a moderate to high success rate in treating ADD/ADHD, this although highly subjective, does pose homoeopathy as a potential form of treatment and warrants further investigation in the form of clinical trials or patient benefit surveys.

Homoeopathy could therefore be considered as first line treatment rather instead than a last resort, as the focus of treatment is on determining and treating the root cause of the behaviour. Parents, teachers and other health professionals need to be made more aware of what Homoeopathy can offer those affected by ADD/ADHD.

RECOMMENDATIONS

- The sample in this study does not adequately reflect the population of Homoeopaths in Johannesburg, Gauteng or South Africa. Future studies should aim to include as many as possible of the other sections of the homoeopathic community (black, older and those in other areas).
- A major stumbling block was the register provided by the AHPSA was significantly outdated and incomplete.

For future studies involving practitioners, researchers should perhaps approach and work with the Homoeopathic Association (H.S.A.). In addition to these listings, other sources of practitioner listings should be consulted: telephone directories, electronic data bases (Board of Health Care Funders), and even institutions (DIT and Uni-Jhb).

- Pressure should be put on the council and practitioners to keep the register up to date.
- As this research was subjective, a patient benefit survey could more accurately quantify the response to treatment. This could be conducted as a treatment outcomes questionnaire (specifically for those being treated for ADD/ADHD) to be completed by patients and/or parents.
- Some of the aspects could be explored more thoroughly i.e. age groups of patients with symptoms of ADD/ADHD.

- Homoeopathic awareness or promotion needs to be a major priority for the Homoeopathic Association and the profession as a whole.

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Appendix 1a			
<u>QUESTIONNAIRE: SECTION A</u>			
0.1. Date (dd/mm/yyyy)		0.2. Code (for researcher only)	
Question 1: <div style="text-align: center;"> Practitioner Demographics Please indicate your response by marking the numbered boxes. </div>			
1.1. Your Age Group?			
1	25 - 30	5	46 – 50
2	31 – 35	6	51 – 55
3	36 – 40	7	56 – 60
4	41 - 45	8	61 or older
1.2. What is your Gender?			
1	Female	2	Male
1.3. What is your predominant Home Language/Mother Tongue?			
1	Afrikaans	7	SeSotho
2	English	8	Setswana
3	IsiNdebele	9	SiSwati
4	IsiXhosa	10	Tshivenda
5	IsiZulu	11	Xitsonga
6	Northern Sotho	12	Other (specify)
1.4. What type of Homoeopathic Qualification do you possess?			
1	M.Tech (Hom)		
2	M.F. Hom		
3	Other (Specify)		
1.5. At which institution did you qualify as a Homoeopath?			
1	Durban Institute of Technology (ex Natal Technikon)		
2	Uni Jhb (ex Wits Technikon)		
3	Other (specify)		
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Appendix 1a Practitioner Demographics Continued...				
1.6. How many complete years have you been in Homoeopathic Practice?				
			<input type="text"/>	Years
1.7. What additional modalities do you make use of in your practice?				
	1	Allopathic medicine	6	Iridology
	2	Acupuncture	7	Phytotherapy
	3	Aromatherapy	8	Traditional Healer
	4	Chiropractic	9	Reflexology
	5	Naturopathy	10	Other (specify)
1.8. What percentage of your practice is homoeopathy?				
	1	25%	3	75%
	2	50%	4	100%
1.9. Area/Location of your Practice:				
	1	Sandton/Randburg	6	Northcliff/Rosebank
	2	Midrand/Diepsloot	7	Johannesburg Central
	3	Johannesburg South	8	Soweto/Diepmeadow/Ennerdale
	4	Roodepoort/Florida	9	Alexandra/Modderfontein
	5	Johannesburg East	10	Edenvale/Kempton Park
1.10. What type of practice do you have?				
	1	Sole Homoeopathic Practice		
	2	Sole Multi-disciplinary Practice		
	3	Group Homoeopathic Practice		
	4	Group Multi-disciplinary Practice		
<div style="text-align: right;">Page 2 of 11</div>				

Appendix 1b					
<u>QUESTIONNAIRE: SECTION B</u>					
Management and Opinions of ADD/ADHD					
2.1. How many patients have you treated in the past 12 months for ADD/ADHD or presumed to have ADD/ADHD (i.e. anyone presenting with the symptoms of ADD/ADHD) that are:					
1.	younger than 5 years old?				
2.	5 to 9 years old?				
3.	10 to 14 years old?				
4.	15 to 18 years old?				
5.	older than 18 years old (adult)?				
<u>Questions 2.2 – 2.5:</u> For each age group, please indicate your response by entering a number in each block, where: 1 = Never 2 = Sometimes 3 = Often 4 = Always Example: How often do you prescribe herbal remedies to an ADD/ADHD patient? If you never prescribe herbal remedies to patients younger than 16 but Always prescribe herbal remedies for patients older than 16 years. The answer will read as follows:					
	Younger than 5 years	5-9 years	10-14 years	15-18 years	Older than 18.
	1	1	1	4	4
If you have not treated anyone with ADD/ADHD or anyone assumed to have ADD/ADHD, please turn to SECTION C and kindly answer the questions that follow.					
Page 3 of 11					

2.2	When treating a patient with ADD/ADHD, <u>how often</u>	Younger than 5 years	5 - 9 years	10 - 14 years	15 –18 years	Older Than 18.
1.	Have you diagnosed the patient yourself ? (refer to 7.1.2)					
2.	Has a colleague Homoeopath made the diagnosis?					
3.	Has a General Practitioner made the diagnosis?					
4.	Has a Neurologist made the diagnosis?					
5.	Has a Paediatrician made the diagnosis?					
6.	Has a Psychologist made the diagnosis?					
7.	Has anyone else made the diagnosis? (specify)					
2.3.	<u>How often</u> have you referred each of these groups of patients to the following:					
1.	Another Homoeopath					
2.	General Practitioner					
3.	Neurologist					
4.	Paediatrician					
5.	Psychologist					
6.	Other (Specify)					

2.4 When treating each of these age groups, how often do you prescribe the following:	Younger Than 5 years	5 – 9 years	10 –14 years	15-18 years	Older than 18.
2.4.1. Simplex (refer to 7.2.2.1)					
2.4.2. Complex (refer to 7.2.2.2)					
2.4.3. Other (specify)					
2.5. When treating each of these age groups, how often do you prescribe the following:					
2.5.1 Vitamins (specify)					
2.5.2 Dietary Changes					
2.5.3 Herbal Remedies					
2.5.4 Bach Flower Remedies					
2.5.5 Other (specify)					
Page 5 of 11					

2.6.1. How often are patients on drug treatment (eg.Ritalin®) <u>before</u> Homoeopathic treatment?					
2.6.2. How often are patients on drug treatment (eg.Ritalin®) <u>during</u> Homoeopathic treatment?					
2.6.3. How often does conventional drug treatment interfere with Homoeopathic treatment? (refer to 7.3.2 and 7.3.3)					
2.7.1. How successful do you believe you are in treating a patient with ADD/ADHD (in each of the age groups)? 1 = Not successful 2 = Little Success 3 = Moderate Success 4 = Very Successful					
2.7.2. How do you assess (criteria) how successful you have been in treating a patient?					
<div style="text-align: right;">Page 6 of 11</div>					

QUESTIONNAIRE: SECTION C**Question 7:****OPEN ENDED QUESTIONS AND COMMENTS**

Please write your comments in the spaces provided.

Please feel free to use the reverse side if there is not enough space provided.

7.1.1.1.	Do you think "ADD/ADHD is misdiagnosed?"	1	Yes	2	No
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7.1.1.2.	Do you think "ADD/ADHD" is over diagnosed?	1	Yes	2	No
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7.1.2. Please comment on the statement in 7.1.1.1. and 7.1.1.2.

7.1.3 If you, as a homoeopathic practitioner, made the diagnosis of ADD/ADHD, on what basis (criteria) did you make this diagnosis? (refer to 2.2.1)

7.2.1. What is your general approach to a patient presenting with the symptoms of ADD/ADHD?

7.2.2.1.	What are the <u>two most common simplexes</u> you would prescribe for a patient presenting with the symptoms of ADD/ADHD? (refer to 2.4.1) 1. 2.
7.2.2.2.	What are the <u>two most common complexes</u> you would prescribe for a patient presenting with the symptoms of ADD/ADHD? (refer to 2.4.2) 1. 2.
7.2.2.3.	What are the two most common groups /families of remedies prescribed for a patient presenting with the symptoms of ADD/ADHD? 1. 2.
7.2.2.4.	What are two most common miasms manifested by patients presenting with the symptoms of ADD/ADHD? 1. 2.
7.3.1.	What is your approach to patients on conventional treatment such as Methylphenidate (e.g. Ritalin® and Concerta®)?
7.3.2.	How do you assess (criteria) whether conventional treatment has interfered with Homoeopathic treatment? (refer to 2.6.3)
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7.3.3. What are the problems you encounter when managing a patient who is on both Complementary medicine and Methylphenidate Hydrochloride? (refer to 2.6.3)

7.4. How do you manage a case where there is pressure from teachers, school or others to place the child on drug treatment (e.g. Ritalin®) or to keep the child on treatment?

7.5.1 In your professional opinion, what do you think are the possible contributing and causative factors for the symptoms of ADD/ADHD? (please include to what extent family history and family dynamics contribute)

7.5.2. How does your homoeopathic knowledge and perspective influence your view of and approach to ADD/ADHD?

7.6.1	Do you think there is a difference in behaviour between childhood and adult (18 years or older) ADD/ADHD?	1	Yes	2	No
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7.6.2.1. If you think there is a difference between childhood and adult ADD/ADHD, Please note down what differences you have observed?

7.6.2.2. Are there differences in the way you treat and manage children and adults that present with the symptoms of ADD/ADHD? Please explain.

7.7. Are there any other observations, experiences you can share with me?

Appendix 2

PARTICIPANT INFORMATION LETTER

Project Title: Survey on the perceptions, opinions and management of
ADD/ADHD Homoeopathic practitioners in the Johannesburg
Metropolitan Area.

Investigator's Name: Susan Margaret Nagle
Supervisor's Name: Dr David Naude (M. Tech: Hom (T.N.))

As Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder (ADHD) are ongoing controversial issues with regards to the causes and management thereof, the purpose of this research is to investigate the perceptions and management of this disorder by homoeopathic practitioners.

In order to do this, I require the participation and co-operation of registered homoeopathic practitioners in the Johannesburg Metropolitan area. Participants will be required to answer a questionnaire within two weeks of receiving it via post followed by a scheduled 30 minute appointment/interview with the researcher.

Inclusion Criteria: (in order to participate you should meet the following criteria)

1. The homoeopathic practitioners must be registered with the Allied Health Professional Council of South Africa
2. The homoeopaths must be currently practicing in the Johannesburg Metropolitan Area: Diepsloot/Midrand; Sandton/ Randburg; Northcliff/ Rosebank; Roodepoort; Soweto; Alexandra/ Modderfontein; Johannesburg Central; Johannesburg South; Diepmeadow; Orangefarm/ Ennerdale.
3. The practitioners must be English literate, as the questionnaire and follow up (checking) appointment will be conducted in English

Participation is completely voluntary and you will be free to withdraw from the study at anytime without providing a reason. Participants will be encouraged to reflect on the principles underlying their practices as a homoeopath. Confidentiality will be strictly adhered to, and participant's identity will not be revealed in the study.

Requirements of Practitioner:

- Completion of a questionnaire within 2 weeks of receiving it.
- A half an hour of your time for an interview, at the time of collection based on the questionnaire.

Benefits of this study to you the Practitioner:

- Satisfaction that the information shared could be of assistance to the medical and Homoeopathic fraternity.
- Summary of outcomes of the survey will be made available to participants (When dissertation is complete).

I believe that this study will provide valuable information regarding homoeopathy in South Africa and will contribute to the development of homoeopathy.

If you have any further questions please feel free to contact Susan Nagle at 0827839657 or 011-7042664 and Fax: 011-4623174 or the research supervisor: Dr D.F. Naude (031) 204 2041/2514.

Thank you for your time

Susan Nagle
(Researcher)

Appendix 3

Telephonic proceedings with practitioners:

Good morning/good afternoon, may I speak to ... (practitioner's name)?
My name is Susan Nagle a student Homoeopath from DIT doing my Master's research towards my Master's Degree in Technology: Homoeopathy.
It is a survey of perceptions and management of ADD/ADHD by Homoeopathic practitioners in the Johannesburg metropolitan area.
Firstly I would like to know if you are currently in practice?
(If yes) ... Would you like to participate in my survey?
(If they answer yes to both questions I will tell them how the research will be conducted):
I will send you a questionnaire with the participation information letter which you (the practitioner) will need to fill out.
I will make an appointment with you to collect and check though the questionnaire. This appointment should not take more than half an hour.

Thank you for your time/participation.

Diagnostic Criteria: Attention-Deficit Hyperactivity Disorder

According to the Diagnostic Statistical Manual (DSM IV)

A. Either (1) or (2):

1. Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:
 - a. Often fails to give close attention to details or makes careless mistakes in school work, work or other activities;
 - b. Often has difficulty sustaining attention in tasks or play activities;
 - c. Often does not seem to listen when spoken to directly;
 - d. Often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions);
 - e. Often has difficulty organizing tasks and activities;
 - f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework);
 - g. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools);
 - h. Is often easily distracted by extraneous stimuli;
 - i. Is often forgetful in daily activities.
2. Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

- a. Often fidgets with hands or feet or squirms in seat;
- b. Often leaves seat in classroom or in other situations in which remaining seated is expected;
- c. Often runs about or climbs excessively in situations in which it is inappropriate;
- d. Often has difficulty playing or engaging in leisure activities quietly;
- e. Is often “on the go” or often acts if “driven by a motor”;
- f. Often talks excessively

Impulsivity

- g. Often blurts out answers before questions have been Completed;

- h. Often has difficulty awaiting turn;
 - i. Often interrupts or intrudes on others
- B. Some hyperactive-impulsive or inattentive symptoms that caused Impairment were present before the age of 7 years.
- C. Some impairment from the symptoms is present in two or more settings (e.g. at school or work and at home).
- D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g. Mood Disorder, Dissociative Disorder, or by a Personality Disorder).

Specific Type:

- **Attention-deficit/hyperactivity Disorder, combined type:**
If both Criteria A1 and A2 are met for the past 6 months
- **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type:** If Criterion A2 is not met for the past 6 months.
- **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-impulsive type:** If the Criterion A2 is met but Criterion A1 is not met for the past 6 months.

Note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, “In Partial Remission” should be specified.

FOCUS GROUP

Date convened: Wednesday 24 August 2005

Place: Conference Room at the Homoeopathic Day Clinic,
Durban Institute of Technology,

Time: 11:15 am

Aim/Purpose of Focus Group: To assess for face validity of Susan Nagle's research questionnaire. Each of the participants were required to review the questionnaire and to make comments on layout, questioning style, grammar and content.

Focus Group Participants :

Homoeopathic Practitioners:	Dr Ingrid Couchman Dr Anton de Waard Dr Corne Hall Dr Russell Hopkins Dr Richard Steele
Senior Homoeopathic students :	Izel Botha Delia Hoffman Claire Speckmeier

Researcher: Susan Margaret Nagle

Research Supervisor: Dr David Naude

**SPECIALISED SUPPLEMENTS, HERBAL AND HOMOEOPATHIC
PREPARATIONS USED FOR ADD/ADHD**

Specialised Supplements:

CALMOLIN A.D.D® :omega 3 and omega 6 Fatty Acids

COGNIScript®: Ginkgo biloba; Huperzia serata; Vinpocentine (Vinca major); L-Phenylalanine; Vitamin B5; Choline bitartrate(1%); L-Arginine-L-Pyroglutamate; Phosphatidylserine; N-Acetyl-L-Carnitine. To improve memory, boost mental performance and increase overall brain function (capsule)

ADVANTAGE AND ADVANTAGE JUNIOR®: DMAE (di-methyl-amino-ethanol); Lecithin; Grape seed and pine bark; chromium and Ginkgo (not in Junior)

The components of this formula deal specifically with concentration, memory, circulation, blood sugar levels and has added antioxidants.

HERBOLOGY SUPER STARS FOR KIDS, BRIGHT SPARKS –
CONCENTRATION AND MENTAL FOCUS ®: vitamin C, lecithin, L- tyrosine, Rhodiola rosea; D L Phenylamine; flaxseed (omega 3 and omega 6); vitamin B3; vitamin B6; Zinc glyconate; Folic acid and fructose. (chewable tablet)

SMART FISH®: EPA; DHA; Omega 6 fatty Acid (sachet form)

EYE Q ®: EPA;DHA; GLA; Natural vitamin E
(capsules or citrus flavoured liquid or sachets, fruit flavoured blend)

FOODSTATE, ESSENTIAL FATTY ACIDS FORMULA®: Flaxseed oil: 54%
Alpha Linolenic Acid (omega 3); 16% Linoleic Acid (omega 6); 18% Oleic Acid
(Omega 9); 5% Palmitic, stearic and other. (capsules)

FOODSTATE, ENTHUSIASM AND JOY®: Vitamin B6; Vitamin C; Zinc; Tyrosine; Lipophosphate; Rhodiola rosea; Arginine; Pyroglutamate; citrus aurantium extract and Ginseng extract. Aids in memory and learning (tablets).

FOODSTATE, SUGAR BALANCE FORMULA®: Chromium; Magnesium;
Vanadium and Omega 3 Fatty Acids. (tablets)

MELOTONE SYRUP®: Evening Primrose oil; Salmon oil; Vitamin D; Vitamin C; B Vitamins; Calcium; Magnesium; Zinc; Methyl Sulphonyl Methane; Glycine; Taurine; Chromium and Vanadium.

MANNA®: Vitamins, Minerals and Amino Acids. Blood sugar stabilizer (tablets or as a shake).

ADVANCE®: Tuna fish oil (DHA and EPA); Vitamin A; Vitamin D; Vitamin E; Vitamin C. Supplement to help maintain levels of concentration in children with ADD, ADHD, Dyslexia and Dyspraxia. (chewy fruit bursts)

ADVANCED BRAIN FOOD®: Phosphatidylcholine; Phosphatidylserine; Vitamin B3; Gingko biloba; Vitamin B12; Folic acid; Pantothenic acid (vitaminB5) and Pyroglutamate (tablets).

SRINKLE VITES®: Vitamin A; B Vitamins; Vitamin C; Vitamin D; Vitamin E; Calcium; Magnesium; Selenium; Iron; Zinc; Lecithin; Natural Vanilla extract; Fructose; Stevia; Cocoa; Coconut oil extract. (granules that can be sprinkled into food/beverages)

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MULTIPHYTONUTRIENT COMPLEX: Multi vitamin and minerals with Amino Acids)

CALCIUM, MAGNESIUM, ZINC POWDER (co-factors for EFA absorption).

HIGH FIVE B-COMPLEX WITH MAGNESIUM ASCORBATE

NUTRITIONAL OILS

Suggested products from SOLAL Technologies:

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OMEGA 3 FISH OIL CONCENTRATE

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Amino Acids: GLUTAMATE; TAURINE; TRYPTOPHAN; TYROSINE; PHENALANINE; PHOSPHATIDYLSERINE (PS)

LIFE FORCE – REFOCUS®: 16 Vitamins; 23 minerals; 50 trace elements; 19 Amino acids; 3 Essential Fatty Acids; herbal extracts and strong antioxidants. Natural cognitive enhancer (capsules).

VITAL KIDSTIME FOCUS MULTIVITAMIN AND MINERAL®: Amino acids; Vitamin B6; Evening Primrose oil and Salmon oil. (capsules).

Homoeopathic and Herbal Preparations:

QUIETUDE SYRUP® (BOIRON): *Passiflora incarnata* (3DH); *Hyoscyamus niger* (9CH); *Stramonium* (9CH); *Chamomilla* (9CH); *Gelsemium* (9CH) and *Kali bromatum* (9CH).

WELEDA CONCENTRATION REMEDY: KALI PHOS. COMP.®: *Aurum metallicum praeparatum* (D10); *Kali phosphoricum* (D6); *Kephaladoron* (D2); *Ferrum sulphuricum* and *Quartz* in special preparation. Indicated to enhance concentration and for mental exhaustion, nervousness and overstrain during exams (tablets).

WELEDA NERVE TONIC: FRAGADOR ®: *Cochlear offinalis* (herba); *Conchea*; *Fragaria vesca* (fructus); *Glycogenum* (D10); *Levisticum* (radix); *Mel* (D1); *Natrium carbonicum* (D1); *Pimpinella anisum* (fructus); *Salvia offinalis* (folium); *Triticum vulgre* (germ.); *Urtica dioica* (folium); *Vivianit* (D4). Indicated for nervous exhaustion, insomnia, studying and exam tension

SELENIUM HOMACORD® (HEEL): *Selenium* in D10; D15; D30; D200 potencies and *Potassium phosphate* in D2; D10; D30; D200 potencies. (tablets).

CERBO® (NATURA): *Belladonna* (D3); *Gelsemium semp.* (D4); *Banisteropsis caapi* (D60); *Atropinum sulphuris* (D6); *Acid picr* (D10); *Kali phos.* (D10); *Veratrum vir.* (D10); *Zincum metallicum* (D10). Helps improve concentration, memory and recall; lessens forgetfulness and excitability; indicated for exam stress and poor co-ordination (drops)

NERVA 2® (NATURA): *Belldonna* (D4); *Nux vomica* (D4); *Coffea crud* (D8); *Banisteropsis caapi* (D60); *Zincum val.* (D6); *Mag.phos.* (D10); *Platina metallicum* (D30). Indicated for hyperactivity; fidgeting, restless behaviour, twitches, muscle spasms, stuttering and bedwetting (drops).

NERVUTON 2® (NATURA): *Artemisia abrot.* (D1); *Chamomilla vulgaris* (D1); *Humulus lupus* (D1); *Valeriana offinalis* (D1); *Cal.phos.* (D1); *Kali phos.* (D3); *Zincum val.* (D4); *Durata stramonium* (D5). Indicated for impulsive behaviour, impatience, irritability, distractability, exam anxiety, night terrors (pills).

KALI PHOS. (TISSUE SALT No. 6)®

MAG PHOS. (TISSUE SALT No.6)®

RESCUE REMEDY®

CONCENTRATION FORMULA® (BIOFORCE- A.VOGEL): Veratrum album (D6); Vinca minor Ø; Anacardium (D6); Zincum metallicum (D12); Staphisagria (D6); Vanilla plantifolia (D12); Cypripedium pubescens (D3); Helleborus niger (D6); Asarum europaeum (D6); Avena sativa Ø; Ginkgo biloba (D3); Piper methysticum Ø. For lack of concentration and memory; dejection and nervous exhaustion; disturbed sleep in children (drops).

DORMEASAN® (BIOFORCE- A.VOGEL): Melissa officinalis Ø; Passiflora incarnata Ø; Humulus lupulus Ø; Valeriana officinalis Ø. For mild sleep disorders; calming effect when over excited; restlessness and mental overexertion.

MARGARET ROBERTS HERBAL REMEDY FOR HYPERACTIVITY® (FITHEALTH): Lemon balm (Melissa officinalis); Chamomile (Chamomilla recutita); Sage (Salvia officinalis); Ginkgo biloba (capsule).

LILIAN TERRY AROMATHERAPY COMPLEXES:

HYPOKIDS®: Children who suffer from lack of concentration, bad memory, intolerance to physical and emotional stress, bad sleeping patterns, can be applied to toddlers and children up to 14 years of age.

LULLABY®: Babies and kids up to 3 years of age, who have a poor sleeping patterns, have nightmares, suffer from hyperactivity and very active intestinal spasms at night.