

**THE PERCEPTIONS AND MANAGEMENT OF ADD/ADHD BY HOMOEOPATHIC
PRACTITIONERS IN KWAZULU-NATAL**

By

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with the requirements for the
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I, Megan Medina, hereby declare that this dissertation
represents my own work both in concept and execution.

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DEDICATION

I WOULD LIKE TO DEDICATE THIS RESEARCH TO THE PARENTS AND CHILDREN WITH ADD/ADHD, AND TO MY FAMILY FOR THIER GUIDANCE, SUPPORT AND LOVE.

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I would like to convey my sincere gratitude to the following people:

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To the homoeopathic practitioners who participated in this survey. Your input and experience is deeply appreciated.

ABSTRACT

INTRODUCTION

Attention-Deficit/Hyperactivity Disorder (ADD/ADHD) is a multifactorial and clinically heterogeneous disorder that is associated with tremendous financial burden, stress to families and adverse academic and vocational outcomes (Bierderman, 2005). ADD/ADHD is currently one of the most researched childhood conditions, yet there is still much controversy and misunderstanding surrounding it. It is also one of the most commonly diagnosed disorders of childhood development (Picton, 2005) and the prevalence of this disorder in adults is increasingly recognized (Bierderman, 2005).

Parents are seeking alternatives, as they are concerned with the side effects of Methylphenidate hydrochloride and other conventional medication used to treat the symptoms of ADD/ADHD.

AIM

The aim of this research was to document the current practices of registered homoeopathic practitioners, with regard to ADD/ADHD. In addition, their perceptions regarding aetiology, treatment, management and success rate was investigated. This research took the form of a qualitative survey targeting homoeopaths practicing within the KwaZulu- Natal region.

METHOD

A total of 42 practitioners were contacted, 35 practitioners initially agreed to participate in the study, and the questionnaires were electronically sent to them via email. Of these 35 homoeopaths, 22 participated in the survey, i.e. giving an overall response rate of 62 percent. The questionnaires were electronically distributed and collected via email. The raw data was coded and captured by Google docs and the results were analysed by utilizing the SPSS for Windows version 18 SPSS/PASW 2009.

RESULTS

The majority of the responding homoeopaths practiced in the more urban areas of KwaZulu-Natal, more specifically within the eThekweni Durban area. The majority of these homoeopaths had qualified from the Durban University of Technology, were English speaking females and were between the ages of 25-35 years old.

The homoeopaths within this study found that most patients who present with ADD/ADHD symptoms are previously diagnosed by paediatrician's neurologists or psychologists. According to the homoeopaths participating in the study, the general consensus is that the diagnosis of ADD/ADHD is given far too easily, and without proper assessment, 86 percent of the homoeopaths are of the opinion that ADD/ADHD is misdiagnosed, and ninety one percent stated that ADD/ADHD is over diagnosed.

The majority of the practitioners prescribe a simplex remedy, or the Simillimum, whereas only a few practitioners prescribe a complex remedy. It was found that the most common complex prescribed is Nervoheel®. Some practitioners prefer to make up their own complexes, which would be patient specific.

In this study it was found that 68 percent of the practitioners reported the sycotic miasm to be most common, and 54 percent of the practitioners reported the tubercular miasm to be the second most common presenting miasm.

The homoeopaths in this study stated that they prefer to use a holistic approach to obtain optimal well being, thus advice, lifestyle adjustments, education and counselling all form part of the treatment and management of a patient with ADD/ADHD, making it unique and specific to each case. Of the adjunctive therapies, Vitamins, supplements, and nutritional changes are recommended, especially if a deficiency has been identified. The most commonly prescribed supplements for ADD/ADHD are the Essential Fatty Acids (EFA's) followed by Vitamin B Complexes, Multi-vitamins and Magnesium, Zinc, and Calcium.

CONCLUSION

The majority of the homoeopaths in this study reported that they are having a moderate to great success in treating and managing patients with ADD/ADHD. Many of these practitioners thought there to be no single cause for ADD/ADHD, however many of them found there to be a few significant contributing factors to the development or aetiology of ADD/ADHD. These factors include; genetics, environment, diet, vaccinations and family dynamics. The majority of the practitioners believe that ADD/ADHD is far too easily diagnosed and that further assessment of the mental, emotional, and physical symptoms of the patient need to be taken into consideration. The majority of the homoeopaths in this study prefer to use Simplex treatment, and consider diet, lifestyle changes, and phytotherapy the most successful adjunctive therapies when treating and managing a patient with ADD/ADHD.

Many of the practitioners within this study reported that homoeopathy should be considered a primary treatment option for patients with ADD/ADHD, as the focus of the treatment is on determining the cause of the symptoms, and then managing the patient as a whole, focusing on changing the diet, altering the lifestyle, and treating the totality of the mental, emotional and physical symptoms.

TABLE OF CONTENTS

DEDICATION	I
ACKNOWLEDGMENTS	II
ABSTRACT	III
TABLE OF CONTENTS	V
LIST OF APPENDICES	X
LIST OF FIGURES	XI
LIST OF TABLES	XIV
DEFINITIONS OF TERMS AND ABBREVIATIONS	XVI

CHAPTER ONE: INTRODUCTION

1.1	INTRODUCTION	1
1.2	PROBLEM STATEMENT	3
1.3	AIMS	3

CHAPTER TWO: LITERATURE REVIEW

2.1	ADD/ADHD EPIDEMIOLOGY, PREVALENCE and PROGNOSIS	4
2.2	IMPLICATIONS OF ADD/ADHD	8
2.3	AETIOLOGY	10
2.4	CLINICAL PICTURE	18
2.5	DIAGNOSIS AND CHARACTERISTICS OF ADD/ADHD	22
2.6	INCORRECT DIAGNOSIS	24

2.7	TREATMENTS AND MANAGMENT	27
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CHAPTER THREE: MATERIAL AND METHODS

3.1	STUDY DESIGN	38
3.2	STUDY POPULATION	38
3.2.1	INCLUSION CRITERIA	38
3.3.2	REQUIREMENTS OF PRACTITIONERS	38
3.3	STUDY SAMPLE	39
3.4	METHODOLOGY	40
3.5	CONFIDENTIALITY	41

CHAPTER FOUR: THE RESULTS

4.1	INTRODUCTION	42
4.2	ADMISSIBILTY OF THE DATA	42
4.3	RAW DATA	42
4.4.1	SAMPLE GROUP	42
4.4.2	DEMOGRAPHICS	43
4.4.2.1	AGE GROUP OF PRACTITIONERS IN THE STUDY	43
4.4.2.2	GENDER OF PRACTITIONERS IN THE STUDY	44
4.4.2.3	PREDOMINANT HOME LANGUAGE OF PRACTITIONERS	45
4.4.3	QUALIFICATION	46
4.4.3.1	HOMOEOPATHIC QUALIFICATION	46
4.4.4	INSTITUTION	47

4.4.5	PRACTICE	48
4.4.5.1	NUMBER OF YEARS IN PRACTICE	48
4.4.5.2	AREA/LOCATION OF PRACTICE	49
4.4.5.3	TYPE OF PRACTICE	51
4.4.5.4	PERCENTAGE OF PRACTICE THAT IS HOMOEOPATHIC	52
4.4.5.6	ADDITIONAL MODALITIES USED IN PRACTICE	53
4.5	OBJECTIVES	54
4.5.1	TOTAL NUMBER OF ADD/ADHD PATIENTS BEING TREATED BY HOMOEOPATHS WITHIN THE PAST 12 MONTHS	55
4.6	DIAGNOSIS	
4.6.1	DIAGNOSIS OF PATIENTS UNDER FIVE YEARS OF AGE	56
4.6.2	DIAGNOSIS OF PATIENTS AGED FIVE TO NINE YEARS	57
4.6.3	DIAGNOSIS OF PATIENTS AGED 10 – 14 YEARS	58
4.6.4	DIAGNOSIS OF PATIENTS AGED 15-18 YEARS	59
4.6.5	DIAGNOSIS OF PATIENTS AGED 18 YEARS AND OLDER	60
4.6.6	MISDIAGNOSIS	61
4.6.7	OVERDIAGNOSIS	62
4.7	REFERRAL	
4.7.1	REFERRAL OF PATIENTS UNDER FIVE YEARS OF AGE	63
4.7.2	REFERRAL OF PATIENTS AGED FIVE TO NINE YEARS	64
4.7.3	REFERRAL OF PATIENTS AGED 10-14 YEARS	65
4.7.4	REFERRAL OF PATIENTS AGED 15-18 YEARS	66
4.7.5	REFERRAL OF PATIENTS AGED 18 YEARS AND OLDER	67
4.8	TREATMENT OPTIONS	

4.8.1	TREATMENT OF PATIENTS UNDER FIVE YEARS OF AGE	68
4.8.2	TREATMENT OF PATIENTS AGED FIVE TO NINE YEARS	69
4.8.3	TREATMENT OF PATIENTS AGED 10-14 YEARS	70
4.8.4	TREATMENT OF PATIENTS AGED 15-18 YEARS	71
4.8.5	TREATMENT OF PATIENTS AGED 18 YEARS AND OLDER	72
4.8.6	PRESCRIBED TREATMENT	
4.8.6.1	SIMPLEX TREATMENT	73
4.8.6.2	COMPLEX TREATMENT	74
4.8.6.3	MIASMS	75
4.8.6.4	FAMILIES/GROUPS OF REMEDIES	76
4.9	CAUSATIVE FACTORS	77
4.10.1	PATIENTS ON DRUG TREATMENT BEFORE HOMOEOPATHIC TREATMENT	78
4.10.2	SUCCESS RATE OF PRACTITIONERS TREATING PATIENTS WITH ADD/ADHD	80
4.10.2.1	SUCCESS RATE IN PATIENTS AGED FIVE YEARS AND YOUNGER	80
4.10.2.2	SUCCESS RATE IN PATIENTS AGED FIVE TO NINE YEARS	81
4.10.2.3	SUCCESS RATE IN PATIENTS AGED 10 – 14 YEARS	82
4.9.6.4	SUCCESS RATE IN PATIENTS AGED 15-18 YEARS	83
4.9.6.5	SUCCESS RATE IN PATIENTS AGED 18 YEARS AND OLDER	84
4.10	DIFFERENCES BETWEEN ADULT AND CHILD ADD/ADHD	85

CHAPTER FIVE:

5.1 DISCUSSION	86
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CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1	CONCLUSIONS	106
6.2	RECOMMENDATIONS	109
REFERENCES		111

LIST OF APPENDICES:

APPENDIX 1A:	QUESTIONNAIRE	116
APPENDIX 1B:	QUESTIONNAIRE	119
APPENDIX 1C:	QUESTIONNAIRE	133
APPENDIX 2:	PARTICIPANT INFORMATION LETTER	138
APPENDIX 3:	FREQUENCY TABLES OF RESULTS FOR CHAPTER FOUR	140

LIST OF FIGURES

Figure 4.1 Bar graph showing the age group distribution of participating practitioners	43
Figure 4.2 Pie chart illustrating the gender percentage of participating practitioners	44
Figure 4.3 Pie chart illustrating the predominant home languages spoken by the participating respondents	45
Figure 4.4 Pie chart shows the distribution of homeopathic qualifications among participating practitioners	46
Figure 4.5 Pie chart illustrating the institution from which the practitioners qualified	47
Figure 4.6 Bar Graph showing the number of years in practice	48
Figure 4.7 Map showing the location of health districts within the KwaZulu-Natal	49
Figure 4.8 showing the area distribution of practices within the KwaZulu-Natal Health Districts	50
Figure 4.9 Bar graph showing the area distribution of practices within the KwaZulu-Natal Region	50
Figure 4.10. Bar graph showing the distribution of the types of practice	51
Figure 4.11 Pie chart illustrating the percentage of practice that is homoeopathic	52
Bar Graph 4.12 illustrating the additional modalities utilized in practice	53
Figure 4.13 Bar chart showing the valid percentage of diagnosis of patients younger than 5 years old	56
Figure 4.14 Bar chart showing the valid percentage of diagnosis of patients 5-9 years old	57
Figure 4.15 Bar chart showing the valid percentage of diagnosis of patients 10-14 years old	58
Figure 4.16 Bar Chart showing the valid percentage of diagnosis of patients younger than 15-18 years old	59

Figure 4.17 Bar Chart showing the valid percentage of diagnosis of patients younger than 18 years and older	60
Figure 4.18 Pie chart showing the opinions of practitioners with regard to misdiagnosis of ADD/ADHD	61
Figure 4.19 Pie chart showing the opinions of practitioners with regard to over diagnosis of ADD/ADHD	62
Figure 4.20 Bar Chart showing the valid percentage of Referral of patients 5 years and younger	63
Figure 4.21 Bar Chart showing the valid percentage of Referral of patients 5-9 Years Old	64
Figure 4.22 Bar Chart showing the valid percentage of Referral of patients 10-14 Years Old	65
Figure 4.23 Bar Chart showing the valid percentage of Referral of patients 15-18 Years Old	66
Figure 4.24 Bar Chart showing the valid percentage of Referral of patients 18 Years and older	67
Figure 4.25 Bar Chart showing the valid percentage of treatment options for patients 5 years and younger	68
Figure 4.26 Bar Chart showing the valid percentage of treatment options for patients aged 5-9 years	69
Figure 4.27: Bar Chart showing the valid percentage of treatment options for patients aged 10-14 years	70
Figure 4.28 Bar Chart showing the valid percentage of treatment options for patients aged 15-18 years	71
Figure 4.29: Bar Chart showing the valid percentage of treatment options for patients aged 18 years and older	72
Figure 4.30 Bar Chart showing the percentage of simplex options prescribed by homoeopaths for patients with ADD/ADHD	73
Figure 4.31 Bar Chart showing the percentage of complex options prescribed by homoeopaths for patients with ADD/ADHD	74
Figure 4.32 Bar Chart showing the percentage of Miasms prescribed by homoeopaths for patients with ADD/ADHD	75

Figure 4.33 Bar chart illustrating the percentage of groups/remedy families as prescribed by practitioners	76
Figure 4.34 Bar Chart showing the valid percentage of patients for all age groups that are on drug treatment before homoeopathic treatment	78
Figure 4.35 Bar Chart illustrating the valid percentage of practitioner's perceptions on their success rate in patients five years and younger	80
Figure 4.36 Bar Chart illustrating the valid percentage of practitioner's perceptions on their success rate in patients 5-9 years	81
Figure 4.37 Bar Chart showing the valid percentage of practitioner's perceptions on their success rate in patients 10-14 years	82
Figure 4.38 Bar Chart showing the valid percentage of practitioner's perceptions on their success rate in patients 15-18 years	83
Figure 4.39 Bar Chart showing the valid percentage of practitioner's perceptions on their success rate in patients 18 years and older	84
Figure 4.40 Bar Graph showing the opinions of practitioners with regard to the difference in adult and childhood ADD/ADHD	85

LIST OF TABLES

Table 4.1 shows the total number of ADD/ADHD patients seen by practitioners over the past 12 months	39
Table 4.26 Most common Simplexes prescribed by practitioners	57
Table 4.27 Most common Complexes prescribed by practitioners	58
Table 4.28 Most common Miasms prescribed by practitioners	59
Table 4.29 Most common Groups/Remedy families as prescribed by practitioners	60
Table 4.30 Shows the total number of causative factors of ADD/ADHD as perceived by the homoeopathic practitioners	61
Table 4.31 Frequency Table showing the valid percentage of patients for all age groups that are on drug treatment before homoeopathic treatment	64
Table 4.2.7 Frequency Table showing the valid percentage of patients for all age groups that are on drug treatment before homeopathic treatment	117
Table 4.2 Frequency table showing the valid percentage of diagnosis of patients younger than 5 years old	117
Table4.3 Frequency table illustrating the valid percentage of diagnosis of patients 5-9 years old	118
Table4.4: Frequency table illustrating the valid percentage of diagnosis of patients 10-14 years old	119

Table 4.5 Frequency table showing the valid percentage of diagnosis of patients younger than 15-18 years old	120
Table 4.6 Frequency table showing the valid percentage of diagnosis of patients 18 years or older	121
Table 4.7: Frequency Table showing referrals in patients younger than 5 Years old	122
Table 4.8 Frequency Table showing referrals in patients 5-9 Years old	123
Table 4.9 Frequency Table showing referral of patients aged 10-14 years	124
Table 4.10 Frequency Table showing referral of patients aged 15-18 years	125
Table 4.11 Frequency Table showing referral of patients aged 18 years and older	126
	127
Table 4.12 Frequency Table showing valid percentage of treatment options for patient 5 years and younger	
Table 4.13 Frequency Table showing valid percentage of treatment options for patients 5-9 Years	128
	129
Table 4.14 Frequency Table showing treatment options of patients 10-14 Years	
	130
Table 4.15 Frequency Table showing treatment options for patients aged 15-18 Years	
	131
Table 4.16 Frequency Table showing treatment options for patients 18 Years and older	

DEFINITIONS OF TERMS AND ABBREVIATIONS

Attention Deficit Hyperactivity Disorder (ADHD): Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behaviour, and hyperactivity (over-activity) (NIMH, 2008).

Clinical Picture: The presenting pathological or functional disorder or existing syndrome named according to conventional medicine (Lewis, 2003).

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).

Constitutional remedy: A remedy relating to the underlying chronic symptoms or particular signs presented by a patient (including hereditary factors) which correspond to the patient's personality traits, physical make up, behaviour, lifestyle and habits (Jayasuriya, 2005).

D.U.T: Durban University of Technology, as of 2006. Previously called Durban Institute of Technology 2002, before that it was called Natal Technikon.

Dopamine: A neurotransmitter secreted by the neurons that originate in substantia nigra. The effect of dopamine is usually inhibition, and active during emotional responses, addictive behaviours and pleasurable experiences (Tortorra and Derrickson, 2006)

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)

Essential Fatty Acid: A long chain monobasic organic acid that is essential to human health, but cannot be manufactured in the body, and must be obtained from a food source (Stedmann's Medical Dictionary, 1995).

Holistic: Pertaining to the concept that a whole cannot be reduced to the sum of its parts in a living organism. Holistic medicine considers the human being not only as a material body made out of chemical compounds, but also as a mind, emotions and, above all, a spirit in the organismic whole(Jayasuriya,2006).

Law of Similiars: “Like cures like” , i.e. the principle that a substance which produces certain symptoms in healthy people can cure the same symptoms in the sick (De Schepper, 2006)

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)

Neurotransmitters A chemical that is released from a nerve cell which thereby transmits an impulse from a nerve cell to another nerve, muscle, organ, or other tissue. A neurotransmitter is a messenger of neurologic information from one cell to another (Tortora and Derrickson, 2006).

Simillimum: The medicine that is most closely congruent to the totality of the patient's symptoms (based on the Law of Similars) and therefore, has the maximum curative power (Jaysuriya, 2006).

The totality of symptoms: The complete clinical picture of a patient during the “illness” comprises of all mental, general and local symptoms and signs; the complete symptom pattern from which the Simillimum is found (Swayne, 2000).

Chapter 1:

INTRODUCTION

1.1: INTRODUCTION

Attention-deficit/hyperactivity disorder (ADD/ADHD) is one of the most common childhood behavioural disorders, with an estimated worldwide prevalence of approximately five percent in school-age children (Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007). Children receiving a diagnosis of ADD/ADHD display persistent levels of inattentive and/or hyperactive and impulsive behaviour that is developmentally inappropriate and causes significant impairment across situations (DSM-IV; American Psychiatric Association, 2000). Studies conducted in a number of countries over the last 10 to 15 years have revealed that ADD/ADHD exists in every country and in every ethnic group studied (Barkley, 2004). According to recent research ADD/ADHD is prevalent in urban areas and is increasing at a rapid rate in developing countries (Picton, 2005).

According to the ADHD-In-Depth Report, four percent of adults aged 18 to 44 are affected. Only 10-20 percent of children with ADD/ADHD reach adulthood without any significant symptoms of their disorder (Barkley, 2005). Untreated adult ADD/ADHD leads to under-functioning even if the person has average to above average intelligence (Picton, 2005).

Most substantiated causes of ADD/ADHD appear to fall into the realm of a neurophysiological disorder, caused by an imbalance in neurotransmitters (NIMH, 2008). Evidence is quickly accumulating that suggests that ADD/ADHD is a disorder in brain development or brain functioning that originates in genetics (Barkley, 2005).

A diagnosis can only be given once a comprehensive multidisciplinary evaluation has been conducted. An assessment leads to conclusions as to the presence, type and characteristics of the disorder in the child. The final diagnosis of ADD/ADHD is made by careful clinical history, a thorough physical examination, psychometric testing and a concurrence with the DSM IV criteria (Kroeneberger, 2000, Wilens, 2008).

Multi-modal treatment is advised and should consist of medication, behavioral therapy and educational accommodations. The prescribing of the stimulant Methylphenidate Hydrochloride (Ritalin®) is the conventional form of treatment used by neurologists and doctors. Depending on the severity of the symptoms, the use of other disciplines like psychology, occupational therapy, speech and hearing therapy as well as nutrition can all be incorporated into the treatment plan. In addition, other complementary therapies, like Homoeopathy, Chiropractic, meditation and relaxation are available as an adjunct or an alternative to conventional treatment. According to (Picton, 2005), the ideal way to manage an individual with ADD/ADHD is with an integrated approach.

Homoeopathy is becoming a preferred choice of treatment as parents seek to find alternatives to Methylphenidate hydrochloride (Jones, 2007). According to previous research, homoeopaths consult with a significant number of ADD/ADHD patients. From 2005 - 2006, 63 homoeopaths within Johannesburg Metropolitan were contacted, 41 completed a questionnaire, and of that 39 practitioners stated that they treat patients with ADD/ADHD, thus it can be seen that 43 percent of the homoeopaths within the Johannesburg Metropolitan were treating patients with ADD/ADHD (Nagle, 2007).

However this research into ADD/ADHD has focussed on homoeopaths practicing in predominantly affluent urban areas, omitting the populous rural areas where ADD/ADHD may also be prevalent. Thus this research conducted as a

quantitative survey, will incorporate both urban and rural areas by targeting homoeopaths practicing in different regions of KwaZulu-Natal.

This survey targeted homoeopaths, practicing throughout the rural and urban areas of KwaZulu-Natal. It explored and compared the homoeopathic practitioner's approach to these patients, as well as the treatment, management and success rate in treating ADD/ADHD within the urban and rural areas of KwaZulu-Natal. In addition, their perceptions regarding aetiology, treatment, management and success rate was investigated, as well as compared to that of Nagle (2007). This research also included a demographic study of the practitioners and their practices within KwaZulu-Natal.

1.2.1 PROBLEM STATEMENT

The perceptions and management of ADD/ADHD by homoeopathic practitioners in KwaZulu-Natal, by means of an electronically administered questionnaire created using Google docs.

1.2.2 AIMS

- To determine the number of registered homoeopathic practitioners who treat patients with ADD/ADHD within the region of KwaZulu-Natal.
- To determine the perceptions of registered homoeopathic practitioners in KwaZulu-Natal, with regard to the diagnosis, referral, treatment and management of patients with ADD/ADHD.
- To determine the perceptions of registered homoeopathic practitioners in KwaZulu-Natal with regard to the aetiology and contributing factors of ADD/ADHD.
- To determine the perceptions of registered homoeopathic practitioners in KwaZulu-Natal, with regard to the difference in diagnosis and treatment of ADD/ADHD in adults and children.

- To determine the perceptions of registered homoeopathic practitioners in KwaZulu-Natal with regard to their success rate in treating patients with ADD/ADHD.

1.2.2.1) Assumptions:

- The sample of practitioners who responded was representative of the population of practitioners in KwaZulu-Natal.
- The practitioners completed the research questionnaire truthfully, based on their personal experience.
- The practitioners interviewed represented both the urban and rural practices, giving an overview of how ADD/DHD is managed in all sectors of KwaZulu-Natal.

1.2.2.2) Delimitations:

- ADD/ADHD management and treatment by General practitioners, psychologists, neurologist, and paediatricians was not investigated.
- Provinces other than KwaZulu-Natal and Gauteng were not considered or investigated.
- Health-care providers who prescribe homoeopathic remedies, but who are not registered with the AHPCSA, were not included in the population.

1.2.2.3) Conclusions:

The purpose of this study was to investigate the perceptions as well as management and treatment of ADD/ADHD by homoeopathic practitioners within the urban and rural areas of KwaZulu-Natal.

Chapter 2: LITERATURE REVIEW

2.1 ADD/ADHD- EPIDEMIOLOGY, PREVALENCE and PROGNOSIS

Attention-Deficit/Hyperactivity Disorder (ADD/ADHD) is a multifactorial and clinically heterogeneous disorder that is associated with tremendous financial burden, stress to families and adverse academic and vocational outcomes (Bierderman, 2005). ADD/ADHD is currently one of the most researched childhood conditions, yet there is still much controversy and misunderstanding surrounding it. It is also one of the most commonly diagnosed disorders of childhood development (Picton, 2005) and the prevalence of this disorder in adults is increasingly recognized (Bierderman, 2005).

According to the DSM IV Criteria, ADD/ADHD is an Axis 1 childhood disorder, characterized by inattention, restlessness, impulsivity, and hyperactivity. ADD/ADHD characteristics cause disruption and create socio-environmental problems for the child (Kroeneberger, 2000). More boys than girls are diagnosed with ADD/ADHD; the ratio of male to female is 6:1, although ADD/ADHD tends to be under diagnosed in girls. The reason for this is thought to be that boys more frequently present with the easily identifiable hyperactivity/impulsivity symptoms, where as girls more frequently present with the inattentive symptoms (Barkley, 2004). Diagnosing psychiatric disorders in children is far from an exact science and the absence of objective evaluation methods and relying on the observations of parents and teachers introduces uncertainty into the diagnostic process (Barkley, 2004). 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. An assessment is made of the child's academic, social and emotional functioning (National Institute of Mental Health, 2008).

It is a current argument as to whether it is over-diagnosed or under-diagnosed (American Accreditation Healthcare Commission, 2008; Nagle, 2007). According to the most recent data, approximately between eight and ten percent of the South African population suffer from ADD/ADHD. It could be present from birth (often not recognized) or early childhood and usually persists throughout a person's lifetime (Attention Deficit Hyperactivity Disorder Support Group of South Africa, 2011).

Epidemiological studies indicate a high prevalence of ADD/ADHD throughout the world (Wilens, 2008). However there is no definite consensus on the incidence rate of hyperactivity and figures differ according to the source of information (Picton, 2005). Studies conducted in a number of countries over the past 10 to 15 years have revealed that ADD/ADHD exists in every country and in every ethnic group studied (Barkley, 2004).

It is unknown whether these figures reflect an increase in the incidence of ADD/ADHD, or simply a better recognition of it. It may also be an indication of a culture that places excessive emphasis on normalcy and academic achievement at the expense of over diagnosis (ADHD In-Depth Report, 2008).

It has been suggested that ADD/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 being a minimal awareness and understanding of the condition (Badat, 2004).

A study published in the South African Journal of Psychology on cross-cultural similarities in ADD/ADHD, for example the behaviour, amongst South African primary school children. The study analysed data from 6094 children from six different language groups in Limpopo Province. The study aimed to shed greater light on social effects within South African cultures, and between South African,

United States and European cultures, in the context of ADD/ADHD. Results of the study showed that prevalence rates of ADD/ADHD sub-types were in line with the prevalence rates in the United States and Europe. Furthermore the prevalence across language and gender groups of ADD/ADHD was very similar to those reported in the western countries (Meyer *et al*, 2004).

Up to 80 percent of school-aged children, given a clinical diagnosis of ADD/ADHD will have the disorder persisting into adolescence; and thirty to sixty five percent will carry it chronically into adulthood (Barkley, 2005; Wilens, 2008). Diagnosing adult ADD/ADHD can be difficult, since hyperactivity typically decreases, as children get older, whilst attention and organizational problems may be more prominent. 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). Jeeva (Cameron, 2011), a Johannesburg psychiatrist, is of the opinion that the symptoms of adult ADD/ADHD is different to the symptoms experienced by children. Adults with ADHD usually suffer from a multitude of behaviour problems for example, (anxiety, depression, drug abuse, bipolar disorder, anger frustration and personality disorders), other manifestations include poor time management and an inability to relax. Despite these very concrete symptoms, Jeeva says that in South Africa, adult ADHD has been poorly diagnosed, and it is still a belief among doctors and medical aids that adult ADHD does not exist (Cameron, 2011). According to the ADHD-In-Depth Report, four percent of adults aged 18 to 44 are affected. Between 19 to 37 percent of adults with ADD/ADHD have co-existing depression or bipolar disorder, between 25 to 50 percent have an anxiety disorder and approximately 20 percent of these adults have learning disorders usually dyslexia and auditory processing problems (ADHD-In-Depth Report, 2008). Only 10 to 20 percent of children with ADD/ADHD reach adulthood without any significant symptoms of their disorder (Barkley, 2005). Untreated adult ADD/ADHD leads to under-functioning even if the person has average to above average intelligence (Picton, 2005).

As with most conditions, there are degrees of the disorder exist within the population, where some people have mild or even borderline ADD/ADHD, whilst others exhibit moderate or severe ADD/ADHD. With regard to intelligence, children with ADD/ADHD represent the entire spectrum of intellectual development (Barkley, 2005).

Once ADD/ADHD has developed, the severity and prognosis is partly related to how the condition is managed. Failure and underachievement are likely to dominate the life of a child who's ADD/ADHD is left unrecognized and untreated (Barkley, 2005).

Early diagnosis and appropriate treatment in children is key to maximizing positive outcomes and minimizing the negative long-term effects of ADD/ADHD in adulthood. Without effective treatment, the risks associated with ADD/ADHD are very great. Children with ADD/ADHD 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/ADHD becomes a stigma with resultant long-term negative implications (Lawlis, 2005).

2.2) IMPLICATIONS OF ADD/ADHD

ADD/ADHD is a problem for society as a whole. The challenges associated with this condition have enormous implications. The economic, educational, social and personal costs of ADD/ADHD can be significant (Meyer, *et al*, 2004). According to a study published in the Journal of American Academy of Child and Adolescent Psychiatry, the costs of ADD/ADHD are reflected in the entire family medical profile. They would have more medical claims and the direct medical care costs per annum per family member were found to be twice as high as non-ADD/ADHD families. The indirect costs for disability and absenteeism were sixty-one percent higher than non-ADD/ADHD families (Lawlis, 2005, NIMH, 2008).

Once children with ADD/ADHD enter school, a major social burden is placed on them that will last for at least the next 12 years. Up to 30 to 50 percent of these children may be retained in a grade at least once and as many as 35 percent may fail to complete high school altogether. It is a major area of impact of the disability and may create the greatest source of distress for the child and parents (Barkley, 2005).

A 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).

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 percent of students with ADD/ADHD never finish school.
- Individuals with ADD/ADHD have significantly more hospital visits than non-sufferers.
- Parents of ADD/ADHD children divorce three times more often than those whose children do not have ADD/ADHD.
- 50-57 percent of incarcerated inmates in prison have some form of ADD/ADHD.
- 52 percent of ADD/ADHD sufferers abuse drugs at some time or other in their lives.

According to the ADHD in Depth Report, ADD/ADHD affects approximately four percent of adults aged 18 to 44 years. Even though many of these adults are employed and self-supporting, their educational level and socio-economic status tends to be low, even when compared to their own siblings (Barkley, 2005).

2.3) AETIOLOGY

Although ADD/ADHD is one of the most extensively studied of all the childhood psychological disorder, it remains misunderstood and controversial in the minds of the general public as well as the medical profession. 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 (Barkley, 2005). It is commonly accepted that ADD/ADHD has multiple causes and how they influence the brain and behaviour has increased significantly (Barkley, 2005). A vast number of different theories on ADD/ADHD have been suggested (Picton, 2005). In the following chapters the contributing and aetiological factors will be discussed.

Neurotransmitters:

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). According to the Britannica Encyclopaedia (2006), the neurotransmitters responsible for attention and motor behaviour are the catecholamines. The catecholamines occurring naturally in the body serve as hormones or as neurotransmitters in the sympathetic nervous system. These are namely dopamine, norepinephrine and epinephrine these substances arouse and excite us emotionally, mentally and physically, they help us to focus and be attentive. They keep a person alert to the important events taking place around and within them, thus allowing them to act quickly and with decision. These catecholamines are said to be dormant or non-active in individuals with ADD/ADHD (Hoffman, 1997).

The catecholamine hypothesis states that ADD/ADHD is caused by a deficiency in these neurotransmitters. The hypothesis stems from the fact that drugs

(methylphenidate and dextroamphetamine) used to treat ADD/ADHD increase the amount of catecholamines in the brain (Kroeneberger, 2000)

According to a study found in the archives of General Psychiatry, scientists argue that ADHD may well be the result of reduced dopamine levels in the brain. Dopamine plays an important role in behaviour and thinking, attention, learning, motor activity, motivation and reward, sleep, and mood. This brain chemical is very important in the ADHD symptoms of hyperactivity, attention, motor activity, and the tendency to substance abuse. Scientists at the National Institute of Drug Abuse studied a control group made up of 19 ADHD adults, who were not on medication, and 24 healthy adults. They gave each subject PET (positron emission tomography) scans before and after administering a drug, which binds with dopamine in the brain. The study revealed depressed dopamine activity in the caudate and the preliminary evidence in limbic regions in adults with ADHD that was associated with inattention and with enhanced reinforcing responses to intravenous methylphenidate. This suggests that dopamine dysfunction is involved with symptoms of inattention associated with ADHD (Volkow, Wang, Newcorn, Telang, Solanto, Fowler, Logan, Ma, Scgulz, Pradhan, Wong, Swanson, 2007).

Brain Development:

Evidence is mounting that suggests that ADD/ADHD is a disorder in brain development or brain functioning that originates in genetics (Barkley, 2005). The specific factors inherited in ADD/ADHD probably include a tendency toward problems in the development of the frontal cortex of the brain as well as the caudate nucleus (Barkley, 2005). An imaging study by Shaw, Rapoport & Evans, published in 2007 by the National Institute of Mental Health (NIMH) has revealed that brain changes mirror symptoms in ADD/ADHD. The study showed that the brain matures in a normal pattern in children with ADD/ADHD but is delayed an average of three years in the circuitry of the frontal and temporal regions, compared to children without the disorder. They discovered a normal yet delayed

pattern in the cortex maturation. This area integrates information from the sensory areas with high-order functions. The motor cortex was found to develop faster in these children, possibly due to their hyperactive component. Although the ADD/ADHD group initially had a thinner cortex, most prominently in the frontal areas that control attention and motor activity. After being re-scanned approximately six years later, these changes turned out to be much greater in patients who showed less improvement, and in children with improvement, the scans showed the area of the cortex associated with attention, had increased thickness and resembled that of healthy peers (NIMH, 2006). These findings support theories that ADD/ADHD results from a delay in cortex maturation (NIMH, 2006).

Genetic Factors:

Predictors of persistence of ADD/ADHD include family history of the disorder, psychiatric co-morbidity, and psychosocial adversity. Family studies of ADD/ADHD have consistently supported its strong familial nature (Bierderman, 2005).

Experts have documented a hereditary aspect of ADD/ADHD because it often occurs in families. The hereditary aspect can also be seen in children who are mirror images of a parent; they tend to share behavioural and learning styles. Researchers at the University of California at Irvine reported finding the first abnormal gene associated with ADD/ADHD. The gene controls dopamine receptors in the brain and this abnormality causes less sensitivity to dopamine (Reichenburg-Ullman & Ullman 2000; Stordy and Nicholl, 2002).

There is a forty percent chance that at least one parent of a child with ADD/ADHD also has the disorder and approximately 15 to 20 percent of mothers and 20 to 30 percent of fathers of children, may have had ADD/ADHD at the same time as their children. Having a sibling with ADD/ADHD increases the

likelihood to 25 to 35 percent that another child in the family will have ADD/ADHD (Barkley, 2005).

Studies of twins are even more persuasive. Scientists have found that if one twin has symptoms of ADD/ADHD, the risk that the other twin will have the disorder is as high as 80 to 90 percent (Barkley, 2005)

Recent research published in the Lancet by scientists at Cardiff University, provides the first direct evidence that ADD/ADHD is a genetic condition. The research found that children with ADHD were more likely to have small segments of their DNA duplicated or missing compared with other children. The study also found a significant overlap between these segments, known as copy number variants (CNVs), and genetic variants implicated in autism and schizophrenia, proving strong evidence that ADHD is a neurodevelopment disorder. The genomes of three hundred and sixty six children, all of whom had been given a clinical diagnosis of ADHD, were studied against over one thousand control samples, in search of variations in their genetic make-up that were more common in children with the condition. It was found that children with ADD/ADHD had a significantly higher rate of missing or duplicated DNA segments, compared to other children. The researchers also found that the rate of CNVs was almost twice as common in children with ADD/ADHD compared to the control sample. It was concluded that ADD/ADHD is not caused by a single genetic change, but is likely caused by a number of genetic changes, including CNVs, interacting within the child's environment (Williams, Martin, Langley, Mantripragada, Fossdal, Stefansson, Manusson, Gudmundsson, Gustafsson, Holmans, Owen, O'Donovan, Thaper, 2010).

Dietary Factors:

It has been claimed that diet plays an integral and influential role in ADD/ADHD symptoms. Food can affect our moods, concentration and behaviour, especially

the modern eating habits of today's world, which does not necessarily ensure an adequate intake of essential nutrients (Holford, 2004; Picton 2005).

Some of the most important nutrients for brain development are absent in the average modern diet (Holford, 2004). A deficiency in Essential Fatty Acids (EFAs) is being singled out by some as a cause of ADD/ADHD. EFA's, namely Omega 3 and Omega 6, influence ADD/ADHD primarily in two ways; on influence of gut permeability as well as contributing to proper development of brain tissue (Burgess, Stevens, Zhang and Peck, 2000; Lottering, 2006, Middleborough, 2004). Symptoms of essential fatty acid deficiency are common in many children with ADD/ADHD, these include, excessive thirst, dry skin, eczema and asthma (Holford, 2004).

Nutritional deficiencies in ADD/ADHD children could severely increase the problems they already face. Identifying and correcting existing deficiencies may not only clear up some of the problems but may also help the child cope more effectively with those that remain (Picton, 2005).

Children, who consume a diet that is predominant in refined food, increase the risk of nutritional deficiencies developing. More than sixty percent of ADD/ADHD children are short of zinc this is often as a result of the refining process that is applied to certain foods, like white sugar, flour and rice. Nutrients like zinc and the B vitamins are found in whole grain food, but are destroyed or absent in the refined product. The B vitamins are important for the regulation of the nervous system and the metabolism of fats carbohydrates and proteins (Picton, 2005).

According to research conducted by Konofal, Lecendreux, Arnulf and Mouren (2004), Iron deficiencies cause abnormal dopaminergic neurotransmission and thus this deficiency may contribute to the pathophysiology of ADD/ADHD. The study found that the mean serum ferritin levels were twice as low in children with ADD/ADHD when compared to the age and sex matched children without

ADD/ADHD. It was found that children with the more severe iron deficiency were the most inattentive, impulsive and hyperactive. The researchers suggest that supplementing with iron could therefore improve the central dopaminergic activity in these children, thus decreasing the need for stimulant treatment (Konofal, et al., 2004).

Recent research findings published online in the international *Journal of Attention Disorders* found an association between ADD/ADHD and a 'Western-style' diet in adolescents. The study examined the dietary patterns of 1800 adolescents from the long-term Raine Study and classified diets into 'Healthy' or 'Western' patterns, and found a diet high in the Western pattern of foods was associated with more than double the risk of having an ADD/ADHD diagnosis compared with a diet low in the Western pattern. In the study, 115 adolescents had been diagnosed with ADHD, 91 were boys and 24 were girls.

According to the outlines of the research, a "healthy pattern" is a diet high in fresh fruit and vegetables, whole grains and fish. It tends to be higher in omega-3 fatty acids, folate and fibre. A "Western pattern" is a diet with a trend towards fast foods, confectionary, processed, fried and refined foods. These diets tend to be higher in total fat, saturated fat, refined sugar and sodium. When the specific foods were examined, having an ADD/ADHD diagnosis was associated with a diet high in takeaway foods, processed meats, red meat, high fat dairy products and confectionary. The research suggested that a Western dietary pattern may indicate the adolescent has a less optimal fatty acid profile, whereas a diet higher in omega-3 fatty acids is thought to hold benefits for mental health and optimal brain function, it was also suggested that the Western dietary pattern doesn't provide enough essential micronutrients that are needed for brain function, particularly attention and concentration, or that a Western diet might contain more colours, flavours and additives that have been linked to an increase in ADD/ADHD symptoms (Howard, Robinson, Smith, Ambrosini, Piek, Oddy, 2010).

Environmental Factors:

The environment has an important role to play and it has been suggested that unfavourable environmental conditions, physical and emotional can cause symptoms of hyperactivity (Picton, 2005). Physical environmental conditions include: smoke, excess lead exposure, exposure to chemicals and pollutants.

In a recent study published in the journal *Paediatrics*, a team of scientists from the University of Montreal and Harvard University had discovered that exposure to organophosphate pesticides may be associated with increased risk of Attention-Deficit Hyperactivity Disorder (ADHD) in children. The study found a connection between exposure to pesticides and the presence of symptoms of ADHD. In the study, over 1000 children from the general U.S. population were tested and the pesticide level in their urine was measured. Children with higher urinary dialkyl phosphate concentrations, especially dimethyl alkylphosphate (DMAP) concentrations, were more likely to be diagnosed as having ADD/ADHD. For the most-commonly detected DMAP metabolite, dimethyl thiophosphate, children with levels higher than the median of detectable concentrations had twice the odds of ADD/ADHD compared with children with undetectable levels. The study found that exposure to organophosphates in developing children might have effects on neural systems and could contribute to ADD/ADHD behaviours, such as inattention, hyperactivity, and impulsivity (Bouchard, *et al.*, 2010).

Poor environmental factors have been implicated in the development of the symptoms of ADD/ADHD. According to, Richman, Stevenson and Graham (1982), poor environmental, emotional and social factors can negatively affect the behaviour of children who suffer with AD/ADHD. The research concluded that children who grew up with inadequate housing and lack of financial security were more likely to display behavioural difficulties. Children who are raised with unskilled parenting are not given consistent and predictable limit setting, are not equipped to deal with the demands of a structured school day (Robertson,

Allwood and Gagiano, 2000; Middleborough, 2003). Although a chaotic family life and parental psychiatric problems are associated with, and may well cause, serious defiant and aggressive behaviour, they are not causative of ADD/ADHD (Barkley, 2005).

According to results on the cross-cultural differences in children with ADD/ADHD behaviour, the children who scored highest on the motor performance tests were the children who had attended pre-primary schooling and had come from the affluent urban areas, where money and resources were spent on education (Meyer *et al.*, 2004).

DeGrandpre (2002) poses the question of whether ADD/ADHD is really a new discovered medical disease or if it is a culture-induced brain dysfunction that results from our growing need for speed. He hypothesized that an over-stimulated, hurried society, could contribute to the problem, and as our society move faster so do the rhythms of our own consciousness. The growing atmosphere of hurriedness, intensity, urgency and pressure to perform, only perpetuates the problem.

Gifted Children:

In recent years, several authors have expressed concern that giftedness is often misconstrued as ADD/ADHD and that the diagnosis of ADD/ADHD among the gifted population has run amok (Kaufmann, Kalbfleisch, and Castellanos 2000).

A child displaying behavioural symptoms of ADD/ADHD could actually have a high Intelligence Quotient (IQ) and their perceived inability to stay “on task” might be related to boredom, curriculum, mismatched learning or teaching styles as well as environmental factors mentioned above. Gifted children may demonstrate ADD/ADHD behaviour in some settings but not in others. These children may spend 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, thus these children can be incorrectly diagnosed.

Kaufmann, *et al.*, (2000), believe that acknowledging that a child can be both gifted and have ADD/ADHD is vital in the treatment of the child. The most relevant element that must be considered in evaluating ADD/ADHD is the degree of impairment a child experiences as a result of the behaviours. A child whose behaviour causes him to be impaired academically, socially or in the development of the self, should be examined from a clinical perspective to exclude potentially treatable conditions, even if the behaviour may be similar to the traits typically ascribed to creativity or giftedness or to “over excitabilities”. However, this does not mean that every child who is impaired needs medication. As many authors have noted, non-medical interventions can be used within the school and home and should be tried before more intrusive interventions are employed (Kaufmann *et al.*, 2000).

2.4 CLINICAL PICTURE

According to The Diagnostic and Statistical Manual of Psychiatric Disorder, 4th Edition (DSM IV), ADD/ADHD is an Axis 1 childhood disorder, characterized by inattention, restlessness, impulsivity and hyperactivity (DSM-IV-TR, 2000). ADD/ADHD characteristically causes disruption and creates socio-environmental problems, as sufferer's behaviour is not developmentally appropriate for their age (Kroeneberger, 2000).

According to the DSM-IV criteria, the child must have at least six of the below-mentioned symptoms of inattention or hyperactivity-impulsivity. They must be present for at least six months and be more severe than is normally observed in individuals at a comparative level of development. These symptoms must be persistent and noted before the age of seven. They should cause clinically

significant impairment (e.g. in school, academic, or occupational functioning) and must be present in at least two settings (e.g. home and school). Symptoms must not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder or be better accounted for by another mental disorder (e.g. Mood disorder, Anxiety disorder, Dissociative disorder, or a Personality disorder) (DSM-IV-TR, 2000).

Symptoms of inattention:

- Fails to give close attention to details or makes careless mistakes in school or other activities
- Has difficulty sustaining attention in tasks or play activities
- Does not seem to listen when spoken to directly
- Does not follow through on instructions and fails to finish schoolwork, chores, or duties
- Has difficulty organizing tasks and activities
- Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- Loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books, or tools)
- Is easily distracted by extraneous stimuli
- Is forgetful in daily activities

Symptoms of hyperactivity-Impulsivity:

- Fidgets with hands or feet, or squirms in seat
- Leaves seat in classroom or in other situations in which remaining seated is expected
- Runs about or climbs excessively in situations in which it is inappropriate
- Has difficulty playing or engaging in leisure activities quietly
- Is “on the go” or acts as if “driven by a motor”
- Talks excessively
- Blurts out answers before questions have been completed

- Has difficulty awaiting turn
- Interrupts or intrudes on others

Many individuals present with characteristics of both inattention and hyperactivity-Impulsivity, however there are individuals on whom one or the other pattern is predominant. The appropriate subtype should be diagnosed based on the predominant symptoms pattern for the past six months (DSM-IV-TR, 2000).

DSM-IV has created three subcategories, namely:

1. Attention-deficit/hyperactivity disorder, Predominantly Inattentive Type: Inattention but not hyperactivity-impulsivity symptoms.
2. Attention-deficit/hyperactivity disorder, Predominantly Hyperactive-Impulsive Type: Hyperactivity-impulsivity but not inattention symptoms.
3. Attention-deficit/hyperactivity disorder combined Type: Both inattention and hyperactivity-impulsivity symptoms.

Characteristic Symptoms and Signs:

According to the DSM-IV-TR (2000), ADD/ADHD can be divided into three subgroups due to symptom presentation:

1. Primarily Inattentive type:

The patient 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, is easily distracted or is forgetful in daily activities

2. Primarily Hyperactive/impulsive type:

Hyperactive symptoms include: Fidgeting with hands or squirms in the chair, has difficulty remaining seated, runs about or climbs excessively, has difficulty playing or engaging in activities quietly, often “on the go” or “driven by a motor” or talks excessively. Impulsive symptoms are characterized by behaviour where action is taken without indication or thinking of consequences. They include: blurting out answers before the questions have been completed, difficulty waiting or taking turns, interrupts or intrudes on others.

3. Combined Type:

The individual meets both sets of inattention and hyperactivity/impulsivity

The following criteria 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 six 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 social, academic or occupational functioning.
5. The disturbances 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).

2.5) DIAGNOSIS AND CHARACTERISTIC SYMPTOMS OF ADD/ADHD:

Diagnosing psychiatric disorders in children is far from an exact science and the absence of objective evaluation methods and relying on the observations of parents and teachers introduces uncertainty into the diagnostic process (Barkley, 2005). In order to diagnose ADD/ADHD, substantial information about the child and family must be obtained. The information must be sifted through to establish symptoms of ADD/ADHD and rule out other disorders or problems (Barkley, 2005). Ideally the assessment gathers information from multiple informants who have observed the child in diverse situations. Both cognitive and behavioural components of ADD/ADHD must be assessed in order to understand the pattern of symptoms for the individual child. A comprehensive ADD/ADHD assessment

leads to conclusions as to the presence, severity, type, and characteristics of the disorder in the child (Kroeneberger, 2000).

Under optimal circumstances, a team, including a qualified clinician, such as a paediatrician, a family physician, psychiatrist, neurologist, or psychologist should make the diagnosis of ADD/ADHD because only these types of specialists can assess the physical and psychological problems that mimic ADD/ADHD (Kaufmann, *et al.*, 2000). The final diagnosis of ADD/ADHD is made by careful clinical history, applying the DSM-IV criteria (Wilens, 2008).

Not all children and adults with ADD are hyperactive, so the diagnosis is either ADD or ADD with hyperactivity (ADHD). The DSM IV sets out the criteria that must be met in order for a diagnosis to be made (Picton, 2005). 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 (Riechenburg-Ullman and Ullman, 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:

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, lead poisoning, severe anaemia, and 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 (Picton, 2005).

2.6) INCORRECT DIAGNOSIS

Incorrect diagnosis has become a very controversial topic for parents, teachers and all the professionals involved in the treatment of ADD/ADHD.

ADD/ADHD is one of the least understood medical afflictions, because the specific aetiology for ADD/ADHD is unknown, there are no laboratory tests, neurological assessments or attentional assessments that have been established in the clinical assessment of ADD/ADHD (DSM-IV-TR, 2000). When hyperactivity, distractibility, poor concentration and impulsivity impact performance in school, social relationships, or behaviour at home, ADD/ADHD may be suspected (NIMH, 2008).

As there are no specific tests available, misdiagnosis has become a common and often devastating outcome. Social and economic problems such as single parent households, lack of pre primary education and poorly resourced schools are some factors contributing to misdiagnosis (Meyer, *et al.*, 2004) often these children are sent to school when they are too young for their grades and are therefore socially and intellectually immature (ADHD In-Depth Report, 2008).

According to Sir Ken Robinson (2010), ADD/ADHD is a fictitious epidemic. Children are being medicated as routinely as having their tonsils out. Children are living in the most intensely stimulating period, in the history of the earth, they

are besieged with information and calls for their attention from every platform; computers, iphones, advertising holdings, hundreds of television programmes, and society is penalizing them from getting distracted, from boring information presented at school. Robinson believes that it is not a coincidence that the incidence of ADD/ADHD has risen in parallel with the growth of standardisation in schools.

Many teachers mislabel children as having ADD/ADHD because they don't have the time or the resources to develop real expertise. Children who are placed in academic environments that are intellectually inappropriate for their ability could be misdiagnosed as ADD/ADHD. Characteristics of inattention are common in children with a low intelligence quotient (IQ) or mental retardation. On the other hand, children of a high intelligence may have problems with inattention that could be misdiagnosed as ADD/ADHD when placed in academically understimulating environments (DSM-IV-TR, 2000). It is dangerous to label a child without scientific basis for the diagnosis and too often the treatment that follows treats only the symptoms and not the person affected (Lawlis, 2005).

According to a recent study published in the Journal of Health Economics, Nearly 1 million children in the United States are potentially misdiagnosed with attention deficit hyperactivity disorder simply because they are the youngest and most immature in their kindergarten class. The research that was conducted by Economics Department, of Michigan State University, found that the teachers' perceptions and opinions are instrumental in decisions to send children to be evaluated by mental health professionals. According to Elder, many of the ADD/ADHD diagnoses are driven by the teachers' perceptions of poor behaviour among the youngest children in a kindergarten classroom, but these 'symptoms' may merely reflect emotional or intellectual immaturity among the youngest students (Elder, 2010).

Standardisation in schools favours conformity and obedience. Creativity and ingenuity is frowned upon and the arts and science subjects are victims of this mentality. The arts especially address the idea of an aesthetic experience. This is where the senses are operating at their peak, you are present in the current moment, you are resonating with the excitement of the thing you are experiencing and you are fully alive. An anaesthetic shuts your senses off, and you deaden yourself to what is happening around you. ADD/ADHD drugs work like an anaesthetic to the child. Robertson believes that we are getting our children through the education system by anesthetizing them, and we should be waking them up to what they have inside of themselves as appose to putting them to sleep (Robinson, 2010).

ADD/ADHD has become a fashionable diagnosis that is made far too easily and quickly. There are innumerable studies of under diagnosis and over diagnosis and it is estimated that millions of children are incorrectly labelled and treated for nothing more than immaturity. A review of these studies showed clearly that 50 percent of children diagnosed with ADD/ADHD do not fit the officially accepted criteria and are therefore wrongly diagnosed (Goldberg, 2004).

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

- 1.) The process of establishing “objective” diagnostic standards for ADD/ADHD has been quite subjective
- 2.) Official guidelines for evaluating ADD/ADHD symptoms are vague and open to interpretation, yet they lead to an all-or-nothing diagnosis.
- 3.) The ADD/ADHD 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 into account of family systems and other environmental factors.
- 5.) In its current phase as a “disorder for all seasons”, ADD/ADHD has 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 certain other childhood psychiatric disorders. And many children meet criteria for some, but not all of the symptoms of several different conditions.

2.7)TREATMENTS AND MANAGEMENT

Most children require help from a variety of disciplines, and the period of time that they attend the different therapies depend on the individual needs of the child and the nature of the therapy (Picton, 2005). Most professionals agree that a team approach is required and this includes medicinal, psychological, educational, behavioural management and life style changes. Parents, teachers and the child all need to be involved in the treatment and management process (Nagle, 2007).

The psychologist Lawlis (2005), offers advice on a multimodel treatment that should include medication, counselling and biofeedback, electromagnetic treatments, nutritional adjustments, strategies for sleep disturbances, neuropathy and self-development management. This is not always a realistic goal for standardized ADD/ADHD treatment within South Africa due to financial constraints. The management of ADD/ADHD traditionally includes consideration of 2 major areas: pharmacotherapy and non-pharmacological therapy (Wilens, 2008).

2.7.1) Pharmacotherapy

Current medications do not cure ADD/ADHD. Rather, they control the symptoms for as long as they are taken. Medications can help a child pay attention and complete schoolwork. It is not clear, however, whether medications can help children learn or improve their academic skills. Adding behavioural therapy, counselling, and practical support can help children with ADD/ADHD and their families to better cope with everyday problems. According to research done at the National Institute of Mental Health (NIMH), medication works best when the prescribing doctor regularly monitors treatment and the dose is adjusted based on the child's needs (NIMH, 2008).

The most conventional type of medication used for treating ADD/ADHD consists of psychostimulants (Davidson & Neale, 2001). The more commonly used compounds in this class include methylphenidate, amphetamine and magnesium pemoline (Willens, 2008). Stimulants are sympathomimetic drugs, which increase intrasynaptic catecholamines via inhibition of the presynaptic uptake mechanism and the release of catecholamines (Wilens, 2008).

Stimulants:

Stimulant medication deals directly with the under-active part of the brain that is responsible for inhibiting behaviour and maintaining an effort or attention to things. The hyperactive-impulsive subtype demonstrate a much greater therapeutic response to stimulant medication, as the stimulants improve the child's attention, impulse control, fine motor co-ordination and reaction time (Barkley, 2005).

Methylphenidate is said to have a greater tendency to relieve 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).

The greatest benefit of this therapy seems to be that it increases the effectiveness of psychological and educational treatments. Thus it is usually recommended that medication be used as part of a combination of treatments, not as the sole form of therapy (Barkley, 2005).

Common adverse effects associated with stimulants include loss of appetite with subsequent loss of weight, headaches, nausea, abdominal pain, sleeplessness and depression (Picton, 2005).

Non-Stimulants:

About one third of the children placed onto stimulant medication like Methylphenidate do not respond, or cannot tolerate this type of drug (Willens, 2008). Other medications like non-stimulants and anti-depressants are therefore considered in the treatment of ADD/ADHD. These other medication options are not as effective as stimulant medication, however antidepressant and non-stimulants can be of benefit in the treatment of ADD/ADHD in cases where there is unacceptable side effects from medication, or in cases where a co morbid condition such as depression, or anxiety is present (Barkley, 2005).

Tricyclic Antidepressants act by blocking the reuptake of neurotransmitters, including norepinephrine. These drugs are effective in controlling abnormal behaviours and improving cognitive impairments associated with ADD/ADHD (Wilens, 2008). Side effects include, dry mouth, constipation, weight gain, blurred vision, nearsightedness, nervous tics and an increase risk of seizures and convulsions (Barkley, 2005).

Other non-stimulant drugs like Atomoxetine (Strattera®) work by increasing the levels of the neurotransmitter norepinephrine and inhibit the reuptake of noradrenalin by the presynaptic neurons (NIMH, 2008).

Herbs:

The use of herbal remedies for ADD/ADHD shows beneficial results without the risks of abuse found in pharmacological medications and usually with significantly less side effects. Herbal remedies have shown promise without side effects; these herbs enhance alertness without the use of caffeine.

Herbalists may recommend other supplementation and dietary changes in addition to herbs in the treatment of ADD/ADHD symptoms (Holford, 2007).

Brahmi (Bacopa monnery): This herb has shown to be effective for concentration and positive release of energy; it also acts as an antioxidant and has been shown to increase learning and cognition (Bone & Dey, 2003).

Ginkgo biloba: This is an effective herb for improving concentration and memory as it increases blood flow to the brain by maintaining a healthy circulatory system, and acts as an antioxidant to the nervous system. It also improves glucose metabolism to the brain (Bone & Dey, 2003).

Gotu Kola (Centella asiatica): This herb is a tonic herb for ADD/ADHD; it supports the brain and nervous system. This herb helps with mental clarity, healthy memory, brain function & mood. It also works to improves cerebral blood flow and circulation in general (Bone & Dey, 2003).

Green Oats (Avena sativa): This herb is known as a nerve tonic and demonstrates a stimulating effect over time (Bone & Dey, 2003).

German Chamomile (*Matricaria recutita*): Chamomile is used to help relieve simple nervous tension. It is used to ease frustrations caused by common overwork and fatigue (Bone & Dey, 2003).

Skullcap (*Scutellaria laterifolia*): This herb is helpful as it eases feelings of being overwhelmed. It also promotes a natural equilibrium and contributes to the maintenance of an even keel and healthy attitude (Bone & Dey, 2003).

Schisandra (*Schisandra chinensis*): One of the multi-use ADD/ADHD herbal remedies that increases brain efficiency & work capacity. It is also useful in insomnia, night sweats & diarrhoea (Hoffman, 1997; (Bone & Dey, 2008).

2.7.2) Non-Pharmacological:

Most children require help from a variety of disciplines, and the period of time they attend the different therapist will depend on the individual needs of the child and the nature of the therapy. A team approach is usually needed with both the parents and professionals playing a role in the child reaching his/her best potential (Picton, 2005).

Psychological treatment:

Psychological or behavioural therapy is mainly required for the secondary problems that develop such as low self-esteem, anxiety and depression. Children with ADD/ADHD need guidance and understanding from their parents and teachers to reach their full potential and to succeed in school. Before a child is diagnosed, frustration, blame, and anger may have built up within a family. Parents and children may need special help to overcome these feelings.

Mental health professionals can educate parents about ADD/ADHD and how it impacts a family. A therapist will teach the patient certain social skills and models

of appropriate behaviours that are important in developing and maintaining social relationships (NIMH, 2008). Behaviour therapy, emotional counselling, and practical support help ADD/ADHD children handle everyday problems (NIMH, 2008) whilst environmental changes are implemented to decrease limitations caused by ADD/ADHD.

Sometimes, the whole family may need therapy. Therapists can help family members find better ways to handle disruptive behaviours and to encourage behaviour changes. Finally, support groups help parents and families connect with others who have similar problems and concerns. Groups often meet regularly to share frustrations and successes, to exchange information about recommended specialists and strategies, and to talk with experts. Support Groups such as Attention Deficit Hyperactivity Support Group of South Africa (ADHASA) provide an important function for families (NIMH, 2008).

Remedial Schools:

Many remedial schools offer a multidisciplinary approach for assessing children with learning or behavioural disabilities. These schools have the facilities to accommodate specific learning problems, and after a few years the child is able to return to the mainstream school system better able to cope with academic demands. These schools offer small classes with individualized attention, as the teachers are qualified to handle learning problems. The multidisciplinary approach is very beneficial as the schools offer excellent services with the support teams of speech therapists, occupational therapists and remedial therapists (Picton, 2005).

However children with ADD/ADHD may not have such extreme behavioural disabilities to warrant the emotional and psychological disruption that moving schools may incur, and so assistance from a remedial facilitator may be more beneficial. Julia Medina, a remedial facilitator at *Ican special needs centre* says

that children with special needs are children none the less and require the interaction with neuro-typical children. Children with ADD/ADHD have issues when it comes to discipline and routine and they benefit more by being exposed to aspects of routine and normality- like attending assembly or playing in a sports team. Their special needs should not exclude them from day to day activities, and that is why facilitation is so important. Not only can a facilitator adjust behaviour where necessary, she can also adapt the academic curriculum, thus allowing the child to remain in the routine of a normal day to day school, and at the same time receive the more personal assistance of a remedial school in the form of a facilitator (Medina, 2011).

Bach flower remedies:

Bach flower remedies are a series of 38 preparations made from wild flowers and plants. The remedies are designed to treat the whole person and not just the symptoms of an illness. The remedies are chosen according to psychological and emotional symptoms. Bach flower remedies may be beneficial in the treatment of ADD/ADHD as they operate in areas of inattention, hyperactivity, impulsivity and concentration (Vermeersch, 2011).

Diet:

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).

A properly balanced diet aids in the development of healthy brain cells and healthy cellular functioning (Holford, 2004) It is important to ensure that the child has no deficiencies and it is advisable to remove as many processes and

unnatural substances as possible from the diet. This will eliminate any dietary contributions to behavioural problems and hyperactivity (Holford, 2004).

The Feingold Diet was originally devised for patients suffering from allergies. It was then noticed that the behaviour of many hyperactive children improved dramatically when put on the same diet. The diet avoids salicylates, synthetic flavours and colourants, selected preservatives and some natural foods. Chemical antioxidants and fried foods are avoided. Unrefined and unprocessed foods are preferable and vitamin, mineral and essential fatty acid supplementation is encouraged (Picton, 2005).

2.7.3) Homoeopathy:

Homoeopathy is a medical art and science developed by Samuel Hahnemann. The word homoeopathy is derived from the Greek words *homoeos*, meaning like or similar and *pathos* meaning suffering. The foundations of homoeopathy are the Law of Similars and the infinitesimal dose (De Schepper, 2006).

The entire concept of health and healing, according to homoeopathy is based on the vital force, or the energy force within the body. The role of homoeopathy is to reduce the patient's susceptibility to external and internal factors, by strengthening the vital force through the application of homoeopathic remedies (De Schepper, 2006).

Homoeopaths aim to treat the person, not the disease. The totality of symptoms is a comprehensive picture of the whole person (Reichenburg-Ullman & Ullman, 1996). The role of the homoeopath is to find the totality of symptoms through careful, thorough case taking. This involves taking into account the mental, emotional and physical states of the patient in their current state (De Schepper, 2006). 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.

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).

Research into Homoeopathic and Alternative treatments of ADD/ADHD:

Homoeopathy provides a valuable service in the treatment of ADD/ADHD (Picton, 2005) as many homoeopaths have been successful in treating ADD/ADHD and other behavioural conditions using specific, individualized homoeopathic remedies (Reichenburg-Ullman & Ullman, 1996). A homoeopath observes and explores a child's thought processes, emotional state, physical aspects and nutritional status (Picton, 2005). One of the most fundamental tenets of homoeopathy is that we do not treat a disease, but rather a patient with a disease (De Schepper, 2006). The success rate is estimated to be at least 70 percent, when individually chosen homoeopathic remedies are used to treat ADD/ADHD for one year (Reichenburg-Ullman and Ullman, 1996). Furthermore homoeopathic remedies do not suppress symptoms and even when given for a period of time, do not cause dependency. Remedies are safe, non-toxic, and relatively free from side effects, and they will not interfere negatively with other medication (Reichenburg-Ullman and Ullman, 1996).

Homoeopaths base the evidence for the effectiveness of homoeopathy on clinical results with many patients. These results are shared in the homoeopathic journals and at conferences (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 homoeopathic treatment for ADD/ADHD in children.

At the Durban University of Technology, Middleborough (2004) conducted a study to determine the efficacy of supplementation using Evening Primrose Oil and low Homoeopathic potency 6ch, Gamma Linolenic Acid (GLA) in the management of ADD and ADHD in boys, the results showed an overall improvement with the mean scores of Evening Primrose oil as there was a significant improvement in the attention scores. The homoeopathically prepared GLA did not show any statistically significant improvement, although there was a slight improvement in the attention scores.

Lottering, (2005) conducted a trial to determine and compare the relative efficacy of a nutritional supplement (Advanced Brain Food®) and the homoeopathic complex (Quietude®) in the management of ADD/ADHD in boys. There was a significant improvement in the attention spans of the subjects who took advanced brain food®, thus it was found to be an effective intervention treatment. Quietude® did not show any statistically significant improvement, however it was clear that there was a slight improvement in the sustained attention levels.

Jones (2009) conducted a study to determine the efficacy of the Homoeopathic simillimum in the treatment of ADD/ADHD. This research proved to be successful, as across the whole trial and within each group, subjects had significant reductions in symptoms.

At the University of Johannesburg, Smith (2001) investigated the use of Cerbo® which is indicated for impaired concentration and Nerva2®, which is indicated for nervous hyperactivity. Both homoeopathic complex preparations include remedies that are indicated for the symptoms expressed by the majority of

ADD/ADHD Patients. The participants in the study showed statistically significant improvement in the teacher rating scores.

Nagle (2007) conducted a survey to determine the perceptions and management of ADD/ADHD by homoeopathic practitioners in the Johannesburg Metropolitan Area. According to the results of the above mentioned survey no statistically significant association can be made between the type of qualification and the success rate with treating ADD/ADHD. Regardless of the qualification, the majority of the homoeopaths in study report that they are moderately to very successful (Nagle, 2007).

Chapter 3:

MATERIALS AND METHODS

3.1 Study Design

The research was conducted as an exploratory survey in order to determine the perceptions, treatment and management of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder by Homoeopathic practitioners within KwaZulu-Natal.

The survey was conducted by distributing a detailed web-based questionnaire to the homoeopathic practitioners. The questionnaire was formulated from Nagle (2007); it was subsequently modified according to her recommendations, to ensure the questionnaire was clear concise, specific and non-time consuming (Appendix 1A, 1B and 1C).

The questionnaire with three sections was electronically sent out to the practitioners to complete. Section A of the questionnaire focused on the practitioner demographics. Section B looked at the diagnosis, treatment and referral, as well as the comparisons between the treatment of children and adults with ADD/ADHD. It also examined the success rate of the practitioner with regards to treatment and management, as well as interference of conventional treatment with homoeopathic treatment. Section C was comprised of open-ended questions, which were related to the questions in Section B.

3.2 Study Population:

All the Homoeopathic practitioners registered with the Allied Health Professions Council of South Africa (AHPSCSA), in KwaZulu-Natal were contacted, as recommended by Nagle (2007).

One hundred and four homoeopathic practitioners in KwaZulu-Natal were registered with Medpages as at May 2011, of that 39 homoeopathic practitioners were registered with the Allied Health Professions Council of South Africa (AHPCSA) to be practicing in the KwaZulu-Natal region (Allied Health Professions Council, 2011).

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 within KwaZulu-Natal.
3. The homoeopaths had to be proficient in the English language, as the questionnaire will be delivered in English.

3.2.2 Requirements of the practitioners:

1. Completion of the questionnaire was within four weeks of receiving it.
2. Participants were encouraged to reflect on personal issues and disclose personal principles and practices as a homoeopath.

3.3 Study Sample:

The study sample included all the practitioners who fitted the inclusion criteria and completed the questionnaire. All homoeopaths listed under medpages.co.za and the Allied Health Professions Council of South Africa, that fall under the KwaZulu-Natal region were contacted as the sample group in order to ensure a complete demographic spread.

According to the statistician Esterhuizen (2011), when you are inviting the whole population to participate, then there is no sampling. The sample was determined by the response rate.

According to Esterhuizen (2011), it was not possible to know what percentage of participants will respond. Questionnaires normally have a low return rate, but for

this study, the survey was sent out electronically, hoping to ensure a better response rate. The rule of thumb is to aim for the highest response rate, at least 70 percent or more to reduce bias.

3.4. Methodology:

Data collection started in July, when initial contact with practitioners was made and continued for the four week duration. The response rate was very poor, so further contact was made with the homoeopaths at an HSA Meeting, whereby hard copies of the survey were handed out, and filled in. Once the required amount of surveys were answered and returned the raw data was handed to the statistician for analysis.

The study involved four stages:

Stage 1: Initial Contact:

A list of registered homoeopaths practising within the KwaZulu-Natal region was obtained from the AHPCSA in May 2011. The researcher contacted the registered practitioners by telephone and email in order to request their participation in the study. From the positive responses the study sample was formed. The demographics of age, sex, race and region of practice were noted by the researcher of all contactable registered practitioners.

Stage 2: Delivery of questionnaires:

Upon receiving verbal consent the participants were sent an email by the Homoeopathic Association of South Africa (H.S.A). The email contained an information letter (Appendix 2) detailing the nature of the study, together with the link to the online questionnaire (Appendix 1a, 1b, and 1 c). Completion of the questionnaire implied that the practitioner had given consent, as the questionnaire included a tick box reminding them of their consent.

Stage 3: Collection of questionnaires:

It was initially stated that a four week period was given for the completion of the questionnaire. Due to the poor response rate by the practitioners, either they had forgotten about the questionnaire, or did not have enough time to complete the survey; a further four week extension period was given. Any questionnaires not completed and returned by the end of this time period were not included in the study.

Stage 4: Data Analysis:

The data was coded and captured by Google docs and the results were analysed by utilizing the SPSS for Windows version 18 (SPSS/PASW 2009).

Frequency tables and bar charts were used to summarize and display results for categorical variables. Descriptive statistics were used in the form of frequency tables, bar graphs, and pie charts to describe data.

3.5 Confidentiality:

The researcher had assigned a code to each practitioner, so that the practitioners name did not appear on the questionnaire or in the final dissertation.

Chapter 4:

RESULTS

4.1 Introduction:

This chapter will detail the results from the statistical analysis of the data collected from the questionnaires (appendix 1 A, B and C) completed by the AHPCSA registered homeopathic respondents practicing in KwaZulu-Natal.

4.2 Admissibility of the Data:

Only the data collected during this research project was accepted for use in this chapter.

4.3 Raw Data:

The questionnaire was used to gather the raw data. Results will be stored for five years in a secure setting; thereafter it will be destroyed. Statistical analysis of the data is presented in this chapter.

4.4.1 Sample Group

Thirty nine homoeopaths were registered with the Allied Health Professions Council of South Africa (AHPCSA), within the selected geographic area of KwaZulu-Natal, according to the list supplied by the (AHPCSA) in May 2001. This list was incomplete and not up to date, as many of the practitioners on the list had changed their contact details, moved out of the required area or had stopped practicing.

A total of 42 practitioners were contacted with 35 respondents initially agreeing to participate in the study, and the questionnaires were electronically sent to them via email. Of the 35 only 14 completed the questionnaire within the required time period. A further four week period was extended with an email encouraging all

practitioners to respond, as well as a personalized delivery and collection of eight more questionnaires at a regional H.S.A meeting held in September. This then pushed the response rate up to 22 participants. These practitioners formed the study sample (n=), i.e. giving an overall response rate of 63 percent.

This is a fairly good response rate as compared to Nagle (2007), whose response rate was 42 percent.

4.4.2.Demographics:

4.4.2.1 Age groups of practitioners in the study

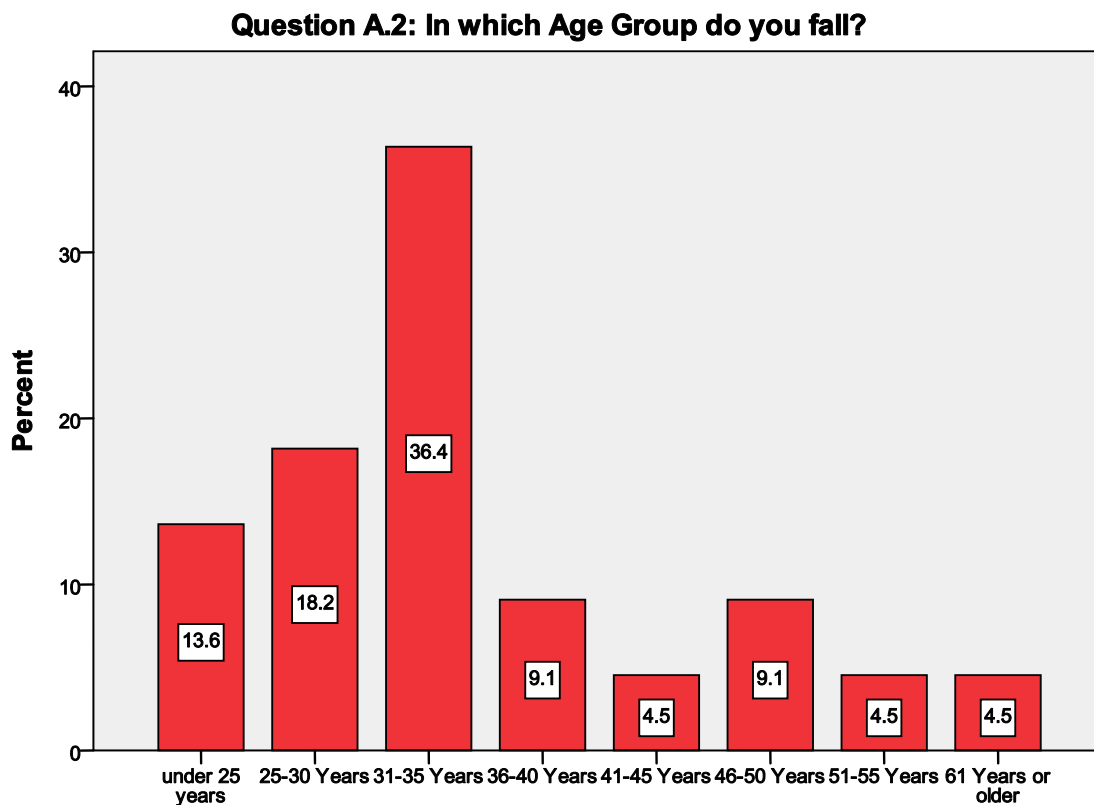


Figure 4.1 Bar graph showing the age group distribution of participating practitioners

It can be seen from Figure 4.1 that the majority of participants were in the 31-35 year age group (36 percent), followed by the 25-30 year group (18 percent). The majority of the participants were thus under 35 years of age (68 percent).

4.4.2.2. Gender of practitioners in the study

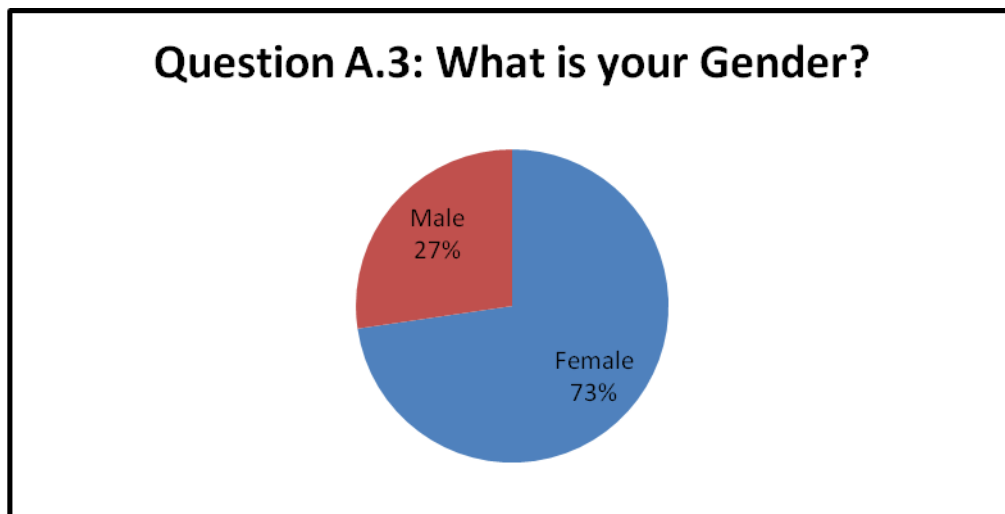


Figure 4.2 Pie chart illustrating the gender percentage of participating practitioners

It can be seen from Figure 4.2 that the majority of participants were Female (72 percent) whereas only 27 percent were male.

4.2.2.3. Predominant Home Language or Mother tongue

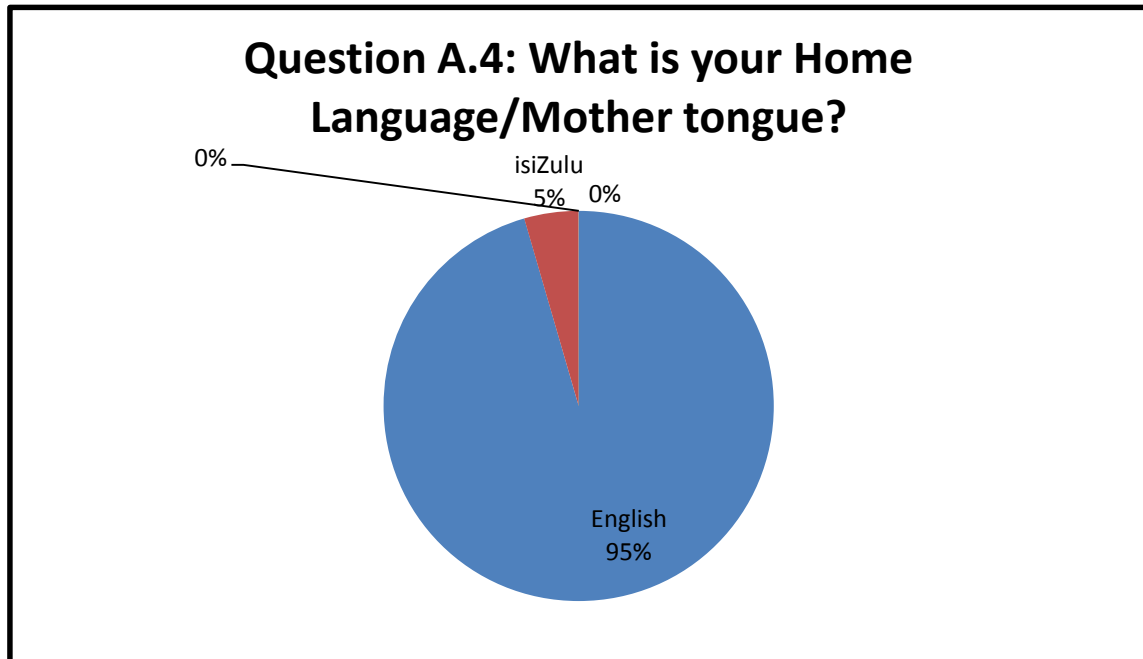


Figure 4.3 Pie chart illustrating the predominant home languages spoken by the participating respondents

It can be seen from Figure 4.3 that the majority of the respondents were English speaking 95 percent, whereas only five percent of the respondents speak isiZulu.

4.4.3. Qualifications

4.4.3.1. Homeopathic Qualification

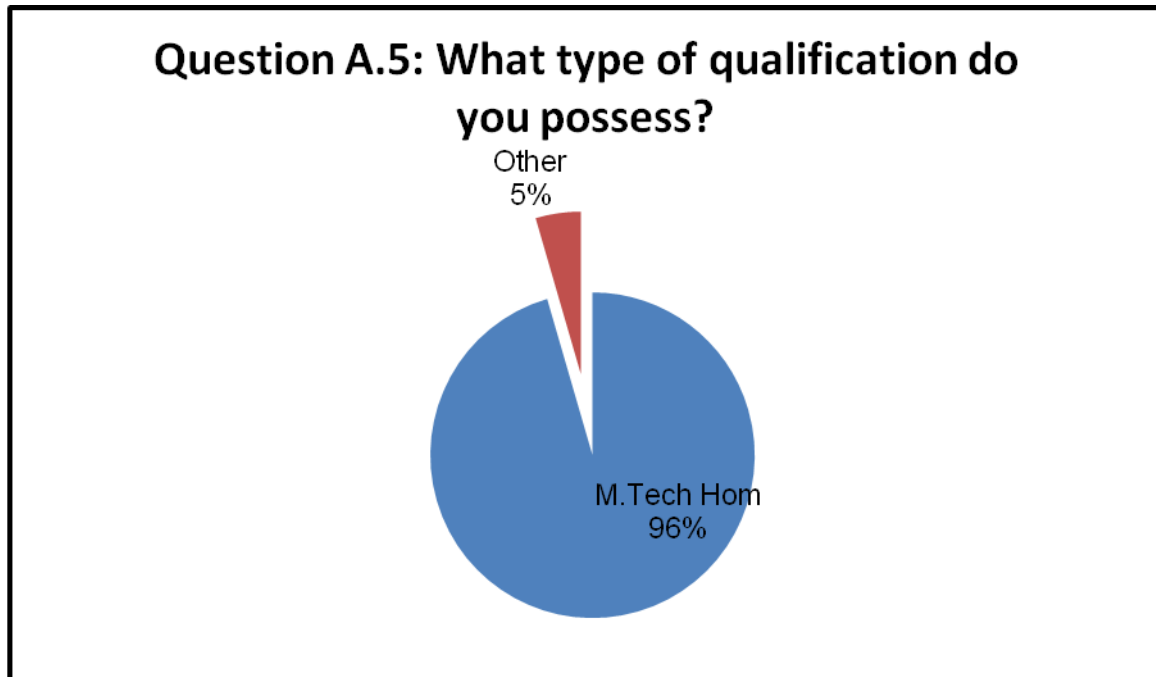


Figure 4.4 Pie chart shows the distribution of homeopathic qualifications among participating practitioners

It can be seen that 21 participants graduated with an M.Tech Hom, (96 percent).

4.4.3.2. Institution

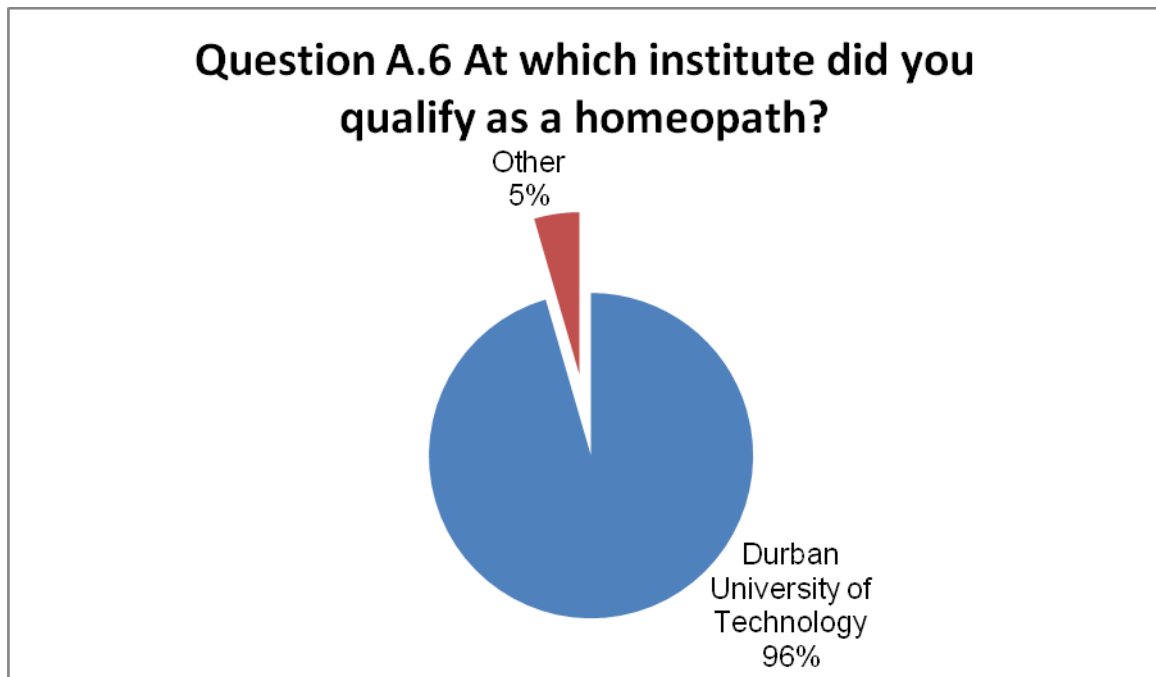


Figure 4.5 Pie chart illustrating the institution from which the practitioners qualified

The above pie chart, Figure 4.5, indicates that 95 percent (n=21) respondents have an M.Tech (Hom) and were trained and qualified at the Durban University of Technology. The remaining five percent (n=1) practitioner have another type of qualification and graduated elsewhere.

4.4.5 Practice

4.4.5.1. Number of years in practice

Question A.7: How many complete years have you been in Homoeopathic practice?

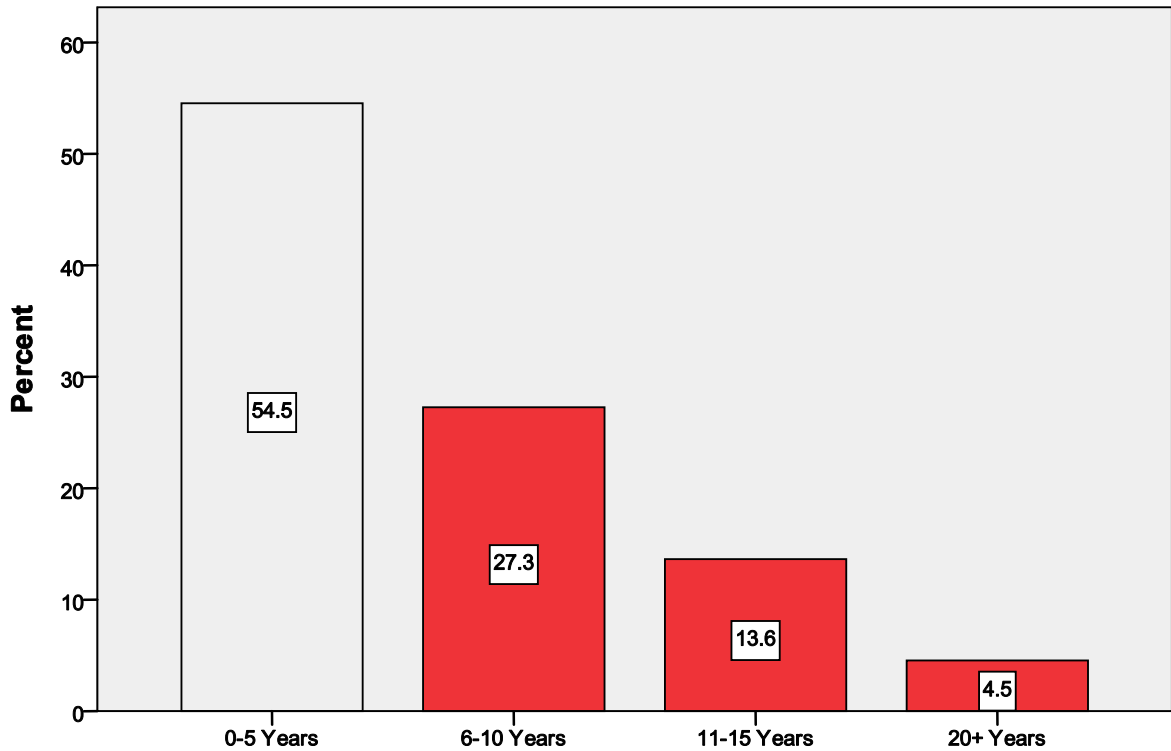


Figure 4.6 Bar Graph showing the number of years in practice

The above Bar Graph gives a breakdown of the number of years practitioners have been practicing homoeopathy. It can be seen that over half of the respondents have been practicing for less than five years.

4.4.5.2. Area/Location of Practice

Map Of KwaZulu-Natal indicating the Health Districts:

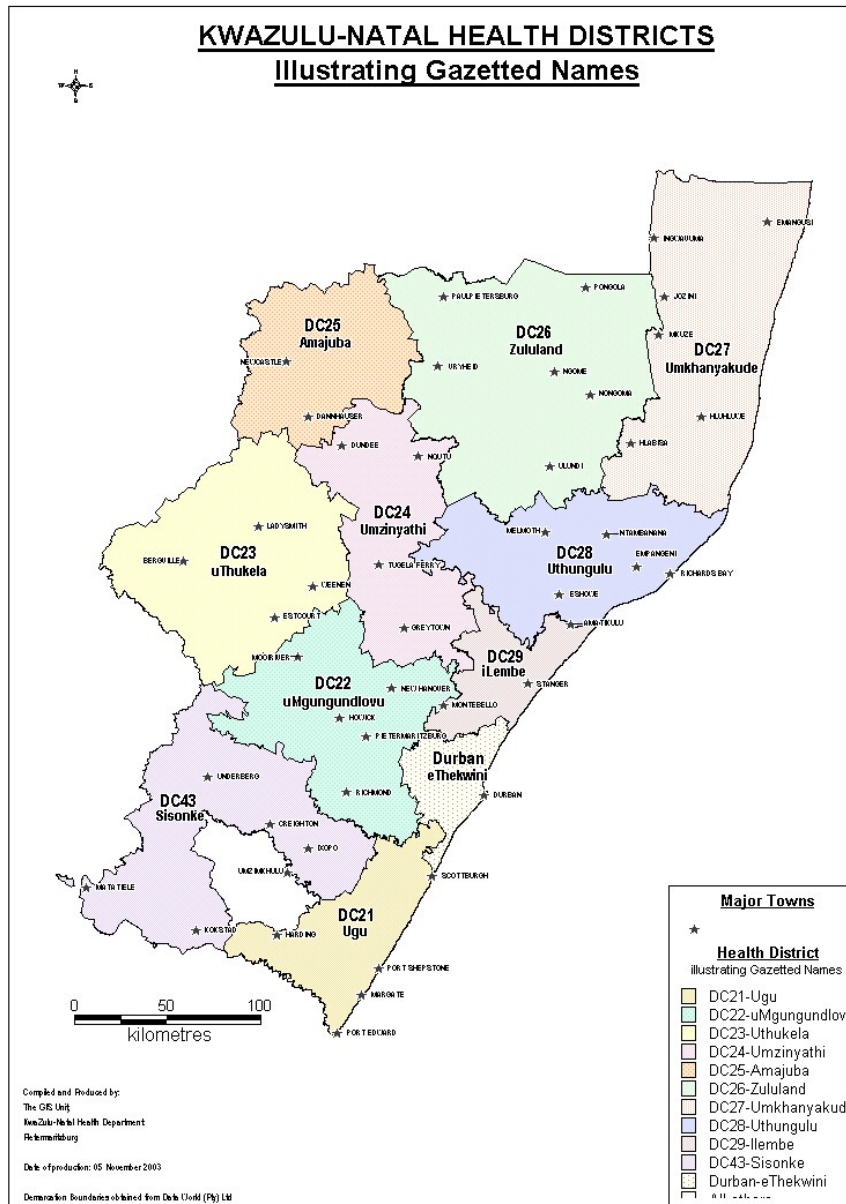


Figure 4.7 Map showing the location of health districts within the KwaZulu-Natal (GIS, 2003)

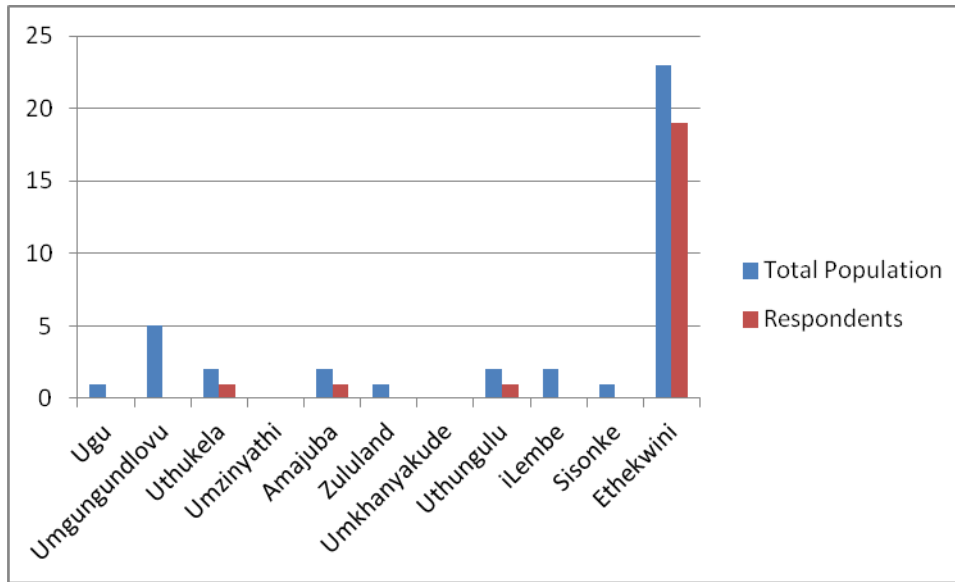


Figure 4.8 showing the area distribution of practices within the KwaZulu-Natal Health Districts

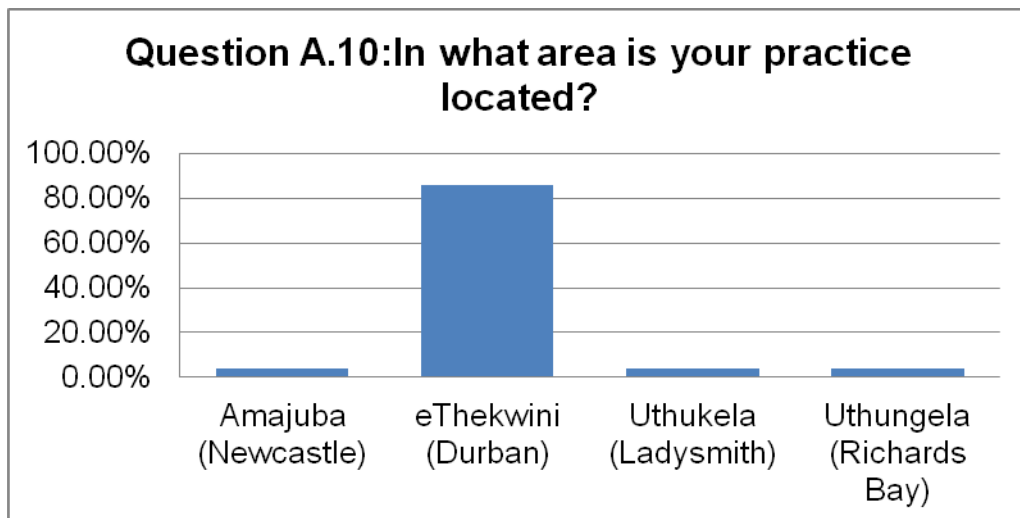


Figure 4.9 Figure showing the area distribution of respondents within the KwaZulu-Natal Region

It can be seen that the majority of the respondents (n=19) 86 percent are situated within the eThekweni area. Only four percent of the respondents practice within Newcastle, Ladysmith, and Richards Bay respectively.

4.4.5.3. Type of Practice

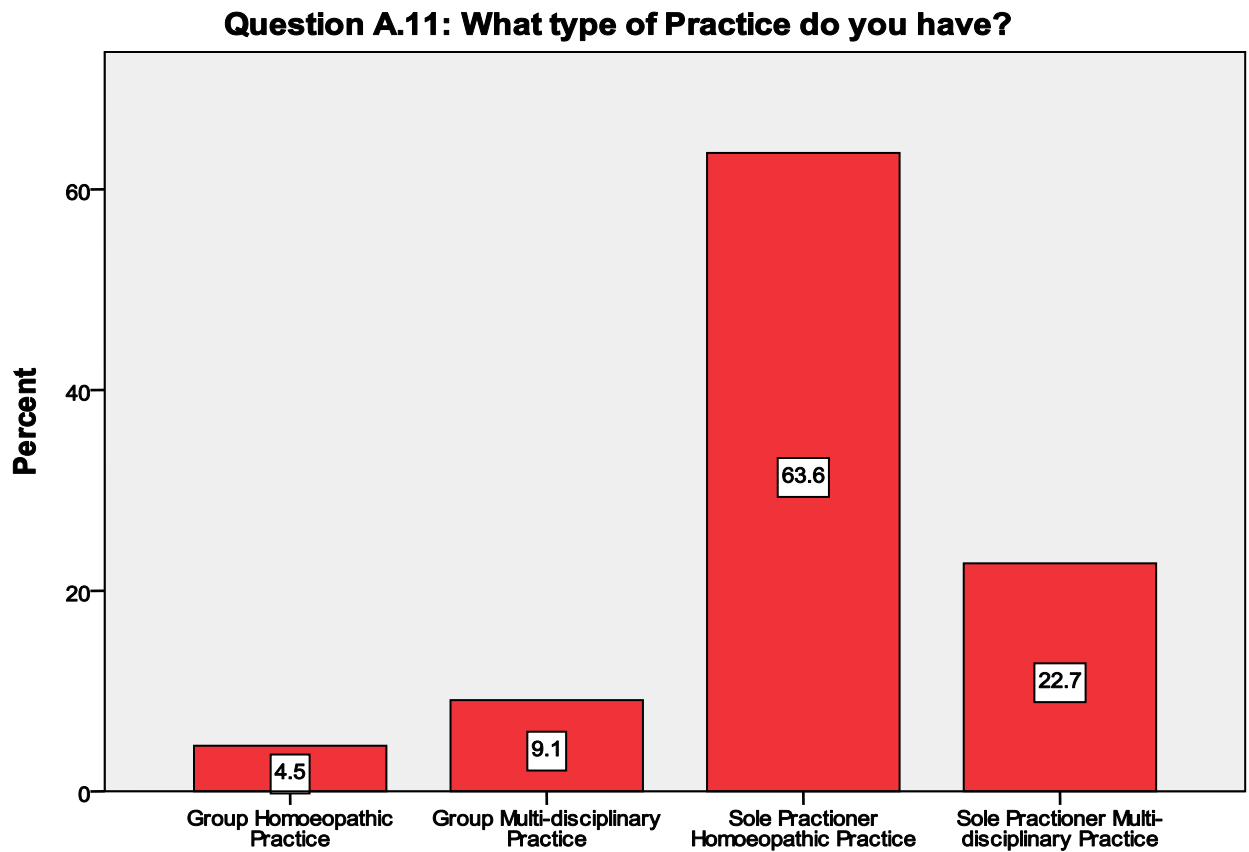


Figure 4.10 Bar graph showing the percentage distribution of the types of practice

From the above figure it is evident that the majority of the respondents, (64 percent) have a Sole Practitioner Homoeopathic practice.

4.4.5.4. Percentage of practice that is homoeopathic:

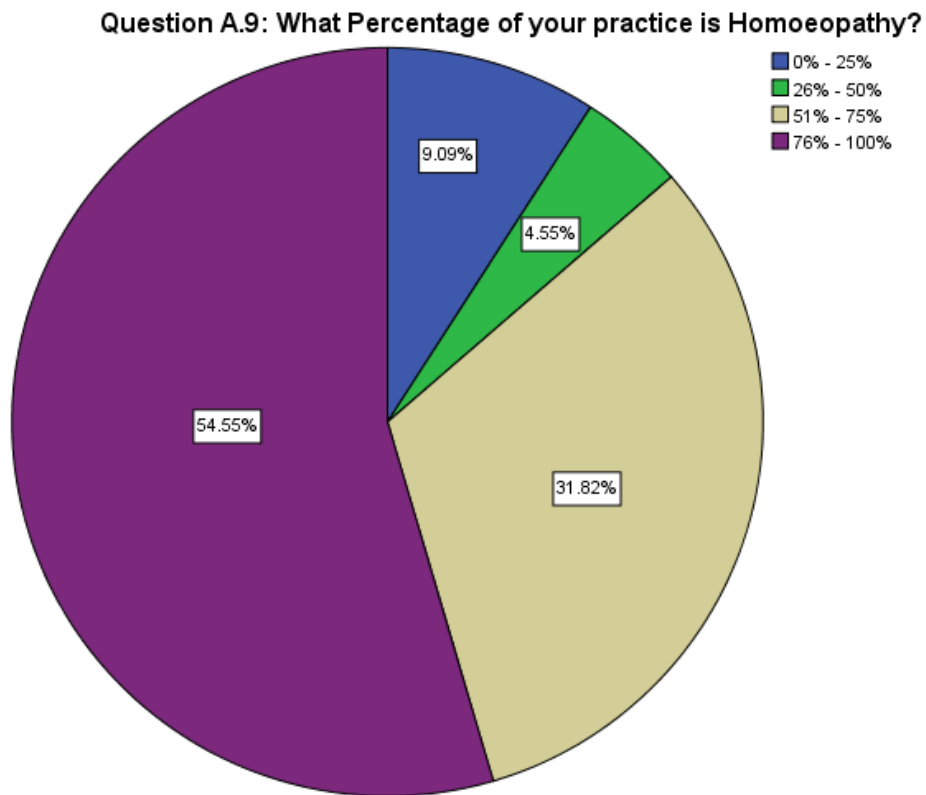


Figure 4.11 Pie chart illustrating the percentage of practice that is homoeopathic

It can be seen in the above pie chart it can be seen that in over half the respondents (54 percent), homoeopathy made up more than 75 percent of their practice.

4.4.5.6 Additional modalities utilized by practitioners

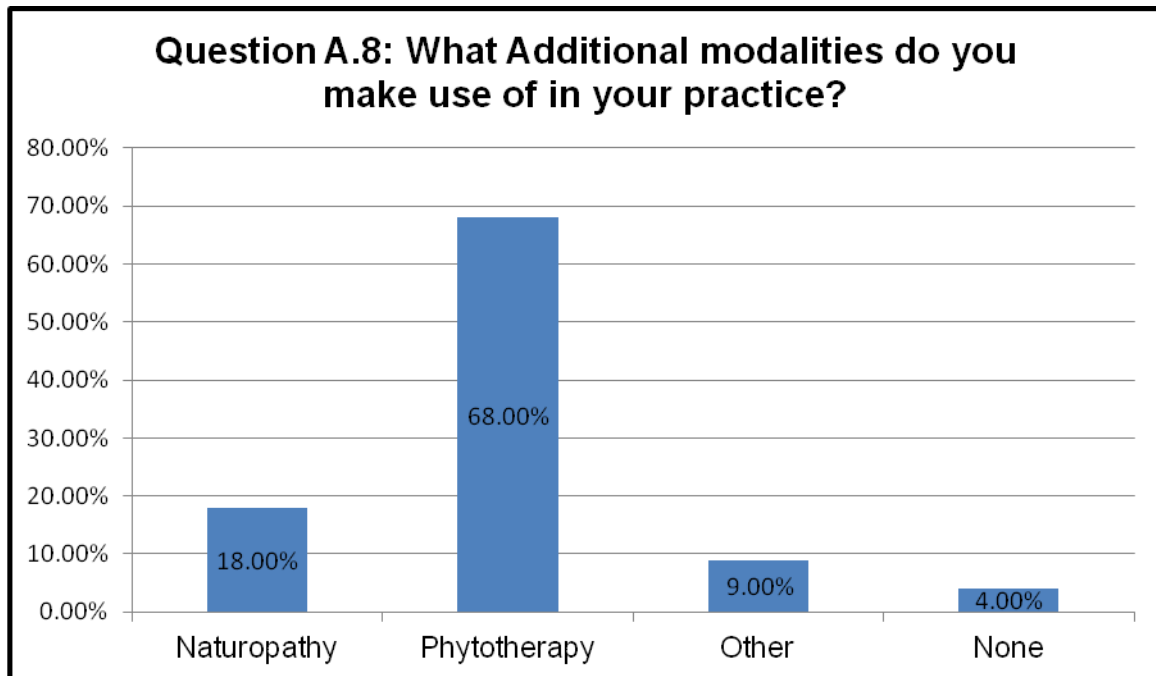


Figure 4.12 Bar Graph illustrating the additional modalities utilized in practice

From figure 4.12, it can be seen that phytotherapy (68 percent), and Naturopathy (18 percent) were the two most common additional modalities utilized by the respondents.

The conclusion can thus be drawn that the majority of respondents were fairly new practitioners, practicing in the Ethekwini municipality. They practice as sole practitioners and utilize mostly homoeopathy, with phytotherapy and naturopathy as additional modalities.

4.5. ADD/ADHD

AIMS

- To determine the number of registered homoeopathic practitioners in KwaZulu-Natal, who treat patients with ADD/ADHD.
- To determine the perceptions of registered homoeopathic practitioners in KwaZulu-Natal, with regard to the diagnosis, referral, treatment and management of patients with ADD/ADHD.
- To determine the perceptions of registered homoeopathic practitioners in KwaZulu-Natal with regard to the aetiology and contributing factors of ADD/ADHD.
- To determine the perceptions of registered homoeopathic practitioners in KwaZulu-Natal, with regard to the difference in diagnosis and treatment of ADD/ADHD in adults and children.
- To determine the perceptions of registered homoeopathic practitioners in KwaZulu-Natal with regard to their success rate in treating patients with ADD/ADHD.

For frequency tables on the above information, regarding diagnosis, referral and treatment of the patients throughout all the age groups refer to appendix 3.

4.5.1. Total number of ADD/ADHD patients being treated by homoeopaths in the last 12 months

Age group of patients	Under 5 years	5-9 years	10-14 years	15- 18 years	Older than 18 Years
Number of practitioners	17	19	15	9	9
Percentage of practitioners	77%	86%	68%	40%	40%

Table 4.1 shows the total number of registered practitioners within KwaZulu-Natal that have treated patients with ADD/ADHD over the past 12 months

As can be seen from the above table, the majority of the practitioners treat the patients with ADD/ADHD that fall within the age groups of less than five years old and the 5 to 9 year old age group.

4.6 Diagnosis:

4.6.1. Diagnosis of patients 5 years and younger

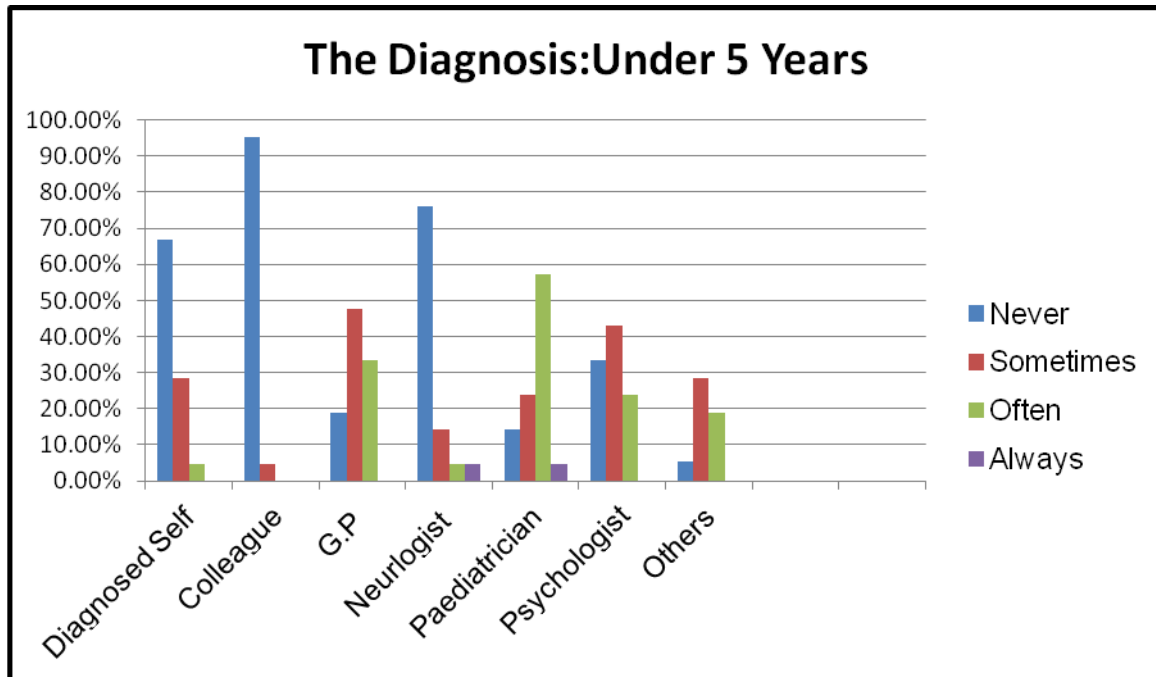


Figure 4.13 Bar chart showing the valid percentage of diagnosis of patients younger than 5 years old

According to these results, paediatricians, general practitioners and psychologists, most frequently make the diagnosis of ADD/ADHD in patients younger than five years old. Homoeopaths and Neurologists never make the diagnosis in a majority of case within this age group.

4.6.2. Diagnosis of patients between the ages of 5- 9 Years

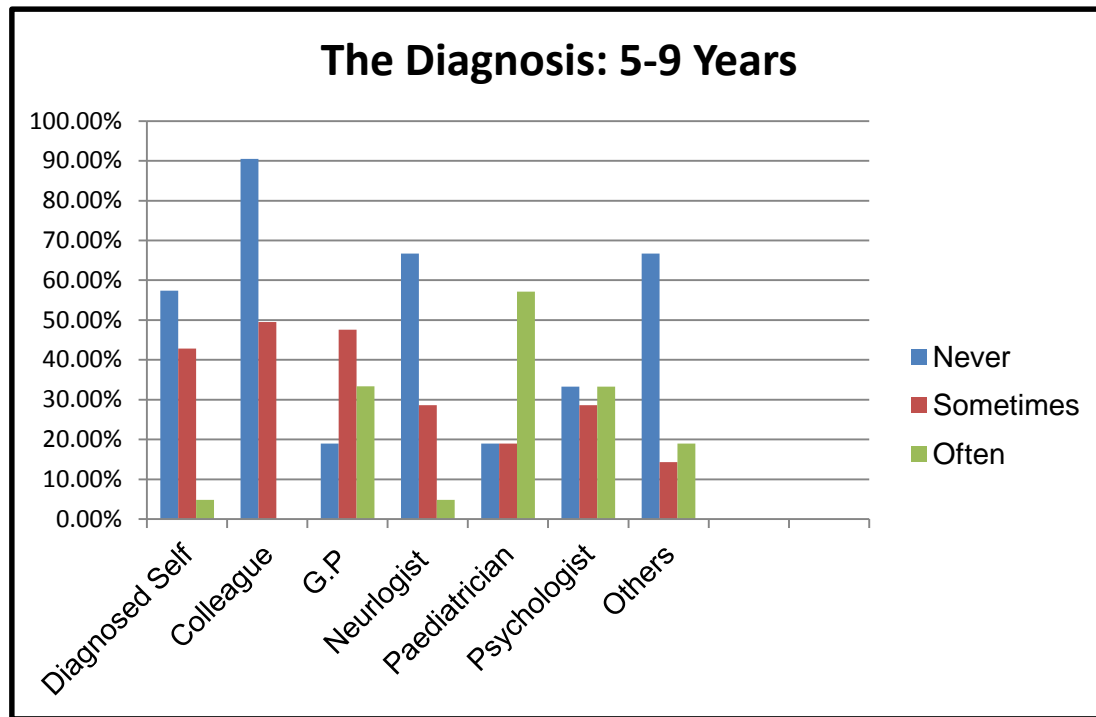


Figure 4.14 Bar chart showing the valid percentage of diagnosis of patients 5-9 years old

According to these results, paediatricians, general practitioners and psychologists, most frequently make the diagnosis of ADD/ADHD in patients aged five to nine years old. Homoeopaths and Neurologists never make the diagnosis in a majority of case within this age group.

4.6.3. Diagnosis of patients 10-14 years old

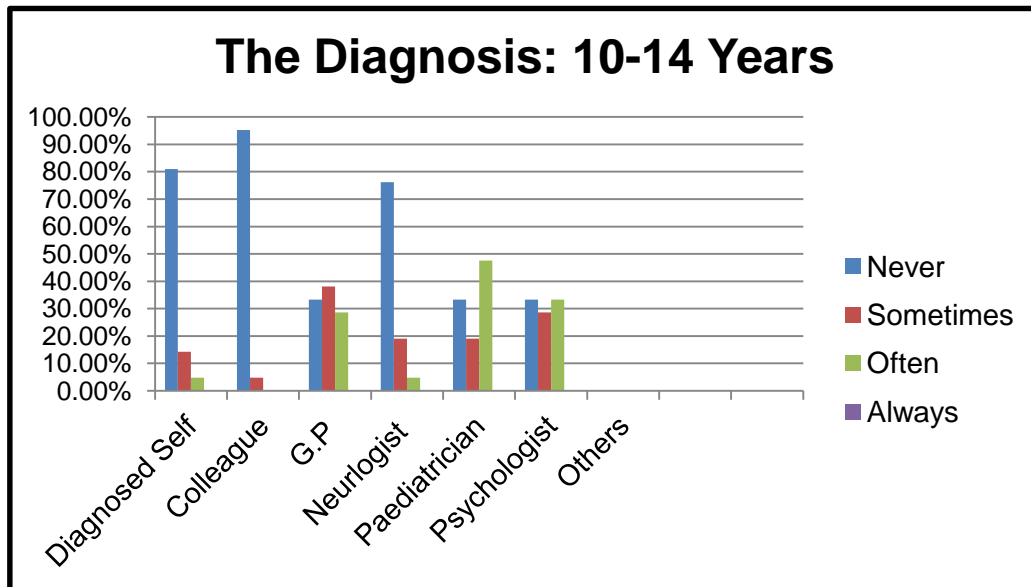


Figure 4.15 Bar chart showing the valid percentage of diagnosis of patients 10-14 years old

According to these results, paediatricians, general practitioners and psychologists, most frequently make the diagnosis of ADD/ADHD in patients aged 10-14 years old. Homoeopaths and Neurologists never make the diagnosis within this age group.

4.6.4. Diagnosis of patients aged 15-18years

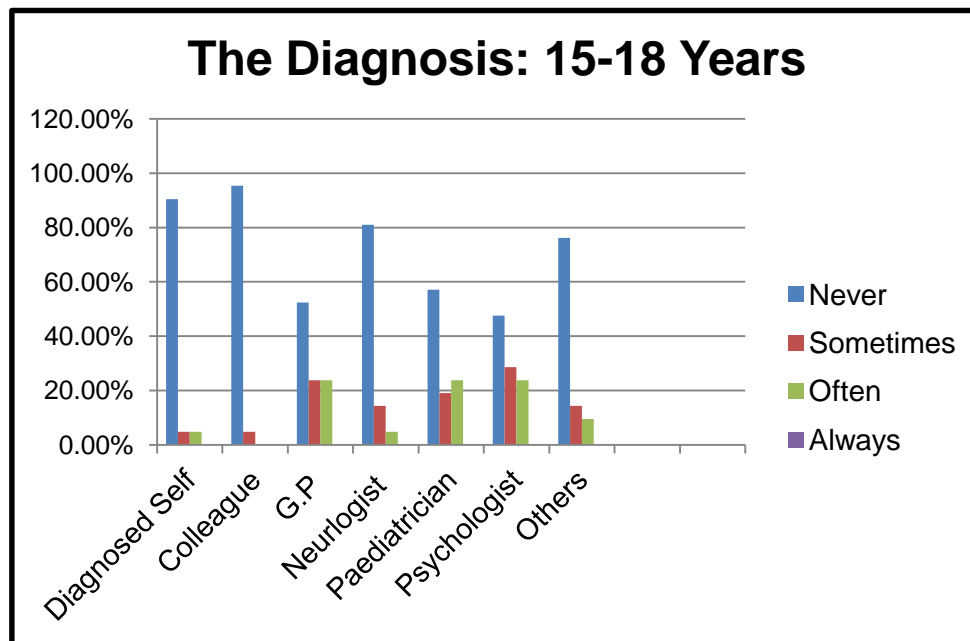


Figure 4.16 Bar Chart showing the valid percentage of diagnosis of patients younger than 15-18 years old

According to these results, paediatricians, general practitioners and psychologists, most frequently make the diagnosis of ADD/ADHD in patients aged 15-18 years old.

4.6.5. Diagnosis of patients 18 years and older

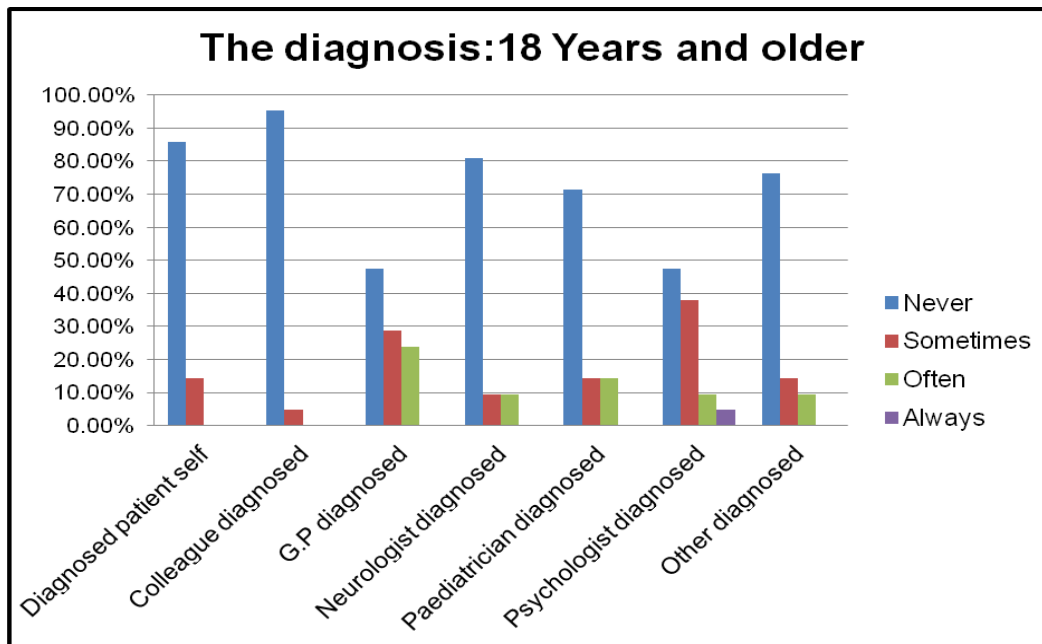


Figure 4.17 Bar Chart showing the valid percentage of diagnosis of patients younger than 18 years and older

According to these results, general practitioners and psychologists, most frequently make the diagnosis of ADD/ADHD in patients aged 18 years old and older. A trend is observable, though, that alludes to diagnoses rarely being made in this age group.

Conclusion:

Across all the age groups the main trends observed regarding diagnosis, that the majority of the diagnoses were made by Paediatricians, Psychologists and General Practitioners. Homoeopaths and Neurologists hardly ever made a diagnosis.

Most of the patients were diagnosed with ADD/ADHD within the age groups five to nine years and 10-14 years old. Across all the practitioners, the patients within the age group of 18 years and older are diagnosed the least.

4.6.6 Misdiagnosis

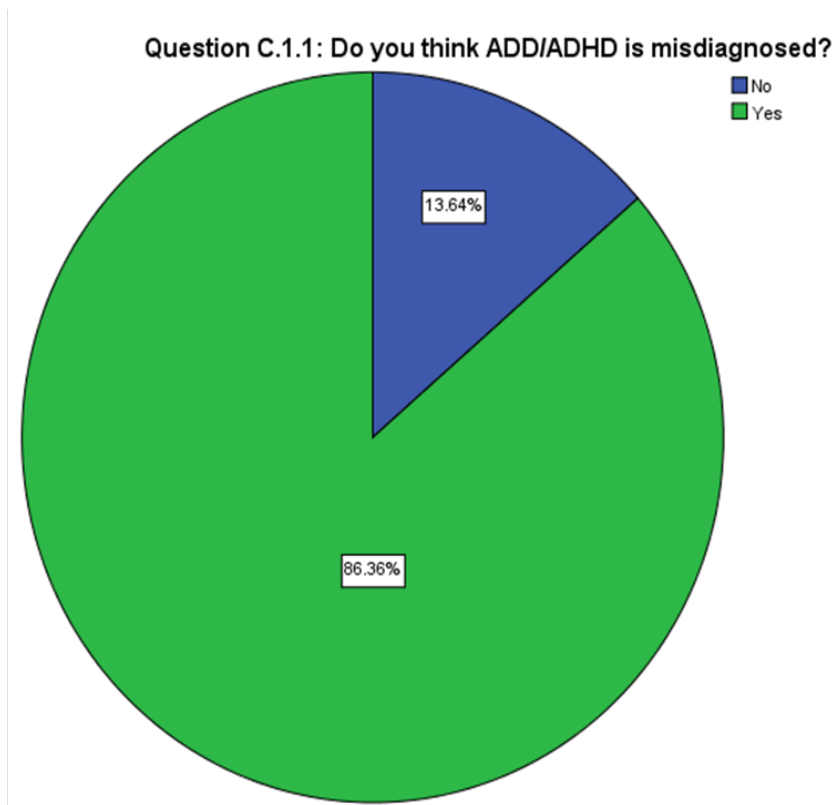


Figure 4.18 Pie chart showing the opinions of practitioners with regard to misdiagnosis of ADD/ADHD

According to respondents 86 percent were of the opinion that ADD/ADHD is misdiagnosed.

4.6.7 Over Diagnosis

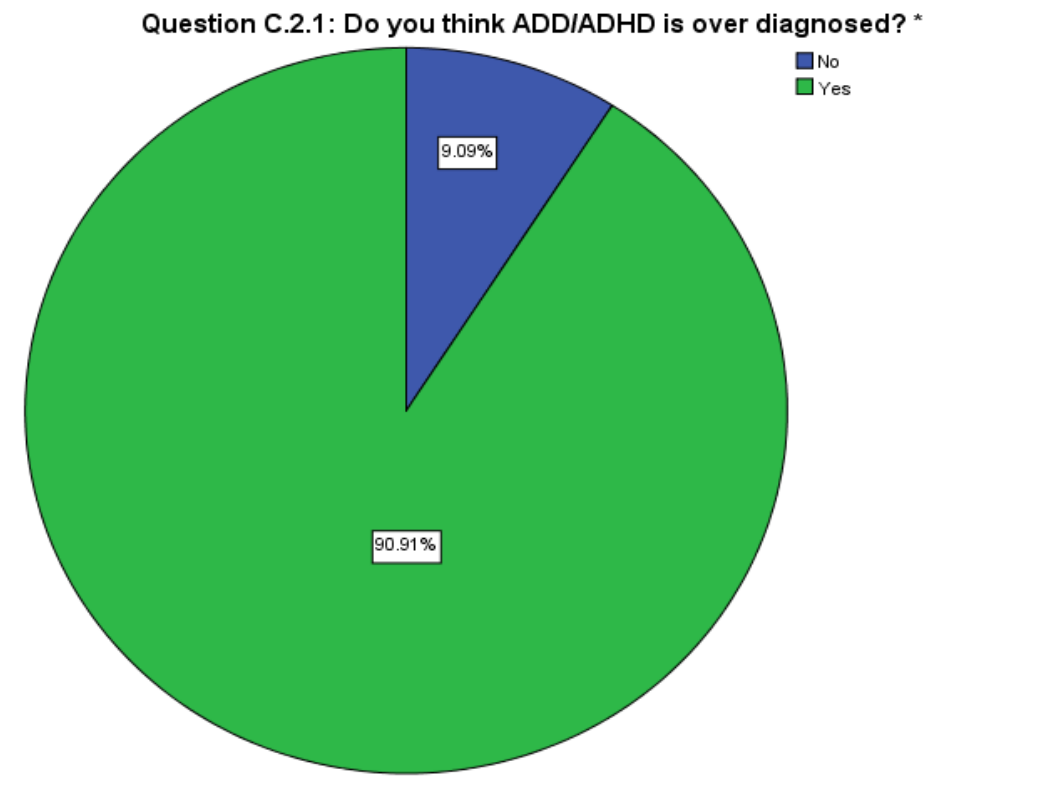


Figure 4.19 Pie chart showing the opinions of practitioners with regard to over diagnosis of ADD/ADHD

According to respondents 90 percent were of the opinion that ADD/ADHD is over diagnosed.

In conclusion it can be seen that the majority of the practitioners within this study believed ADD/ADHD to be misdiagnosed and over diagnosed.

4.7 Referral:

4.7.1 Referral to other practitioners: Patients younger than 5 years old

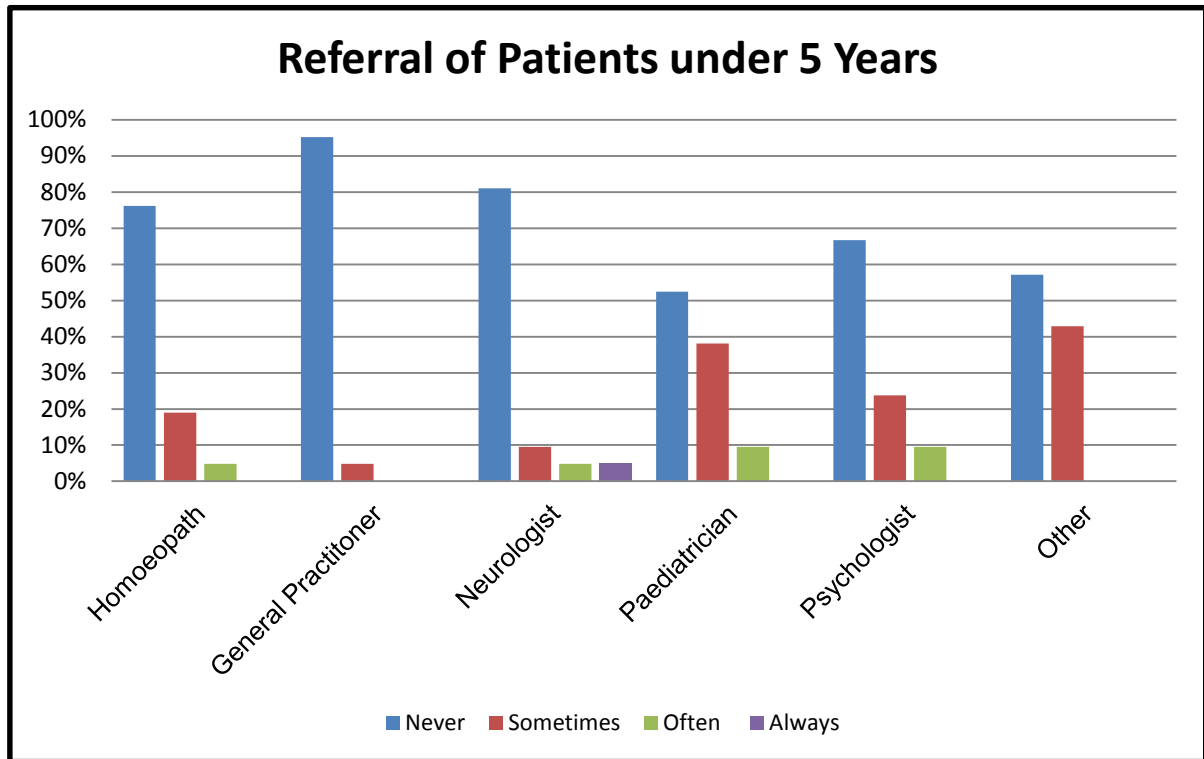


Figure 4.20 Bar Chart showing the valid percentage of Referral of patients 5 years and younger

As can be seen from the above results, homoeopaths will most frequently refer to psychologists and paediatricians for patients aged five years and younger, but never refer to general practitioners, neurologists or other homoeopaths.

4.7.2 Referral of patients: 5-9 Years old

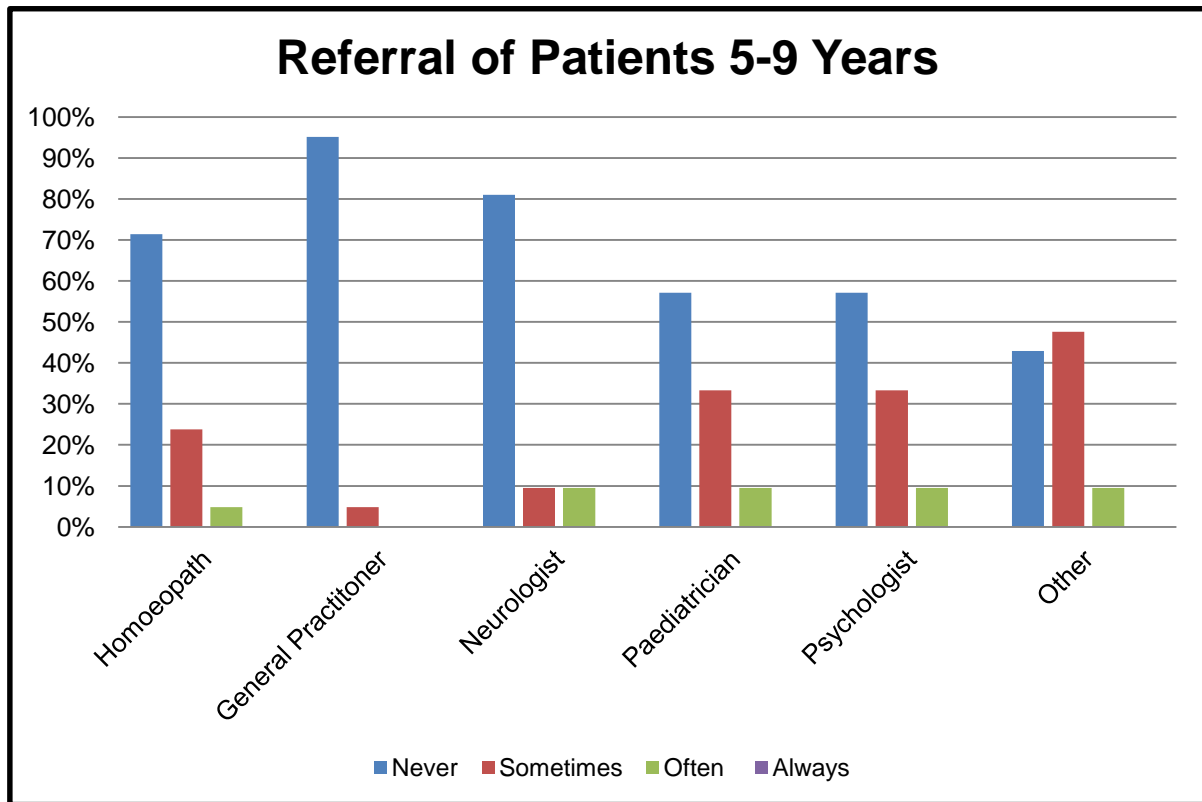


Figure 4.21 Bar Chart showing the valid percentage of Referral of patients 5-9 Years Old

As can be seen from the above results, homoeopaths will most frequently refer to neurologist's psychologists and paediatricians and others for patients aged five to nine years, but never refer to general practitioners, neurologists or other homoeopaths.

4.7.3. Referral of patients: 10-14 years old

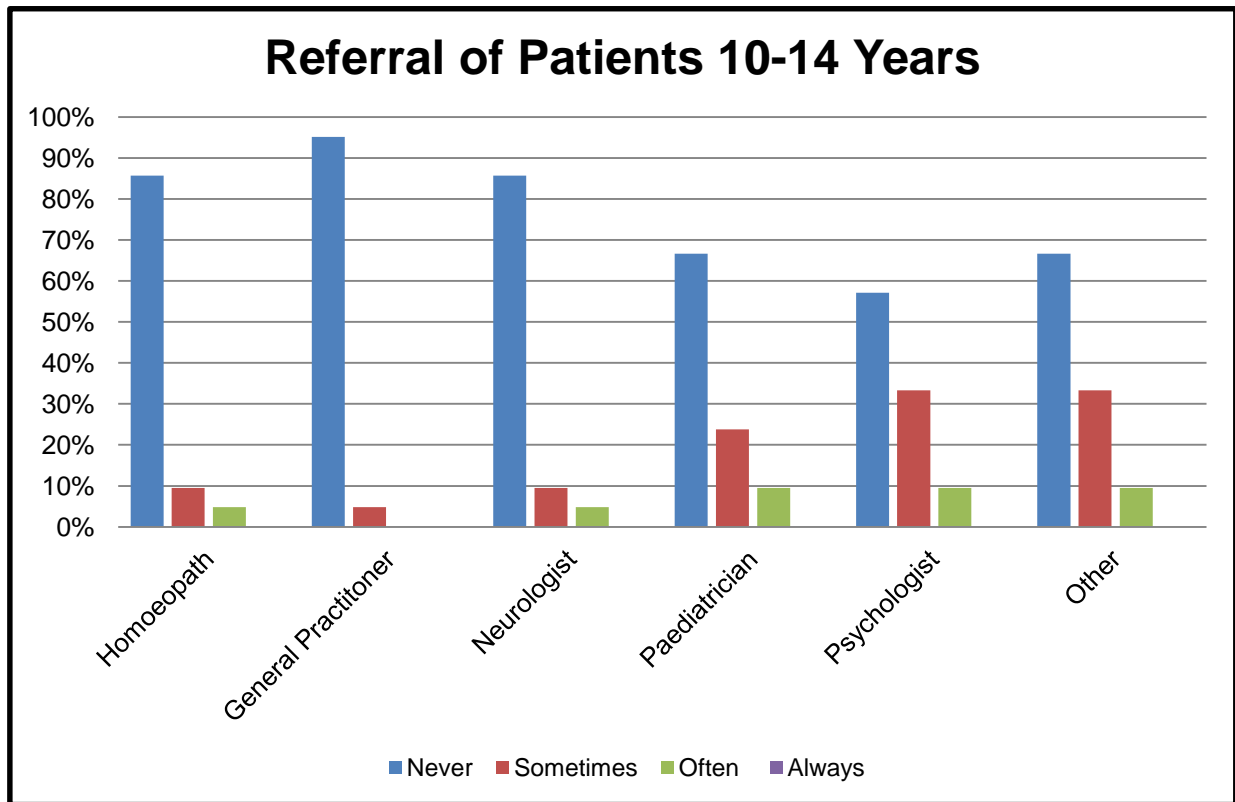


Figure 4.22 Bar Chart showing the valid percentage of Referral of patients 10-14 Years Old

As can be seen from the above results, homoeopaths will most frequently refer to psychologists, paediatricians and others for patients aged 10-14 years, but never refer to general practitioners, neurologists or other homoeopaths.

4.7.4 Referral of patients: 15-18 Years

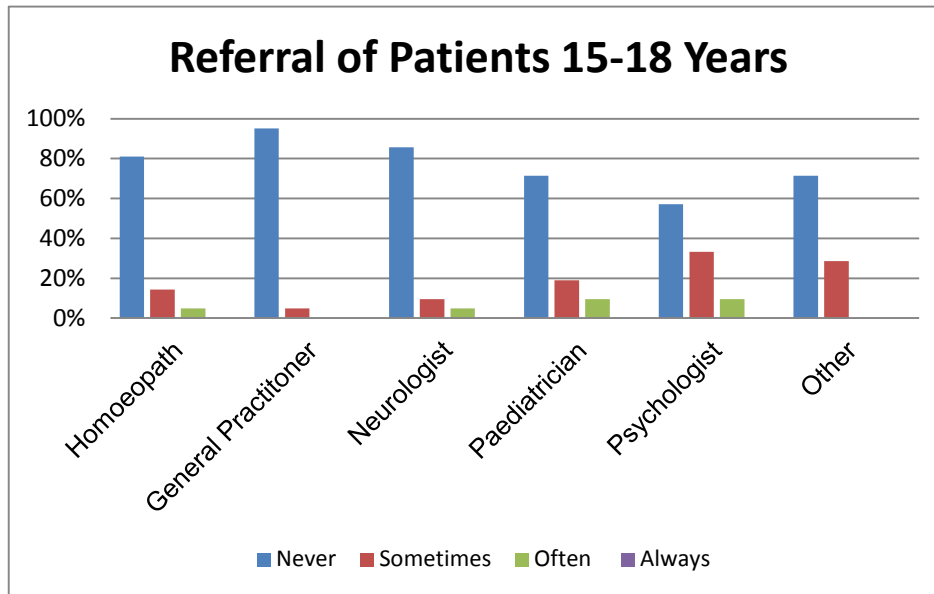


Figure 4.23 Bar Chart showing the valid percentage of Referral of patients 15-18 Years Old

As can be seen from the above results, homoeopaths will most frequently refer to psychologists, paediatricians, as well as neurologists and other homoeopaths for patients aged 15-18 years old, but will never refer to general practitioners.

4.7.5. Referral of Patients: 18 years and older:

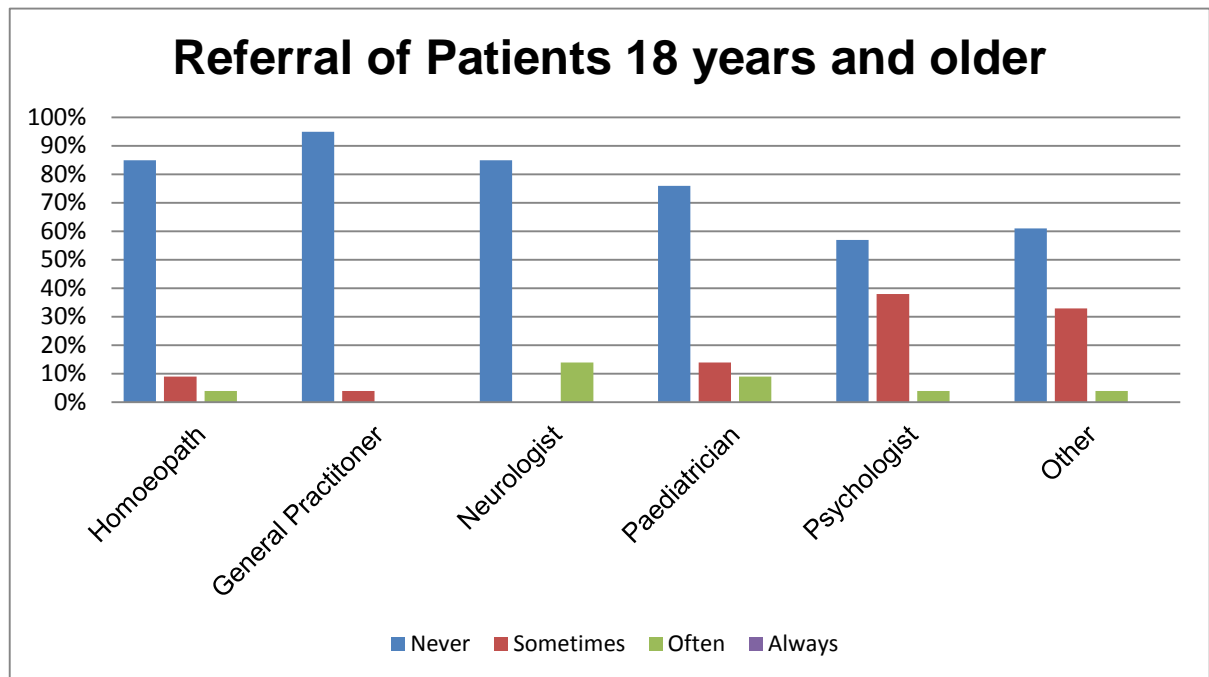


Figure 4.24 Bar Chart showing the valid percentage of Referral of patients 18 Years and older

As can be seen from the above results, homoeopaths will most frequently refer to psychologists, paediatricians, as well as other homoeopaths for patients aged 18 years and older, but never to general practitioners, or other practitioners.

4.8: Treatment options

4.8.1. Treatment options: For patients 5 years and under

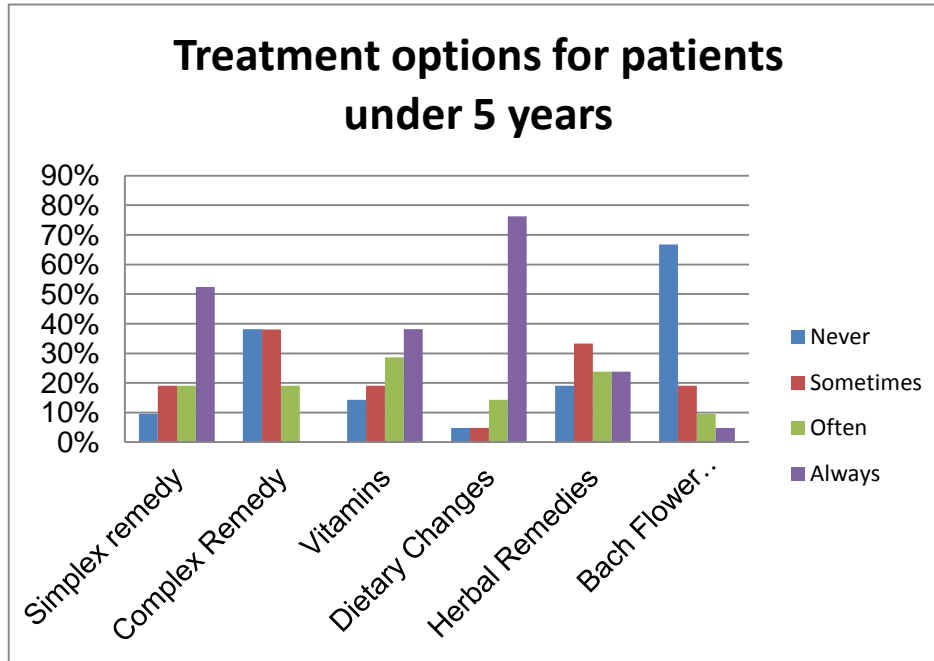


Figure 4.25 Bar Chart showing the valid percentage of treatment options for patients 5 years and younger

As can be seen from the above results, homoeopaths will most frequently prescribe Simplex treatment, dietary changes and herbal remedies and vitamins for patients under five years old.

4.8.2: Treatment options for patients 5-9 Years of age

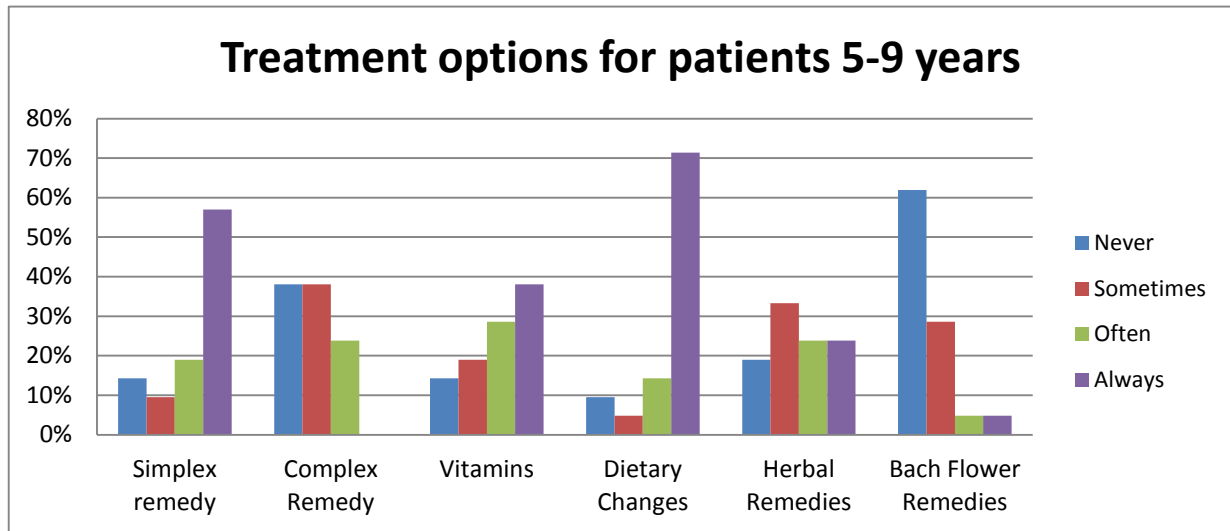


Figure 4.26 Bar Chart showing the valid percentage of treatment options for patients aged 5-9 years

As can be seen from the above results, homoeopaths will most frequently prescribe Simplex treatment, dietary changes and herbal remedies for patients five to nine years old. Bach flower remedies are rarely prescribed.

4.8.3: Treatment options for patients 10-14 years

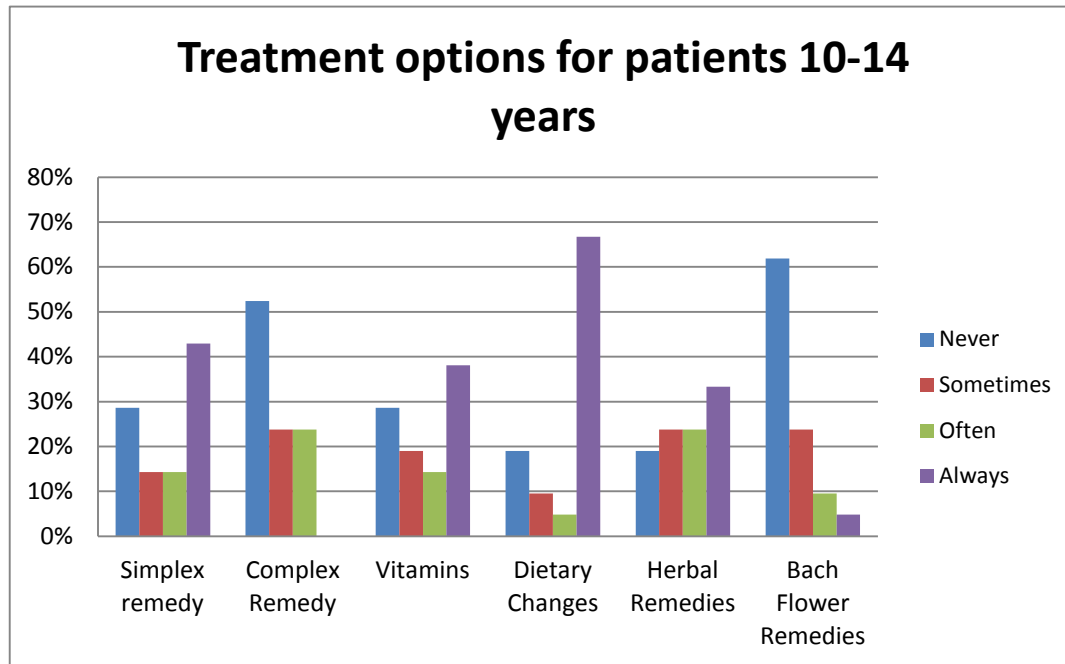


Figure 4.27 Bar Chart showing the valid percentage of treatment options for patients aged 10-14 years

As can be seen from the above results, homoeopaths will most frequently prescribe dietary changes, Simplex treatment, vitamins and herbal remedies for patients 10-14 years old. Bach flower remedies are rarely prescribed.

4.8.4: Treatment options for patients 15-18 years

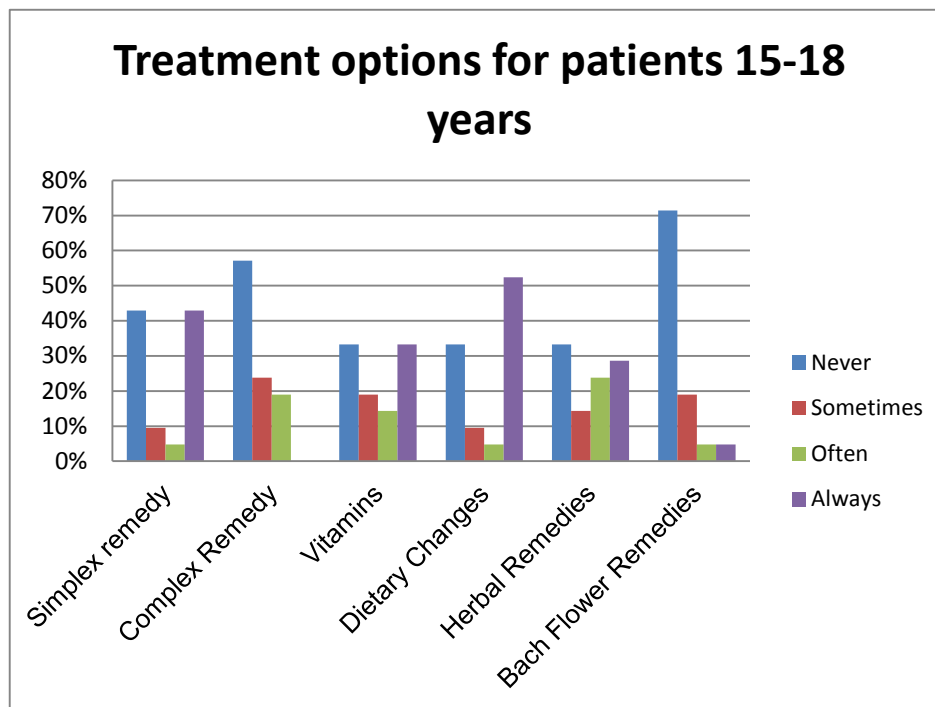


Figure 4.28 Bar Chart showing the valid percentage of treatment options for patients aged 15-18 years

As can be seen from the above results, homoeopaths will most frequently prescribe Simplex treatment, vitamins, dietary changes and herbal remedies for patients aged 15-18 years old.

4.8.5: Treatment options for patients 18 years and older

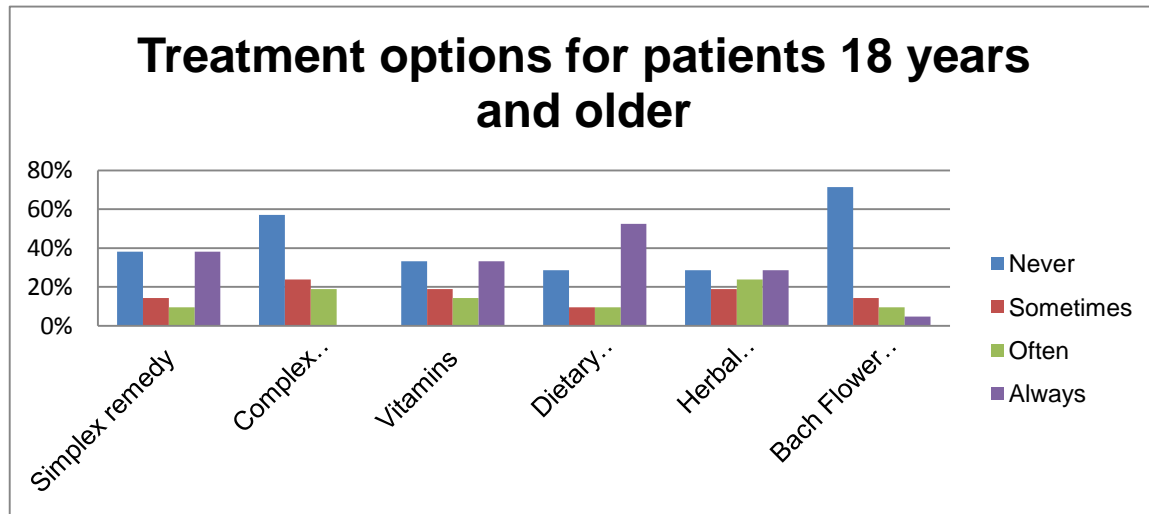


Figure 4.29: Bar Chart showing the valid percentage of treatment options for patients aged 18 years and older.

As can be seen from the above results, homoeopaths will most frequently prescribe Simplex treatment, dietary changes and herbal remedies for patients 18 years and older. Bach flower remedies are rarely prescribed.

In conclusion it can be seen that a similar trend was found across all age categories with regard to treatment options. The majority of the respondents most frequently prescribed Simplex treatment, Herbal remedies and dietary advice as the main forms of treatment. Complex treatment and Bach flower remedies were not as frequently prescribed

4.8.6. Prescribed Treatment

4.8.6.1. Simplex treatment

Name of remedies	Number of Practitioners
Medorrhinum	7
Phosphorus	2
Sulphur	2
Spider remedies	1
Tarentula hispanica	7
Tuberculinum	7

Table 4.2 Most common Simplexes prescribed by practitioners

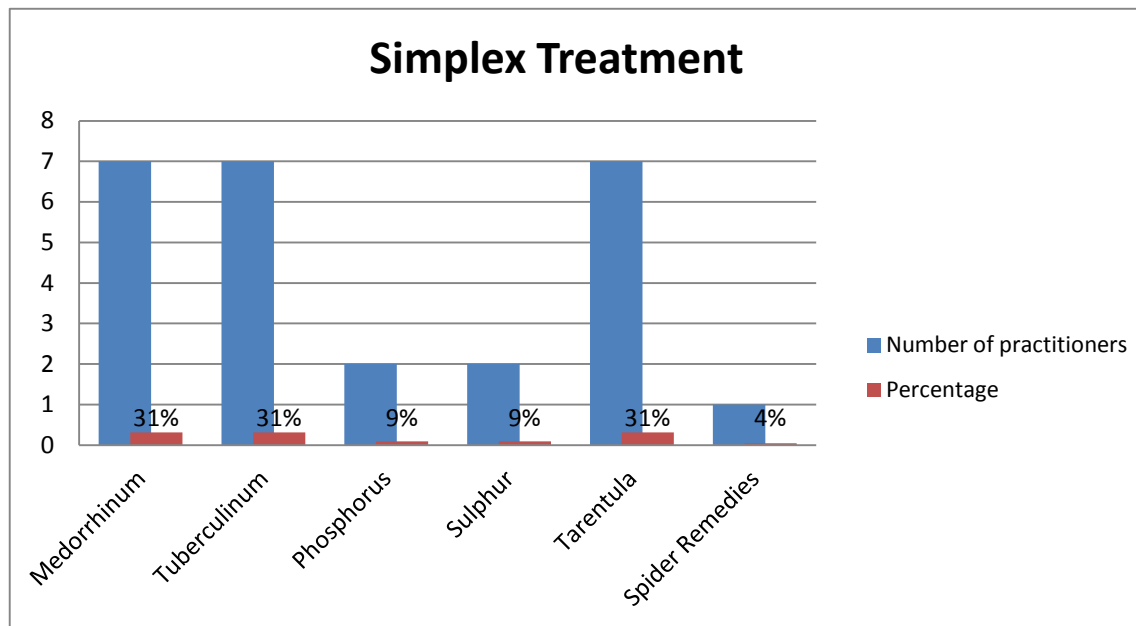


Figure 4.30 Bar Chart showing the percentage of simplex options prescribed by homoeopaths for patients with ADD/ADHD

As can be seen in the table above, the three most commonly prescribed simplexes are *Medorrhinum*, *Tarentula hispanica*, and *Tuberculinum bovinum*.

4.8.7.2. Complex treatment:

Name of Complexes	Number of practitioners
Combin exhaustion	1
Combin Fatigue	1
Nervoheel	2
Neurexo	1
Bacopa Complex	1
Have not treated/No Comment	8

Table 4.3 Most common Complexes prescribed by practitioners

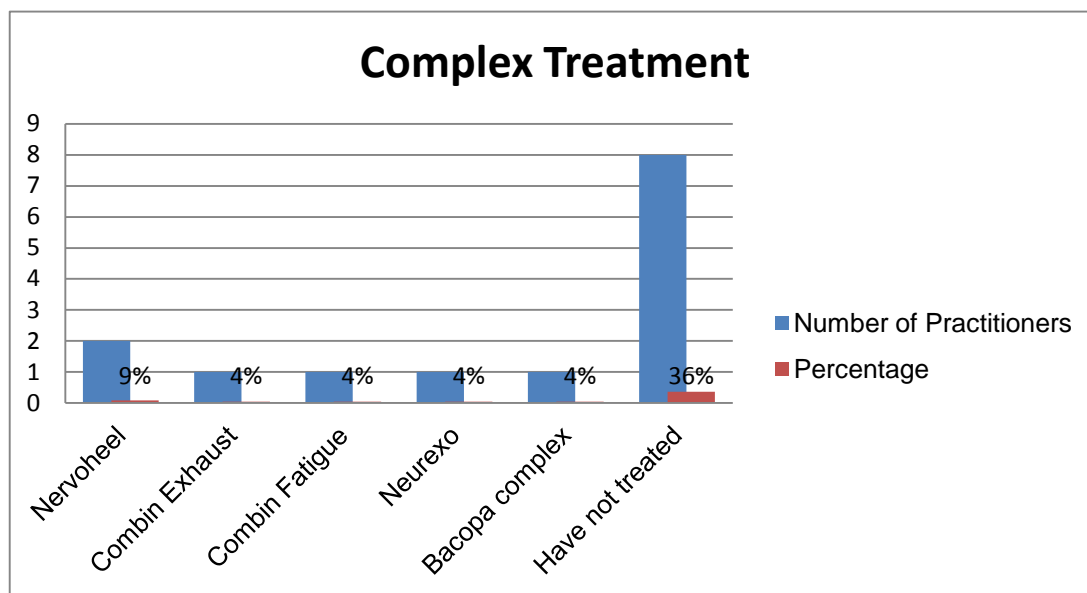


Figure 4.31 Bar Chart showing the percentage of complex options prescribed by homoeopaths for patients with ADD/ADHD

As can be seen in the table above, the most commonly prescribed complex for patients with ADD/ADHD is nervoheel®, but this complex is not used often as a treatment method as seen from the above section 4.8.

4.8.7.3. Miasms:

Miasms	Number of Practitioners
Cancerinic	4
Psoric	1
Sycotic	15
Tuberculinic	12
Syphilitic	1
Have not treated/No Comment	2

Table 4.4 Most common Miasms prescribed by practitioners

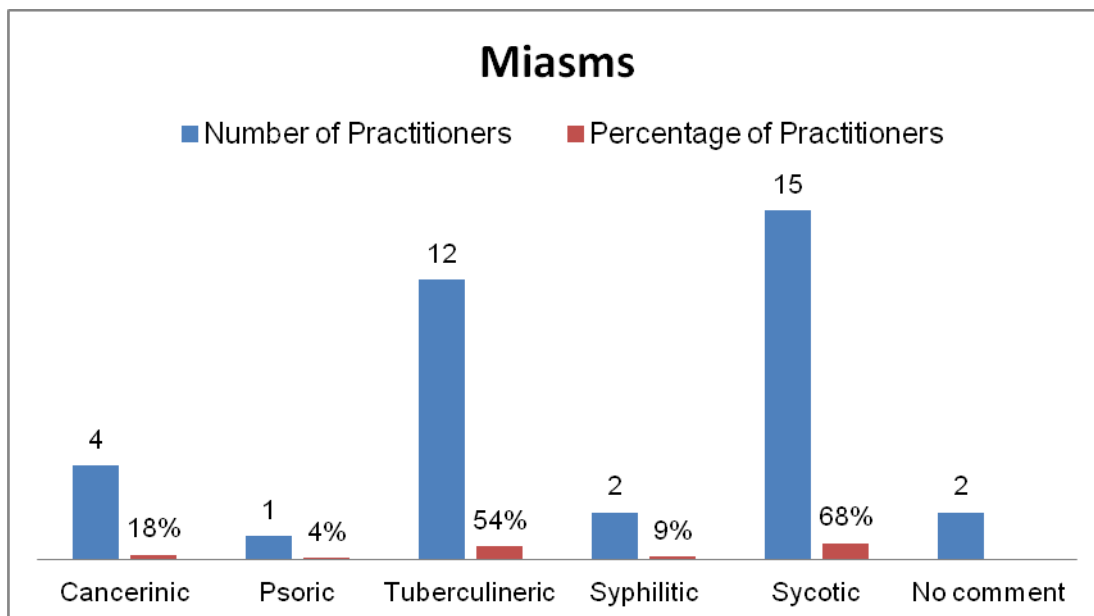


Figure 4.32 Bar Chart showing the percentage of Miasms prescribed by homoeopaths for patients with ADD/ADHD

As can be seen in the table above, the most common Miasms are Sycosis and Tuberculinum. These tie in with the most commonly prescribed Simplexes, being Medorrhinum, and Tuberculinum, both belonging to the Sycotic Miasm.

4.8.7.4. Families/Groups

Group/Family of remedies	Number of Practitioners
Animals	4
Nosodes	6
Plants	2
Minerals	4
Have not treated/No Comment	4

Table 4.5 Most common Groups/Remedy families as prescribed by practitioners

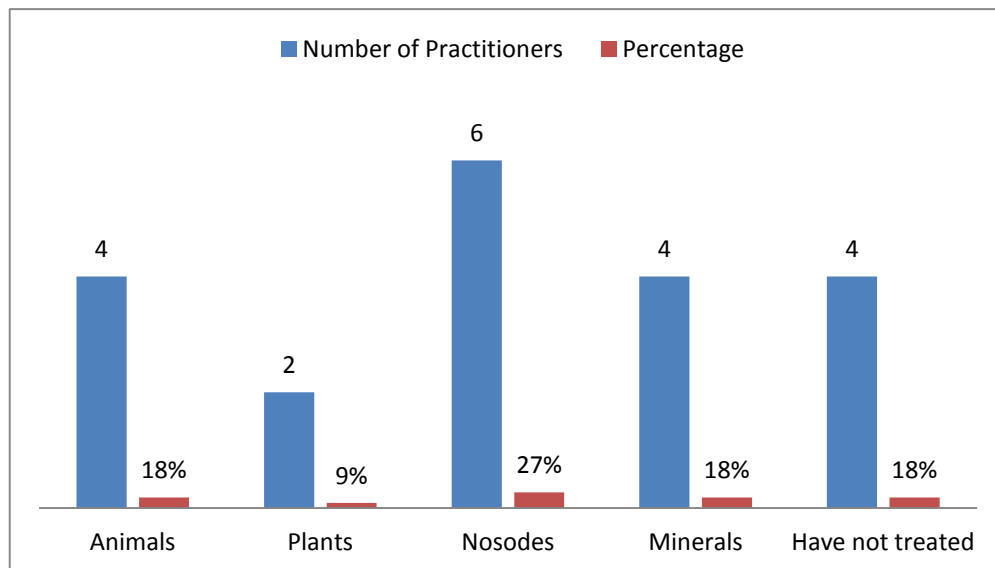


Figure 4.33 Bar chart illustrating the percentage of groups/remedy families as prescribed by practitioners

As can be seen in the table above, Nosodes are the most common groups/family of remedies prescribed for ADD/ADHD; this again validates the previous data, where the Sycotic and Tuberculinic Miasms are the most commonly prescribed Nosodes within the study. Medorrhinum is the more commonly prescribed remedy, belonging to the Sycotic miasm, which is the most commonly prescribed miasm.

4.9 AETIOLOGY

CAUSATIVE FACTORS	Genetics	Environment	Diet	Vaccinations	Family dynamics
Number of practitioners	10	20	18	9	17
Percentage of practitioners	45%	90%	81%	40%	77%

Table 4.6 shows the total number of causative factors of ADD/ADHD as perceived by the homoeopathic practitioners

According to the personal experience and perceptions of the homoeopaths in this study, the following causative factors were found to contribute to the development of ADD/ADHD:

The majority of the homoeopaths found that the environment (90 percent) the diet (81 percent), and the family dynamics (77 percent) of the patient were the most prominent causative factors to the development of ADD/ADHD. Other important factors include; genetics (45 percent) and vaccinations and other suppressions (40 percent).

4.10. Conventional Medicine and Homoeopathy in the treatment of ADD/ADHD

Patients were asked to indicate for each age group how often patients were on conventional drug treatment before homoeopathic treatment.

4.10.1 Patients on drug treatment before homoeopathic treatment

Age Groups	Never	Sometimes	Often	Always
Under 5 years old	23%	42%	23%	9%
5-9 years old	19%	14%	52%	14%
10-14 years	19%	14%	52%	14%
15-18 years	42%	9%	42%	48%
18 years/ older	38%	23%	38%	0%

Table 4.7 Frequency Table showing the valid percentage of patients for all age groups that are on drug treatment before homoeopathic treatment

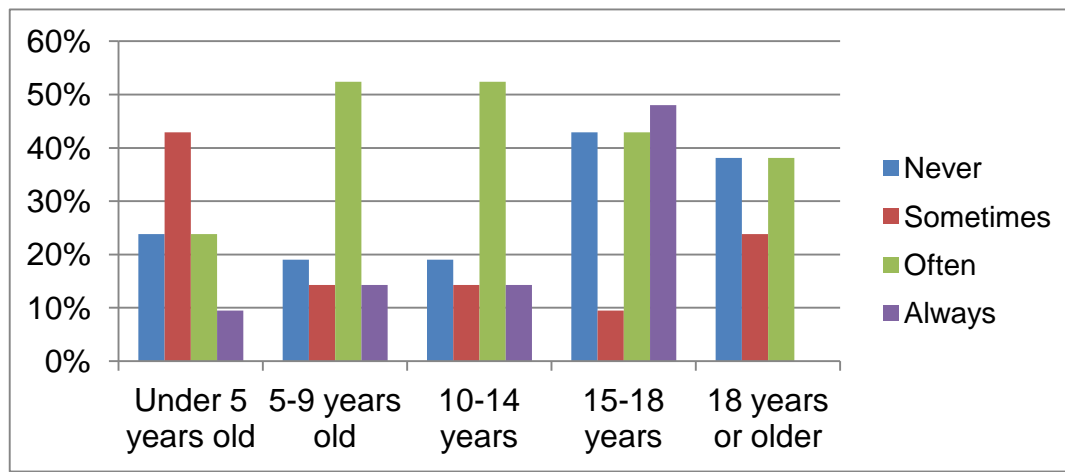


Figure 4.34 Bar Chart showing the valid percentage of patients for all age groups that are on drug treatment before homoeopathic treatment

Children under five years of age were more likely to be on conventional drug treatment before taking homoeopathic treatment, as can be seen with a high percentage ranging from 20-40 percent.

Patients aged between five to nine years and 10-14 years had the highest percentage (52 percent) for being on drug therapy before homoeopathic treatment.

Patients between the ages of 15-18 years (42 percent) as well as over the age of 18 (38 percent) also had a high percentage of being on drug therapy before homoeopathic treatment.

4.10.2 Success rate of practitioners treating patients with ADD/ADHD

Practitioners were asked to indicate how successful they believe they are in treating patients with ADD/ADHD.

4.10.2.1. Success rate in patients aged 5 years and under

Question B.27: When treating a patient with ADD/ADHD how SUCCESSFUL do you believe you are in treating these patients? [Patient younger than 5 years old]

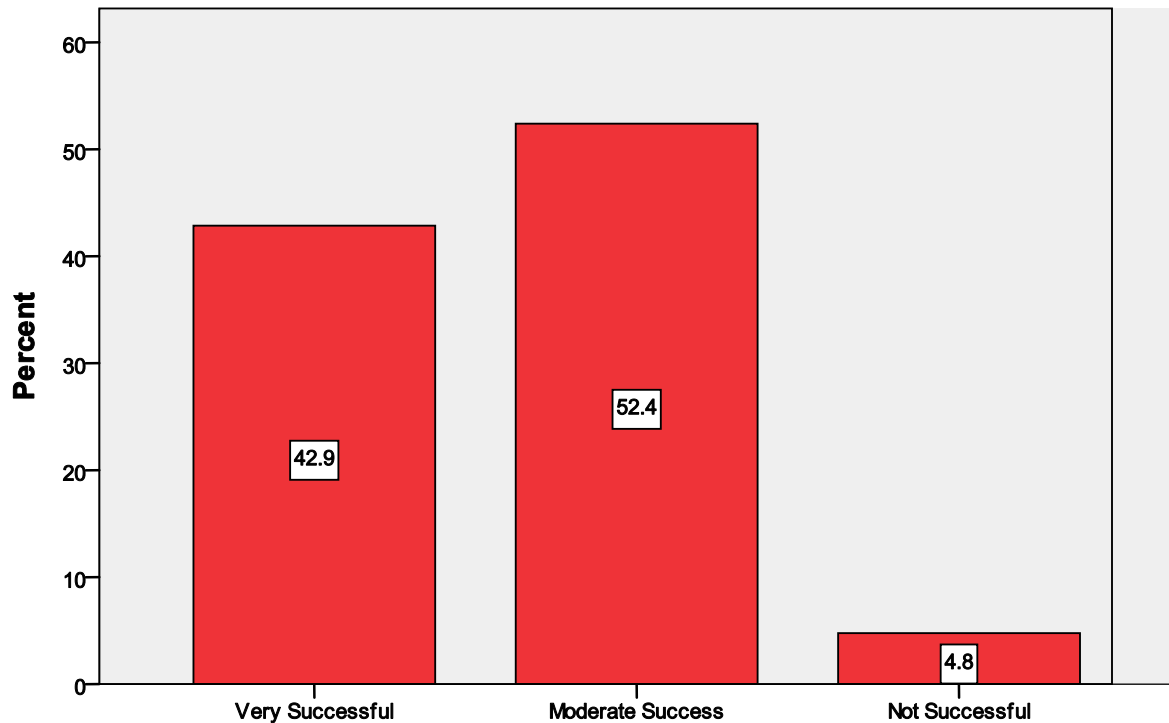


Figure 4.35 Bar Chart illustrating the valid percentage of practitioner's perceptions on their success rate in patients five years and younger

According to the respondents, when treating patients aged five years and younger, 42 percent perceived their treatment to be very successful where as 52 percent perceived their treatment to be moderately successful.

4.10.2.2. Success rate in patients aged 5- 9 years

Question B.27: When treating a patient with ADD/ADHD how SUCCESSFUL do you believe you are in treating these patients? [Patient 5 to 9 years old]

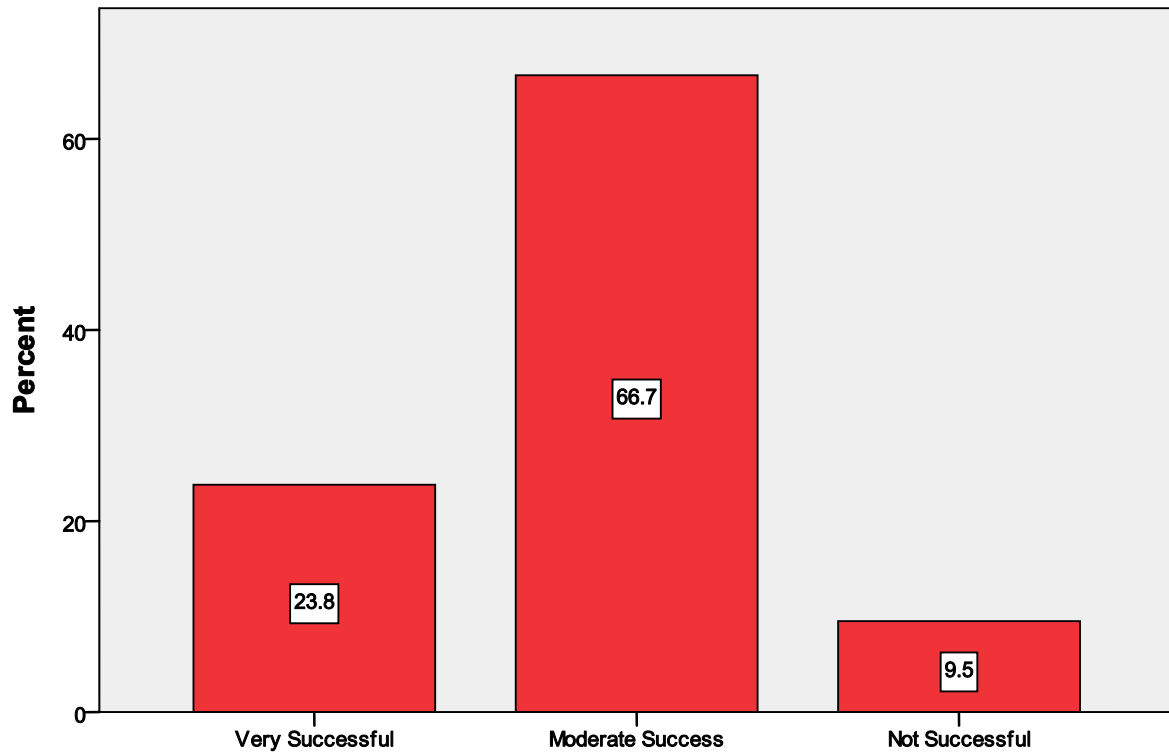


Figure 4.36 Bar Chart illustrating the valid percentage of practitioner's perceptions on their success rate in patients 5-9 years

According to the respondents, when treating patients aged 5-9 years, 23 percent perceived their treatment to be very successful where as 66 percent perceived their treatment to be moderately successful.

4.10.2.3. Success rate in patients aged 10-14 years

Question B.27: When treating a patient with ADD/ADHD how SUCCESSFUL do you believe you are in treating these patients? [Patient 10 to 14 years old]

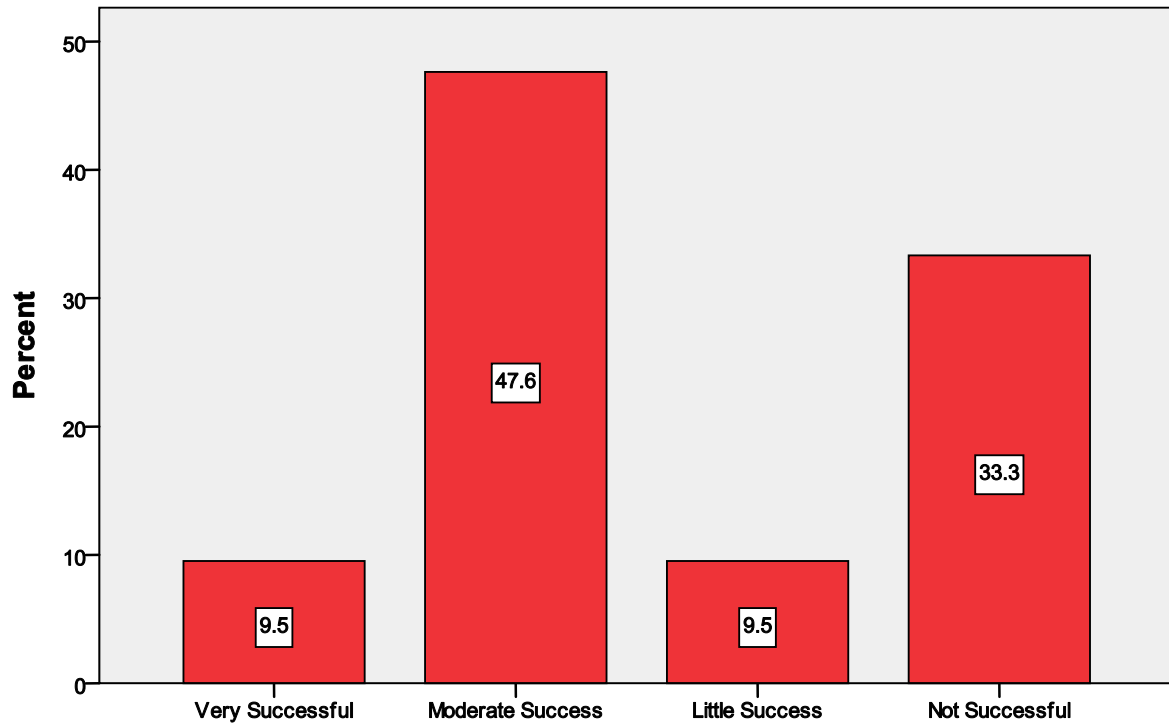


Figure 4.37 Bar Chart showing the valid percentage of practitioner's perceptions on their success rate in patients 10-14 years

According to the respondents, when treating patients aged 10-14 years, only nine percent perceived their treatment to be very successful where as 47 percent perceived their treatment to be moderately successful. Nine percent perceived to have little success and 33 percent perceived their treatment to have no success in the treatment of ADD/ADHD.

4.10.2.4. Success rate in patients aged 15-18 years

Question B.27: When treating a patient with ADD/ADHD how SUCCESSFUL do you believe you are in treating these patients? [Patient 15 to 18 years old]

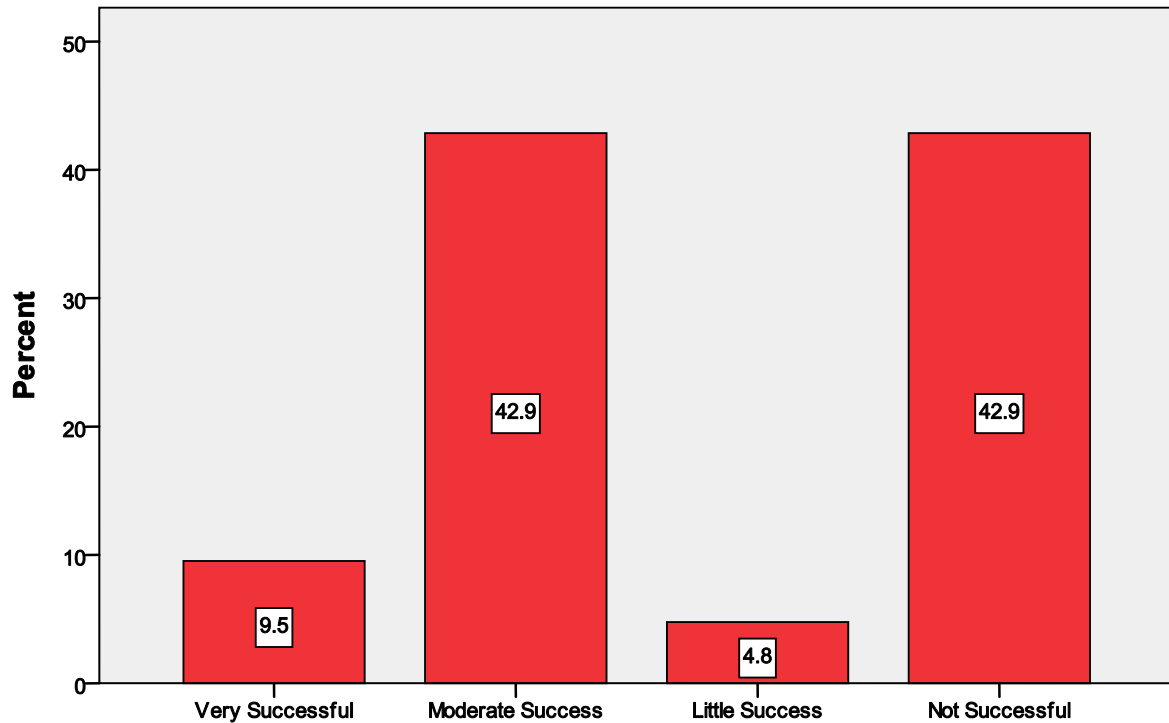


Figure 4.38 Bar Chart showing the valid percentage of practitioner's perceptions on their success rate in patients 15-18 years

According to the respondents, when treating patients aged 15-18 years, only nine percent perceived their treatment to be very successful where as 42 percent perceived their treatment to be moderately successful. Four percent perceived to have little success and 42 percent perceived their treatment to have no success in the treatment of ADD/ADHD.

4.10.2.5. Success rate in patients aged 18 years and older

Question B.27: When treating a patient with ADD/ADHD how SUCCESSFUL do you believe you are in treating these patients? [Patient older than 18 years]

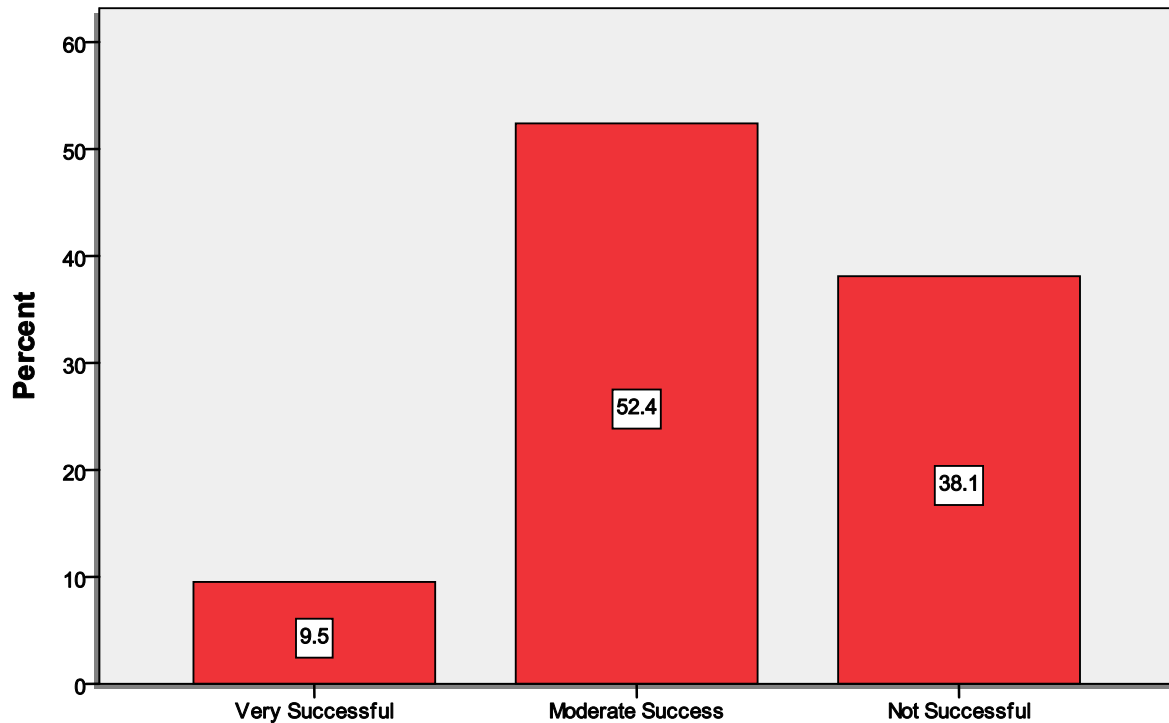


Figure 4.39 Bar Chart showing the valid percentage of practitioner's perceptions on their success rate in patients 18 years and older

According to the respondents, when treating patients aged 18 years and older, only nine percent perceived their treatment to be very successful where as 52 percent perceived their treatment to be moderately successful, while 38 percent perceived their treatment of ADD/ADHD to have no success.

4.10. Differences between Adult and Child ADD/ADHD

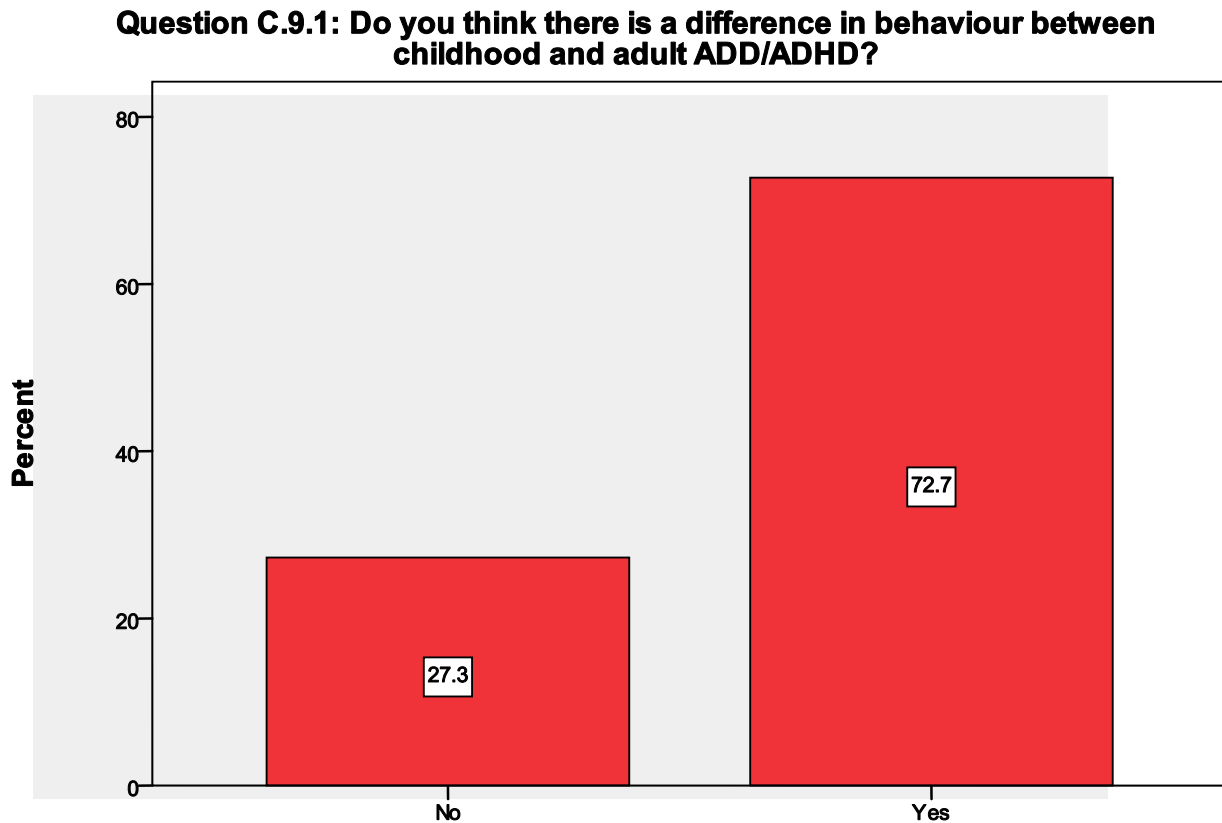


Figure 4.40 Bar Graph showing the opinions of practitioners with regard to the difference in adult and childhood ADD/ADHD

According to the above results 72 percent of practitioners believe there to be a difference between adult and childhood ADD/ADHD.

Chapter 5:

DISCUSSION

5.1) Introduction:

The initial challenge of the research survey was in contacting participants and encouraging them to participate in the research, this was the same challenge as experienced by Nagle's research (2007). Thirty nine homoeopaths are registered with the Allied Health Professions Council of South Africa, within the selected geographic area of KwaZulu-Natal, according to the list supplied by the council in May 2011. This list was incomplete and not up to date, as many of the practitioners were not on the list, and many of them that were on the list had changed their contact details, moved out of the required area or had stopped practicing.

A total of 42 practitioners were contacted. Thirty five practitioners initially agreed to participate in the study, and the questionnaires were electronically sent to them via email. Of the 35 only 14 completed the questionnaire within the required time period. A further four week period was extended with an email encouraging all practitioners to respond, as well as a personalized delivery and collection of eight more questionnaires at a regional H.S.A meeting held in September. This increased the response rate up to 22 participants. These practitioners formed the study sample (n=22), i.e. giving an overall response rate of 62 percent.

This is a fairly good response rate as compared to Nagle (2007), who had a response rate 42 percent.

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

5.2) Practitioner Demographics:

The following demographic information was analysed: Age, Gender, Home Language, Type of practice, Institution from which they qualified, Number of years in practice and any additional modalities used in practice.

The study sample, comprising of 22 registered practicing homoeopaths, was compared to the study conducted by Nagle (2007) in Johannesburg Metropolitan in which there were 41 registered practicing homoeopaths.

5.2.1) Age

The majority of the practitioners were in the 25-30 years (18.2 percent) and 31-35 year age groups (36 percent). A similar trend was found in Johannesburg, in that the majority of the participants were in the 25-30(39 percent) and 31-35 (31 percent) year age groups (Nagle, 2007).

5.2.2) Gender

More than half the participants were female (72 percent) where only (27 percent) were male, these are similar results when compared to the study on Johannesburg homoeopaths (Nagle, 2007), where (58 percent) of the participating homoeopaths were female and (41 percent) were male.

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 (Verhoogt, 2003).

5.2.3) Home Language

Of the participants in the study 95 percent of them had English as their home language, and only 4 percent had isiZulu as their home language.

Some of the rural practitioners were likely to have spoken one of the other ethnic languages, however not all the Homoeopaths' registered in the poorer socio-economic areas were contacted and so a true demographic sample was not reflected.

5.2.4) Homoeopathic Qualification

The majority of the participants within the study (95 percent) held a Masters degree of Technology: Homoeopathy (M.Tech: Hom), of which (95 percent) had qualified from DUT, and only (four percent) had qualified elsewhere. In comparison to the Homoeopaths in the Johannesburg study (Nagle, 2007), 78 percent of the participants held a Masters degree of Technology: Homoeopathy (M.Tech: Hom), of which 19 percent qualified from Durban University of Technology, and 58 percent qualified from University of Johannesburg.

5.3.5) Years in Practice

In KwaZulu-Natal, over half of the respondents had been in practice for less than five years, whereas in Johannesburg, the average number was seven years (Nagle, 2007). In this study, 54 percent had been in practice less than five years, 27 percent for six to ten years, 13 percent had been practicing between eleven and fifteen years, and only four percent had been practicing for over twenty years.

In the Johannesburg study, it was found that 58 percent had less than five years experience, 29 percent had been practicing for six to 10 years, nine percent had

between eleven and twenty years experience, and none of the homoeopaths had more than twenty years of experience, except one practitioner who had 47 years of experience.

In both regions the majority of homoeopaths participating in the studies have less than 10 years experience, this is probably due to the fact that the first M.Tech: Hom graduates were only produced in 1994 at the Technikon Natal now (Durban University of Technology) and in 1998 at the Technikon of Witwatersrand now (University of Johannesburg) and these are the graduates that formed the bulk of the sample group.

5.2.6) Additional modalities used in practice and the percentage of homoeopathic practice

In this study the two most common disciplines practiced were: Phytotherapy (68 percent), and Naturopathy (18 percent). These were also the most common practiced disciplines seen in Nagle's research (2007): Phytotherapy was the most frequently practiced additional modality (87 percent), Naturopathy by (nine percent) as well as Acupuncture, which was utilized by 38 percent of the practitioners in Johannesburg (Nagle, 2007).

It can be inferred that phytotherapy is the major additional modality used by homoeopaths both in KwaZulu-Natal and within Johannesburg Metropolitan, this is most likely because this modality is studied in the Auxiliary therapeutics subjects in the M.Tech: Hom qualification.

In KwaZulu-Natal, for over half the respondents, Homoeopathy made up more than seventy five percent of their practice. This corresponds to the Johannesburg study where thirty homoeopaths indicated that they practiced homoeopathy more than 75 percent of the time, and just over half of these practitioners reported that they practiced homoeopathy 100 percent of the time.

5.2.7) Location of practice

The majority of the homoeopaths that participated in this study came from the more urban areas of KwaZulu-Natal. 19 practitioners (86 percent) came from eThekweni (Durban) where only a small percentage came from the rural areas of KwaZulu-Natal. Only one practitioner (four percent) came from Amajuba (Newcastle), one practitioner (four percent) came from uThungela (Richards Bay), and another one practitioner (four percent) came from uThukela (Ladysmith).

It has been suggested that ADD/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 being a minimal awareness and understanding of the condition (Badat, 2004). However it will be difficult to determine these results as there were too few homoeopaths practicing within the rural areas to provide significant information regarding the prevalence of patients with symptoms of ADD/ADHD.

5.2.8) Type of practice

The majority of the homoeopaths in this study (64 percent) have a sole homoeopathic practice, only (four percent) have a group homoeopathic practice (practice with other homoeopaths), whilst (nine percent) are part of a multidisciplinary practice (practice with other practitioners of other disciplines) and (22 percent) have a sole multidisciplinary practice (they practice on their own, practicing homoeopathy as well as other disciplines). These figures reflect a similar trend in the Johannesburg study, where almost half of the practitioners (41 percent) were in sole practice, (26 percent) were a part of a multidisciplinary practice and (24 percent) practiced with other homoeopaths (Nagle, 2007).

5.3) Management and Opinions of ADD/ADHD

5.3.1 Patients being treated by homoeopaths

Participants were asked the number of patients that attended their practice who had presented with symptoms of ADD/ADHD, within the past 12 months. Seventy two percent of the practitioners had seen patients with symptoms of ADD/ADHD. The majority of the patients were between the ages of 5 and 14 years old; this correlates to the statistics found in the Johannesburg study where nine hundred and five patients with symptoms of ADD/ADHD had been seen by 39 homoeopathic practitioners (Nagle, 2007). This corresponds to the fact that children are generally first diagnosed with ADD/ADHD during their primary school years (Barkley, 2004).

5.3.2) Diagnosis

The majority of the homoeopathic practitioners did not make the diagnosis themselves (Tables 4.2. to 4.11) (Appendix 3), this is possibly because the children had already been diagnosed by another professional and were seeking help from a homoeopath as a last resort, or as an alternative to conventional medicine. This was similar to the results seen in the Johannesburg Metropolitan study.

Homoeopaths can and do make a diagnosis however they do not allow the diagnosis to determine the medicine prescribed. Homoeopaths prescribe medicine according to the totality of symptoms presented by each specific patient. The homoeopaths in this study based their diagnosis on the case history and a physical examination; some make use of the DSM-IV criteria, which is the standard diagnostic method, others use the Conner's rating scale and checking list. Most homoeopaths will also refer patients to specialists like a psychologist, neurologist, and/or paediatrician for a complete diagnosis.

In most cases however, a patient comes to a homoeopath as a final resort, and will often already be pre-diagnosed. It was more likely that a general practitioner, paediatrician, or psychologist had made the diagnosis. The participants also stated that some teachers were at times responsible for making the diagnosis. There is a common temptation to label students behaviour as ADD/ADHD, particularly in the South African school setting, where there are often 35 or more students in a class. Many teachers tend to mislabel children as having ADD/ADHD because they don't have the time or the resources to develop real expertise in diagnosis (Lawlis, 2005).

5.3.3) Incorrect Diagnosis

According to the homoeopaths participating in the study, the general consensus is that the diagnosis of ADD/ADHD is given far too easily, and without proper assessment. Eighty six percent of the homoeopaths are of the opinion that ADD/ADHD is misdiagnosed, and ninety one percent stated that ADD/ADHD is over diagnosed. Diagnosing psychiatric disorders in children is far from an exact science and the absence of objective evaluation methods and relying on the observations of parents and teachers introduces uncertainty into the diagnostic process (Barkley, 2004). These children often have a learning disability, which makes it difficult to keep up with tasks given to them. They may also have mental/emotional difficulties, and/or other medical conditions may also present as ADD/ADHD.

ADD/ADHD has become a fashionable diagnosis that is made far too easily and quickly. There are innumerable studies of under diagnosis and over diagnosis and it is estimated that millions of children are incorrectly labelled and treated for nothing more than immaturity. A review of these studies showed clearly that 50 percent of children diagnosed with ADD/ADHD do not fit the officially accepted criteria and are therefore wrongly diagnosed (Goldberg, 2004).

Troublesome aspects of how ADD/ADHD is currently framed in official psychiatry (Diller, 2009).

1. The process of establishing “objective” diagnostic standards for ADD/ADHD has been quite subjective.
2. Official guidelines for evaluating ADD/ADHD symptoms are vague and open to interpretation, yet they lead to an all-or-nothing diagnosis.
3. The ADD/ADHD 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 into account of family systems and other environmental factors.
5. In its current phase as a “disorder for all seasons”, ADD/ADHD has 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 certain other childhood psychiatric disorders. And many children meet criteria for some, but not all of the symptoms of several different conditions.

This reflects what the majority of the homoeopaths had reported in the survey, the following were the comments made by practitioners with regard to misdiagnosis and over diagnosis:

- “A diagnosis of convenience to put a child on drugs in order to have better control over them.”
- “Our education system is not centred on teaching boys. Boys especially need interaction, and hands on activities, and very few respond to being told to sit and listen. As a result more boys are diagnosed than girls.”

- “An easy diagnosis compared to exploring all relevant medical and psychological variables. A step toward drug therapy as a means of social control.”
- “Children are measured in limited ways, e.g.: exams/tests. Often children who are not only academic, but can excel in different avenues, are pressured by society and school.”
- “Diagnosis is made mostly by teachers, the teacher will often suggest to the parents to medicate their children.”
- “Over diagnosis is when a child is labelled ADD/ADHD without a proper assessment being carried out.”
- “Over diagnosis occurs due to the ever increasing academic demands and pressures put on young children, any child who does not cope is suspected to be ADD/ADHD.”
- “Schools are at a loss at what to do with children regarding discipline. A child who does not “Fit” into the mould is often over diagnosed as ADD/ADHD.”
- “Over diagnosis is primary school children, often diagnosed by teachers and then children are quickly medicated by G.P’s without proper evaluation. However the diagnosis is often missed in adults.”
- “There is a very quick intervention and attempt to control the behaviour in children, when all they actually need is some stability in routine, diet, environment, or emotional state.”
- “Often all a child needs is a dietary change, more nurturing from their parents, and then the behaviour changes. Also G.P’s are often too eager to prescribe drug intervention”

5.3.4). Referrals

The homoeopaths in this study hardly ever referred their patients to other homoeopaths; this is similar to the results found in the research survey of the homoeopaths practicing within Johannesburg (Nagle, 2007). In most cases a

homoeopath will consult with another homeopath for input, or refer if the practitioner does not treat children, or feels that the case is beyond their scope of practice.

A similar trend was found throughout the age groups as can be seen in Tables: (4.7- 4.11) (Appendix 3). The practitioners are most likely to send referrals to a psychologist, neurologist, or a paediatrician.

5.4) Homeopathic Treatment

5.4.1) The General Approach

The majority of practitioners investigate to find the root cause of the problems that the patient is experiencing. The homoeopaths investigate what motivates the patients ADD/ADHD behaviour, they will do a full case history, look into the family history and conduct a physical exam, as well as assess the patients home, family, personal and school environments. The totality of symptoms is assessed, and the best indicated remedy is given.

Some practitioners make use of the DSM-IV Criteria; others make use of the Conner's scale and checking task, which is commonly used by psychologists, and paediatricians. Most practitioners use observations of the child's behaviour energy levels and sleeping patterns to assess the whole clinical picture. Other practitioners assess for nutritional, vitamin and mineral deficiencies, whilst some practitioners investigate by testing, the use of EEG's in order to exclude viral, bacterial, fungal or parasitic infections and any other illness or pathology first.

5.4.2) Remedy Choice: Simplexes and Complexes

The majority of the practitioners prescribe a simplex remedy, or the Simillimum, whereas only a few practitioners prescribe a complex remedy.

In this study the three most commonly prescribed simplexes were: *Medorrhinum*, *Tarentula hispanica*, and *Tuberculinum*. Other simplex remedies include: *Phosphorus*, and *Sulphur*.

As compared to Nagles' research, the two most commonly prescribed simplexes were: *Datura stramonium* and *Tuberculinum*. The other simplex remedies included: *Sulphur*, *Medorrhinum*, *Phosphorus* and *Lycopodium clavatum* (Nagle, 2007).

It was found that the most common complex prescribed is Nervoheel®. Some practitioners prefer to make up their own complexes, which would be patient specific.

This is different to the research conducted by Nagle (2007), where the most common complexes prescribed were, Ignatia-Homaccord® (Heel) (13 percent) Cerbo® (Natura) (13 percent) and Nervuton® (Natura) (eight percent).

5.4.3) Groups/Families of Remedies

The research shows that the Nosodes and Animal family/groups were the highest ranked group of remedies prescribed by homoeopaths within KwaZulu-Natal. Compared to the research conducted by (Nagle, 2007), the Solanaceae and Liliflora plant families were the highest ranked group of remedies prescribed by homoeopaths within Johannesburg.

5.4.4) Miasms

In this study it was found that in cases where ADD/ADHD is suspected the majority of the homoeopaths (68 percent) reported that the sycotic miasm was the most common and the tubercular miasm (54 percent) was the second most

commonly reported miasm. In comparison to the research conducted by Nagle, (51 percent) of the participants reported that Tuberculinum miasm was the most common miasm, and the Sycotic miasm (48 percent) was the second most common miasm seen in cases where ADD/ADHD is suspected (Nagle, 2007).

Both theses miasms are reflective and influenced by today's society. In a person with a sycotic predisposition, rapid overgrowth is expressed on all planes.

Hyper stimulation on the physical plane translates into hyperactivity. It is no coincidence that the number of ADD/ADHD children has skyrocketed. These children often have impulsivity and a thirst for excitement which makes them act like the class clown. Paying attention in school is too difficult for their wandering brain-fagged mind. Locked up in a classroom, they feel like a bird in a cage. Having to sit still is torture, because they need the excessive movement to feel better. The overgrowth features of the sycotic miasm can be seen in their nature: Sycotic people want stimulation and fun. They are exhibitionists, or will do silly things for attention (De Schepper, 2000).

The tubercular miasm (54 percent) is the second most common in this study. It is indicated for patients with extreme restlessness and changeability. Tubercular people are like headless chickens, they look busy and run around all day from one thing to the next, but at the end not much is accomplished. Their combination of quick physical exhaustion and discontentment leads to impatience. They are good beginners but bad finishers, and they tend to have many unfinished projects in their lives (De Schepper, 2000).

5.5.1) Conventional Treatment and Homoeopathy?

Most of the practitioners stated, that patients were already on some kind of conventional medication before seeking Homoeopathic treatment. Practitioners within this study state that 20 to 40 percent of the children under the age five years were more likely to be on conventional drug treatment before taking

homeopathic treatment, where as patients aged between five to nine years and ten to fourteen years had the highest percentage (52 percent) for being on drug therapy before homoeopathic treatment. Patients between the ages of 15-18 years (42 percent) as well as over the age of 18 years, (38 percent) also had a high percentage of being on drug therapy before homoeopathic treatment.

Most of the participants prescribe homoeopathic treatment concurrently with the existing conventional drug treatment, in comparison to Nagles' research, 65, to 78 percent of the homoeopaths within Johannesburg; prescribe homoeopathic treatment whilst their patients remain on conventional treatment. As with both research studies, as the patients show improvement on the homoeopathic treatment, the practitioners work to gradually wean the patient off the conventional treatment. This process usually takes between two to three months.

In the KwaZulu-Natal Study only a few of the homoeopaths say that conventional drug treatment interferes with homoeopathic treatment, as compared to the results in Nagles' study where 77 to 85 percent of the homoeopaths in Johannesburg say conventional treatment interferes with homoeopathic treatment.

Most practitioners said that it is difficult to assess in many cases, as there too many factors or obstacles to cure, so they typically base treatment on the totality of symptoms and address each case individually.

The certain protocol that practitioners utilize to wean a patient off allopathic drug treatment is as follows:

1. Some practitioners do not treat patients homoeopathically whilst they are on conventional medication. These practitioners wean the patient off the conventional drug first and only then will they begin homeopathic treatment.

2. Most practitioners will treat homoeopathically, and allow patients to continue on the Methylphenidate, and then halve the dose with symptom improvement.
3. If parents had concerns regarding symptoms of withdrawal, some practitioners will give a prescription of Ritalin 30ch once daily for two weeks.
4. Many of the practitioners recommended that the child continue conventional treatment during school term and take a break during school holidays and weekends.
5. Some practitioners say that their approach depends on the parents and their feelings and attitudes. Many of these practitioners will spend time educating parents on the side effects and long term effects of conventional treatment.
6. Some homoeopaths recommended the use of herbal alternatives during the school holidays, or over a three-week block.

5.5.2) Adjunctive therapies and treatment

The homoeopaths in this study stated that they prefer to use a holistic approach to obtain optimal well being, thus advice, lifestyle adjustments, education and counselling all form part of the treatment and management of a patient with ADD/ADHD, making it unique and specific to each case. Of the adjunctive therapies, Vitamins, supplements, and nutritional changes are recommended, especially if a deficiency has been identified. The most commonly prescribed supplements for ADD/ADHD are the Essential Fatty Acids (EFA's) followed by Vitamin B Complexes, Multivitamins and Magnesium, Zinc, and Calcium.

Similar responses were reported by the homoeopaths within Nagle's study, some Johannesburg practitioners even recommended specialty products such as Eye Q®, Melatone Syrup®, ADDvantage®, and Foodstate supplements containing

EFA's, B Group vitamins, Zinc, Calcium and Magnesium. In addition to the remedy given, many Johannesburg homoeopaths also recommended Electroloids and/or mineraloids, Chinese medicine or tissue salts (Nagle, 2007).

It can be seen from the above comparisons, homoeopaths within KwaZulu-Natal prefer to treat constitutionally, taking a full case history and exploring the deeper root cause, changing the diet, and focusing on educating parents to change their lifestyle patterns first, then only will adjunctive therapy be utilized, where as the homoeopaths within Johannesburg were utilizing a lot more adjunctive therapies as part of their initial treatment for children with ADD/ADHD.

5.6) Aetiology:

According to the personal experience and perceptions of the homoeopaths in this study, the following causative factors were found to contribute to the development of ADD/ADHD:

The majority of the homoeopaths found that the environment (90 percent) the diet (81 percent), and the family dynamics (77 percent) of the patient were the most prominent causative factors to the development of ADD/ADHD. Other important factors include; genetics (45 percent) and vaccinations as well as other forms of suppressions (40 percent).

Environment:

The majority of the homoeopathic practitioners within this study believed the environment that the patient is exposed to plays a role in their behaviour and mood. Most practitioners stated that a sedentary lifestyle with a lack of exercise, outdoor exposure and sunshine created frustration and hyperactive behaviour. Many also believed that an overstimulation of the nervous system due to an excessive exposure to videogames, Television and/or computers contribute to the symptoms of poor concentration and focus.

Diet:

Almost all of the practitioners agreed that the patient's diet is a major cause of ADD/ADHD cases, and many believed that it aggravated the symptoms. Poor diet and incorrect eating habits are as follows: Processed foods, refined sugars, additives, colourants, or allergens, like gluten, wheat, and/or lactose, this also includes nutritional deficiencies, in terms of essential vitamins and minerals and E.F.A's, often as a result of poor nutritional education or understanding.

Family Dynamics:

A lifestyle of instant gratification, poor parenting skills, lack of attention or nurturing from the family environment, as well as stress or trauma at home are a few of the contributing factors. Children who are raised with unskilled parenting are not given consistent and predictable limit setting, are not equipped to deal with the demands of a structured school day (Robertson, Allwood and Gagliano, 2000).

Genetics:

Predictors of persistence of ADD/ADHD include family history of the disorder, psychiatric co-morbidity, and psychosocial adversity. Family studies of ADD/ADHD have consistently supported its strong familial nature (Bierderman, 2005). Many of the practitioners stated that a family history of ADD/ADHD can predispose a child to developing symptoms of ADD/ADHD, this relates to the hereditary miasmatic influences that are shared among family members.

Vaccinations:

A few of the practitioners stated that vaccinations or medication given to the child, will often suppress the immune system which then predisposes the child to deeper diseases like the symptoms experienced by ADD/ADHD patients.

The following are a few perceptions held by practitioners within KwaZulu-Natal, regarding the factors that contribute to symptoms of ADD/ADHD:

- “Children don’t have parents showing them attention, and they don’t have teachers willing to harness their intelligence.”
- “Diet has a great role to play, as well as vitamin deficiencies. If there are any problems in the home, there is a good possibility the child will act out.”
- “Lifestyle issues, which include psychological issues of the family, divorce, sibling rivalry, abuse or neglect, school bullying, or pressures to perform academically.”
- “Children are often highly intelligent but bored, and thus become disruptive and often appear as a case of ADD/ADHD. Often an underlying trauma can be the cause of ADD/ADHD specifically, and the child is not actually a true ADD/ADHD case.”
- “Often the whole emotional/mental state of the family and the child is ignored. This then plays a role in the reaction of the child. Diet is often omitted, and some children are hypersensitive to certain foods, colourants and additives. Social interaction, like too much TV or computer time can lead to inactive or overactive brain activity.”

5.7) Adult and Childhood ADD/ADHD

5.7.1) The difference between Adult and Childhood ADD/ADHD

According to the results within this study, seventy two percent of the practitioners said there is a difference between adults and children who present with ADD/ADHD symptoms. The remaining twenty seven percent said there is no difference between adults and children but rather a difference between all patients as every case is unique. As compared to Nagle (2007) research, sixty one percent of the Homoeopaths within Johannesburg stated there is a

difference between Adult and Child ADD/ADHD, while 39 percent said there is no difference.

Diagnosing adult ADD/ADHD can be difficult, since hyperactivity typically decreases, as children get older, whilst attention and organizational problems may be more prominent. 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).

The homoeopaths within KwaZulu-Natal reported the following with regards to the differences in adult and child ADD/ADHD:

- “Children present with poor concentration, hyperactivity, distractibility, impulsiveness’ and restlessness. Adults present with trouble concentrating or hyper focus, disorganization and forgetfulness, impulsivity and emotional difficulties.”
- “Adults are non-controlled, which leads to a greater degree of obsessive, destructive behaviours, such as addictions.”
- “Most adults learnt to compensate: they have developed coping skills because they have most probably had the condition their whole life.”
- “Adults with ADD/ADHD have a greater understanding of and more perspective into their situation, this then allows them to cope better.”
- Adults can reflect on their experience and understand what is going on.
- “Children are busy, hard to control, very active and easily distracted, where adults find it hard to focus, often have poor memory, and suffer with poor performance.”

5.7.2) Difference in treatment:

The majority of the homoeopaths within this study stated that they do not have a difference in treatment regarding adults and children, but rather that they treat all patients as individuals, focusing on the totality of the symptoms to determine the constitutional Simillimum, herbal support, and lifestyle and dietary changes unique to each patients.

Many homoeopaths felt that there are more mental/emotional avenues that needed to be explored when treating adults with symptoms of ADD/ADHD, As can be seen from the below statements:

- “There is usually more of an anxiety components to the adults treated, thus more treatment is focused on mood.”
- “Small children require homoeopathy only, however adults require a lot more counselling, insight and behavioural changes, as well as management and lifestyle advice. “
- “Adults often present with other psychological symptoms firsts, and only on further exploration will they share with the homoeopaths that they had ADD/ADHD as a child. Usually adults present with mood disorders rather than the obvious ADD/ADHD symptoms.”

5.8) Perceptions of success in the treatment of ADD/ADHD patients:

Most of the homoeopaths in this study rated the degree of their success in treating ADD/ADHD, as being moderate to very successful. Over 50 percent of all the practitioners rated their treatment as moderately successful across all the age groups, as seen in tables: 4.27-4.31(Appendix 3). These practitioners measure their success in treatment objectively. Most practitioners believe that the feedback from educational psychologists, teachers, parents and other care

givers is important in determining any changes in symptoms and behaviours in the patients.

Most objective changes are seen at the follow up consultations. The follow up allows the patient to report changes in symptoms of ADD/ADHD as well as changes in concomitant symptoms, like energy levels, mental and emotional levels, as well as other health problems like bed wetting, interaction with peers, school teachers, as well as an improvement in energy and social connection.

At follow up consultations many practitioners make an assessment of behaviour changes, by means of teacher's feedback and/or report cards, as well as the use of the DSM-IV Criteria, and the Conner's rating scale.

The majority of the practitioners believe that success in treatment is not only a lessening of ADD/ADHD symptoms, but also a change in mood and energy, better sleeping patterns, and a decrease in concomitant symptoms, like bed wetting and allergies, thus ensuring treatment is holistic.

Chapter 6:

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

The purpose of this study was to investigate the perceptions, treatment and management of ADD/ADHD by homoeopathic practitioners within the KwaZulu-Natal Region.

A questionnaire with three sections was electronically sent out to the practitioners to complete. Section A of the questionnaire focused on the practitioner demographics. Section B looked at the diagnosis, treatment and referral, as well as the comparisons between the treatment of children and adults with ADD/ADHD. It also examined the success rate of the practitioner with regards to treatment and management, as well as interference of conventional treatment with homoeopathic treatment. Section C was comprised of open-ended questions, which were related to the questions in Section B.

The majority of the practitioners that participated in this study were from the more affluent urban areas of KwaZulu-Natal, and had graduated from the Durban University of Technology. The majority of the homoeopaths were female, and were between the ages of 31-35 years old. It is difficult to determine the number of patients with ADD/ADHD who are being treated in the lower socio-economic or more rural areas of KwaZulu-Natal, and because of this, we were unable to determine if the treatment of these patients is any different to the treatment of patients in the urban or higher socio-economic areas of KwaZulu-Natal. This was because there was a difficulty in contacting the practitioners who were listed within the rural areas of KwaZulu-Natal. Although we were able to contact and communicate with a few homoeopaths practicing within rural KwaZulu-Natal, some of the practitioners who were contacted, had poor telephone lines, or did

not have access to email addresses or fax machines, therefore we were unable to send the survey out to them.

As a result the study reflects a bias to the younger practitioners who are predominantly from the white population and are mainly English speaking. These homoeopaths are practicing within the more urban areas of KwaZulu-Natal, so this may not be a true reflection of how homoeopaths are managing and treating ADD/ADHD in the rural areas of KwaZulu-Natal or within South Africa as a whole.

The diagnosis of ADD/ADHD is most often made by paediatricians, general practitioners and psychologists, and only a small percentage of neurologists had made the diagnosis. Homoeopaths usually do not make the first diagnosis when it comes to ADD/ADHD for two main reasons. Most people try homoeopathy as a last resort, and so usually come to see a homoeopath pre-diagnosed, the other reason that homoeopaths don't make the diagnosis, is that the prescription does not rely on a formal diagnosis of ADD/ADHD, but rather the totality of the symptoms being presented.

In terms of referral, most homoeopaths will refer to psychologists, neurologists or paediatricians, if they feel it is required. Other practitioners that are commonly referred to are occupational therapists, nutritionists, and remedial teachers. With regard to the diagnosis, the majority of the homoeopaths in this study believe that ADD/ADHD is misdiagnosed and over-diagnosed.

The main additional modalities utilized by the homoeopaths in KwaZulu-Natal, is naturopathy and phytotherapy. As far as homoeopathic treatment is concerned, Simillimum prescribing is the first choice, followed by complexes, then herbal remedies and dietary advice.

The three most commonly prescribed simplexes were *Medorrhinum*, *Tarentula* and *Tuberculinum bovinum*. The most commonly prescribed complex is Nervoheel® which is a proprietary medicine. In terms of Family groupings, the Animal and Nosodes family of remedies seem to show a close reflection of ADD/ADHD behaviour. The Sycotic and Tuberculinic Miasm are the most common miasms found by the homoeopaths within KwaZulu-Natal.

Seventy two percent of the homoeopaths practicing within KwaZulu-Natal thought that there is a difference between adult and childhood ADD/ADHD; this is a much higher percentage as compared to only 61 percent of the homoeopaths practicing in Johannesburg (Nagle, 2007). The homoeopaths within the study felt that the main reason for the difference in behaviour between adults and children is that adults, who suffer with symptoms of ADD/ADHD, often present with anxiety and mood disorders first, and present symptoms differently because they have developed coping mechanisms over the years.

Social and environmental instability are some of the major contributing factors to developing the symptoms associated with ADD/ADHD. These causative and/or exacerbating factors include unstable family dynamics, and a sedentary lifestyle, combined with overstimulation by computers and/or Television, as well as poor nutrition and highly refined diets. An important factor that was mentioned is that parents need to be more involved with their children, from the diagnosis, to their daily lives as well as during the treatment and management programme.

The majority of the homoeopaths reported that they are moderately to very successful in the treatment and management of ADD/ADHD. As it was to be expected, the more experience a practitioner had, the more likely they were to prescribe other treatments and reported a greater success rate. It should be noted that this survey is highly subjective, and although practitioners state that they have experienced success in the treatment of ADD/ADHD, this does licence further exploration in the form of clinical trials and patient benefit surveys.

Homoeopathy and the holistic treatment offered by practitioners could therefore be considered a primary form of treatment rather than a last resort, as the focal point of treatment is on determining and treating the root cause of the behaviour. Parents, teachers, and other healthcare practitioners involved in the patients treatment, need to be made more aware of what homoeopathy can offer to those affected with ADD/ADHD, in order to ensure a complete holistic method of treatment and management for patients with symptoms of ADD/ADHD.

6.2. Recommendations

- The sample group in the research study does not adequately reflect the population of homoeopaths within the KwaZulu-Natal region, or within South Africa as a whole. Future studies should aim to include as many of the other sections of the homoeopathic communities. In order to access the homoeopaths who work with patients from rural areas, studies should include the outreach homoeopathic clinics, for example Redhill Municipal clinic, and Ukuba Day clinic.
- As the questionnaire was sent out electronically it was difficult to gauge if the practitioners had received the questionnaire or when the practitioners had responded. For future studies where surveys are sent out electronically, it would be useful to create an instant email reply, where once the questionnaire has been completed an email will be sent back to the researcher to be recorded.
- As this research was subjective, a patient benefit survey could be more accurately quantify the response to treatment. This could be conducted as a treatment outcomes questionnaire, to be completed by the patients, and a separate questionnaire to be completed by the parents/guardians, as well as the teachers. That way the more holistic aspects of the treatment to all the symptoms of ADD/ADHD could be explored more thoroughly.

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Appendix 1 A

Questionnaire: ADD/ADHD in KZN [2]

Section A: Practitioner Demographics. Please indicate your response by ticking the numbered boxes

* Required

Question A.1: Informed Consent * By ticking the box below, you acknowledge that you have read the information letter and give consent to participate in this study

- ☐ Yes

Question A.2: In which Age Group do you fall? * Please indicate your response by ticking the relevant box

- ☒ under 25 years
- ☒ 25-30 Years
- ☒ 31-35 Years
- ☒ 36-40 Years
- ☒ 41-45 Years
- ☒ 46-50 Years
- ☒ 51-55 Years
- ☒ 56-60 Years
- ☒ 61 Years or older

Question A.3: What is your Gender? * Please indicate your response by ticking the relevant box

- ☒ Male
- ☒ Female

Question A.4: What is your Home Language/Mother Tongue? * Please indicate your response by ticking the relevant box

- ☒ English
- ☒ Afrikaans
- ☒ isiNdebele
- ☒ isiXhosa
- ☒ isiZulu
- ☒ SePedi
- ☒ SeSotho
- ☒ SeTswana
- ☒ SiSwati

- ☐ TshiVenda
- ☐ XiTsonga
- ☐ Other

Question A.5: What type of Homoeopathic Qualification do you possess? * Please indicate your response by ticking the relevant box

- ☐ M.Tech (Hom)
- ☐ M.F.Hom
- ☐ Other

Question A.6: At which Institution did you qualify as a Homoeopath? * Please indicate your response by ticking the relevant box

- ☐ Durban University of Technology (Former Natal Technikon)
- ☐ University of Johannesburg (Former Witwatersrand Technikon)
- ☐ Other

Question A.7: How many complete years have you been in Homoeopathic practice? * Please indicate your response by ticking the relevant box

- ☐ 0-5 Years
- ☐ 6-10 Years
- ☐ 11-15 Years
- ☐ 16-20 Years
- ☐ 20+ Years

Question A.8: What Additional Modalities do you make use of in your practice? * Please indicate your response by ticking the relevant box

- ☐ None
- ☐ Allopathic
- ☐ Medicine
- ☐ Chiropractic
- ☐ Naturopathy
- ☐ Iridology
- ☐ Phytotherapy
- ☐ Traditional
- ☐ Healing
- ☐ Reflexology
- ☐ Other

Question A.9: What Percentage of your practice is Homoeopathy? * Please indicate your response by ticking the relevant box

- ☐ 0% - 25%
- ☐ 26% - 50%
- ☐ 51% - 75%
- ☐ 76% - 100%

Question A.10: In what Area is your practice located? * Please indicate your response by ticking the relevant box

- ☐ Amajuba (Newcastle)
- ☐ eThekweni (Durban)
- ☐ iLemba (KwaDukuza, formerly Stanger)
- ☐ Sisonke (Ixopo)
- ☐ Ugu (Port Shepstone)
- ☐ Umgungundlovu (Pietermaritzburg)
- ☐ Umzinyathi (Dundee)
- ☐ uThungulu (Richards Bay)
- ☐ Uthukela (Ladysmith)
- ☐ Zululand (Ulundi)

Question A.11: What type of Practice do you have? * Please indicate your answer by ticking the relevant box

- ☐ Sole Practitioner Homoeopathic Practice
- ☐ Sole Practitioner Multi-disciplinary Practice
- ☐ Group Homoeopathic Practice
- ☐ Group Multi-disciplinary Practice

Appendix 1 B

Section B: Questionnaire ADD/ADHD in KZN Management and Opinions of ADD/ADHD

* Required

Question B.1.1: Have you treated patients in the past 12 months that are younger than 5 years old for symptoms of ADD/ADHD? * Please indicate your answer by ticking the relevant box

- ☐ Yes
- ☐ No

Question B.1.2: Please specify how many patients younger than 5 years that you have treated in the past 12 months for symptoms of ADD/ADHD. If you answered YES to question B.1

- ☐ <5 patients
- ☐ 5-9 patients
- ☐ 10-15 patients
- ☐ 15-20 patients
- ☐ > 20 patients

Question B.2.1: Have you treated patients in the past 12 months that are 5-9 years old for symptoms of ADD/ADHD? * Please indicate your answer by ticking the relevant box

- ☐ Yes
- ☐ No

Question B.2.2: Please specify how many patients between 5-9 years that you have treated in the past 12 months for symptoms of ADD/ADHD. If you answered YES to question B.2.1

- ☐ <5 patients
- ☐ 5-9 patients
- ☐ 10-15 patients
- ☐ 15-20 patients
- ☐ > 20 patients

Question B.3.1: Have you treated patients in the past 12 months that are 10-14 years old for symptoms of ADD/ADHD? * Please indicate your answer by ticking the relevant box

- ☐ Yes
- ☐ No

Question B.3.2: Please specify how many patients between 10-14 years that you have treated in the past 12 months for symptoms of ADD/ADHD. If you answered YES to question B.3.1

- ☐ <5 patients
- ☐ 5-9 patients
- ☐ 10-15 patients
- ☐ 15-20 patients
- ☐ > 20 patients

Question B.4.1: Have you treated patients in the past 12 months that are 15-18 years old for symptoms of ADD/ADHD? * Please indicate your answer by ticking the relevant box

- ☐ Yes
- ☐ No

Question B.4.2: Please specify how many patients between 10-14 years that you have treated in the past 12 months for symptoms of ADD/ADHD. If you answered YES to question B.4.1

- ☐ <5 patients
- ☐ 5-9 patients
- ☐ 10-15 patients
- ☐ 15-20 patients
- ☐ > 20 patients

Question B.5.1: Have you treated patients in the past 12 months that are 18 years or older for symptoms of ADD/ADHD? * Please indicate your answer by ticking the relevant box

- ☐ Yes
- ☐ No

Question B.5.2: Please specify how many patients older than 18 years that you have treated in the past 12 months for symptoms of ADD/ADHD. If you answered YES to question B.4.1

- ☐ <5 patients
- ☐ 5-9 patients
- ☐ 10-15 patients
- ☐ 15-20 patients
- ☐ > 20 patients

Question B.6: Have you treated anyone with symptoms of ADD/ADHD or anyone presumed to have ADD/ADHD? *

- ☐ Yes
- ☐ No

Section B (Part 2): Questionnaire ADD/ADHD in KZN

Management of ADD/ADHD

* Required

Question B.7: When treating a patient with ADD/ADHD how often have you DIAGNOSED the patient YOURSELF? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient 5 to 9 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient 10 to 14 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient 15 to 18 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient older than 18 years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Question B.8: When treating a patient with ADD/ADHD how often has a COLLEAGUE HOMOEOPATH made the DIAGNOSIS? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.9: When treating a patient with ADD/ADHD how often has a GENERAL PRACTITIONER made the DIAGNOSIS? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.10: When treating a patient with ADD/ADHD how often has a PAEDIATRICIAN made the DIAGNOSIS? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.11: When treating a patient with ADD/ADHD how often has a NEUROLOGIST made the DIAGNOSIS? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.12: When treating a patient with ADD/ADHD how often has a PSYCHOLOGIST made the DIAGNOSIS? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.13: When treating a patient with ADD/ADHD how often has any OTHER PERSON/PRACTITIONER made the DIAGNOSIS? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.14: When treating a patient with ADD/ADHD how often have you made a REFERRAL to a COLLEAGUE HOMOEOPATH? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.15: When treating a patient with ADD/ADHD how often have you made a REFERRAL to a GENERAL PRACTITIONER? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.16: When treating a patient with ADD/ADHD how often have you made a REFERRAL to a PAEDIATRICIAN? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.17: When treating a patient with ADD/ADHD how often have you made a REFERRAL to a NEUROLOGIST? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.18: When treating a patient with ADD/ADHD how often have you made a REFERRAL to a PSYCHOLOGIST? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.19: When treating a patient with ADD/ADHD how often have you made a REFERRAL to any OTHER type of HEALER/PRACTITIONER? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.20: When treating a patient with ADD/ADHD how often do you PRESCRIBE a SIMPLEX REMEDY? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.21: When treating a patient with ADD/ADHD how often do you PRESCRIBE a COMPLEX REMEDY? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.22: When treating a patient with ADD/ADHD how often do you PRESCRIBE VITAMINS? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.23: When treating a patient with ADD/ADHD how often do you prescribe DIETARY CHANGES? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.24: When treating a patient with ADD/ADHD how often do you prescribe HERBAL REMEDIES? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.25: When treating a patient with ADD/ADHD how often do you prescribe BACH FLOWER REMEDIES? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.26: When treating a patient with ADD/ADHD how often are these patients on DRUG TREATMENT BEFORE homoeopathic treatment? * Please choose the answer corresponding to the correct column

	Never	Sometimes	Often	Always
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.27: When treating a patient with ADD/ADHD how SUCCESSFUL do you believe you are in treating these patients? * Please choose the answer corresponding to the correct column

	Not Successful	Little Success	Moderate Success	Very Successful
Patient younger than 5 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 5 to 9 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 10 to 14 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient 15 to 18 years old	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Patient older than 18 years	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>

Question B.28: How do you assess how successful you have been in treating a patient with ADD/ADHD? * Please explain using criteria



Appendix 1 C

Questionnaire: ADD/ADHD in KZN [2]

* Required

Section C: Questionnaire ADD/ADHD in KZN

Open ended questions and comments: Please write your comments in the space provided.

Question C.1.1: Do you think ADD/ADHD is misdiagnosed? * Please indicate your response by choosing the correct box

- ☒ Yes
- ☐ No

Question C.1.2: Please comment on the statement regarding misdiagnosis



Question C.2.1: Do you think ADD/ADHD is over diagnosed? * * Please indicate your response by choosing the correct box

- ☒ Yes
- ☐ No


Question C.2.2: Please comment on the statement regarding over diagnosis



Question C.3: If you as a Homoeopathic Practitioner, made the diagnosis of ADD/ADHD, on what basis (criteria) did you make this diagnosis?

A rectangular text input box with a thin black border. The bottom edge features a decorative border with a grey and white checkerboard pattern. On the right side, there are three small, vertically stacked square buttons with icons: a triangle pointing up, a square, and a triangle pointing down. On the bottom left, there are two small square buttons with left and right arrow icons.

Question C.4: What is your general approach to a patient presenting with the symptoms of ADD/ADHD?

A rectangular text input box with a thin black border. The bottom edge features a decorative border with a grey and white checkerboard pattern. On the right side, there are three small, vertically stacked square buttons with icons: a triangle pointing up, a square, and a triangle pointing down. On the bottom left, there are two small square buttons with left and right arrow icons.

Question C.5.1: What are the two most common Simplexes you would prescribe for a patient presenting with the symptoms of ADD/ADHD?

A rectangular text input box with a thin black border. The bottom edge features a decorative border with a grey and white checkerboard pattern. On the right side, there are three small, vertically stacked square buttons with icons: a triangle pointing up, a square, and a triangle pointing down. On the bottom left, there are two small square buttons with left and right arrow icons.

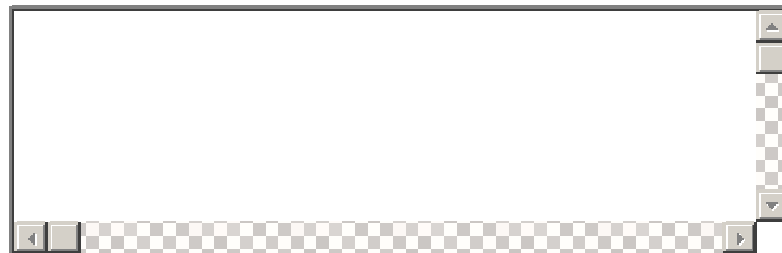
Question C.5.2: What are the two most common Complexes you would prescribe for a patient presenting with the symptoms of ADD/ADHD?

A rectangular text input box with a thin black border. The bottom edge features a decorative border with a grey and white checkerboard pattern. On the right side, there are three small, vertically stacked square buttons with icons: a triangle pointing up, a square, and a triangle pointing down. On the bottom left, there are two small square buttons with left and right arrow icons.

Question C.5.3: What are the two most common Group/Families of Remedies prescribed for a patient presenting with the symptoms of ADD/ADHD?

A rectangular text input area with a thin black border. The bottom edge features a decorative border with a grey and white checkerboard pattern. On the left side of this pattern are two small square buttons with left-pointing arrows. On the right side are two small square buttons with right-pointing arrows.

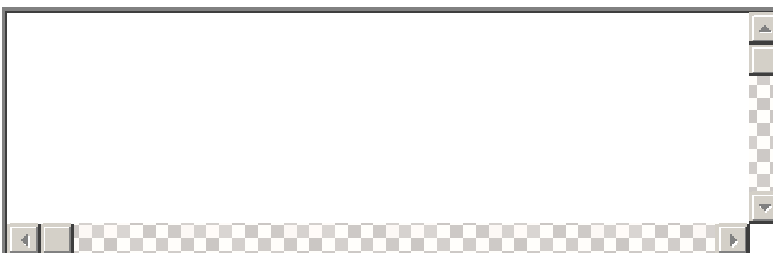
Question C.5.4: What are the two most common Miasms manifested by patients presenting with the symptoms of ADD/ADHD?

A rectangular text input area with a thin black border. The bottom edge features a decorative border with a grey and white checkerboard pattern. On the left side of this pattern are two small square buttons with left-pointing arrows. On the right side are two small square buttons with right-pointing arrows.

Question C.6.1: What is your approach to patients on conventional Drug Treatment such as Methylphenidate? Drug examples: Ritalin and Concerta

A rectangular text input area with a thin black border. The bottom edge features a decorative border with a grey and white checkerboard pattern. On the left side of this pattern are two small square buttons with left-pointing arrows. On the right side are two small square buttons with right-pointing arrows.


Question C.6.2: How do you assess whether conventional Drug Treatment has interfered with Homoeopathic Treatment? Please state the criteria you use for assessment.

A rectangular text input area with a thin black border. The bottom edge features a decorative border with a grey and white checkerboard pattern. On the left side of this pattern are two small square buttons with left-pointing arrows. On the right side are two small square buttons with right-pointing arrows.

Question C.6.3: What are the problems you encounter when managing a patient who is on both Complementary medicine and conventional Drug treatment (Methylphenidate Hydrochloride)?

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Question C.7: How do you manage a case where there is pressure from teachers, school, or others to keep the child on the drug treatment or to place the child on a drug treatment? Drug treatment: Ritalin and Concerta

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Question C.8.1: 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

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Question C.8.2: How does your Homoeopathic knowledge and perspective influence your view of and approach to ADD/ADHD?

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Question C.9.1: Do you think there is a difference in behaviour between childhood and adult ADD/ADHD? * Adult- 18 years or older

- ☒ Yes
- ☒ No

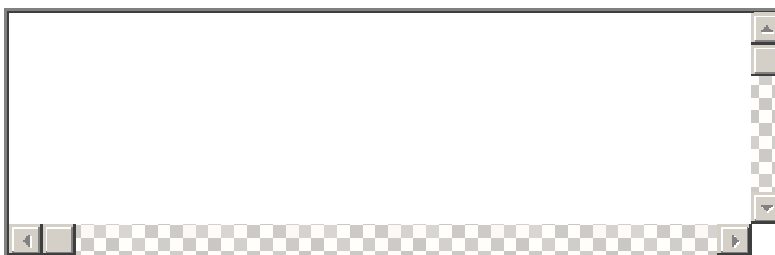
Question C.9.2: If you think there is a difference between childhood and adult ADD/ADHD, please note down what differences you have observed? Please Explain



Question 9.3: Are there differences in the way you treat and manage children and adults that present with symptoms of ADD/ADHD? Please Explain



Question 10: Are there any other observations or experiences you can share with me?



Appendix 2

Participant Information Letter

Project title: The perceptions and management of ADD/ADHD by homoeopathic practitioners in KwaZulu – Natal.

Researchers Name: Megan Medina

Supervisors Name: Dr Izel Botha D.Tech:Hom (DUT)

As Attention Deficit Disorder and Attention Deficit Hyper Activity Disorder are ongoing Controversial issues with regards to causes and management, the purpose of this research is to investigate the perceptions and management of this disorder by homoeopathic practitioners within KwaZulu-Natal.

In order to do this, I require the participation and co-operation of the registered homoeopathic practitioners in KwaZulu- Natal.

Participants will be required to answer and return the questionnaire within four weeks of receiving it.

Inclusion Criteria:

1. The homoeopathic practitioner must be registered with the Allied Health Professional Council of South Africa
2. The homoeopath must be currently practicing in the KwaZulu- Natal.
3. The practitioner must be English proficient, as the questionnaire will be in English.

Participation is completely voluntary and you may free to withdraw from the study at anytime without providing reason.

Participants will be encouraged to reflect in the principles underlying their practices as a homoeopath.

Confidentiality will be strictly adhered to, and participant's identity will not be revealed in this study.

Requirements of practioner:

1. Completion of the questionnaire within four weeks of receiving it.

Benefits of this study to you as the practioner:

1. Satisfaction that the information shared could be of assistance to the medical and homoeopathic profession.
2. Summary outcomes of the survey will be made available to participants when dissertation in complete.

I believe that this study will provide valuable information regarding homoeopathy as a treatment for ADD/ADHD in South Africa and will contribute to the development of homoeopathy as a whole.

If you have further questions please feel free to contact

Researcher Megan Medina: 0798817199

Research supervisor: Dr Izel Botha 031 373 2917

Thank you for your time

Megan Medina
(Researcher)

Appendix 3: RESULTS FROM CHAPTER FOUR

4.6.1. Diagnosis of patients 5 years and younger

	Never	Sometimes	Often	Always
Diagnosed patient self	66%	28%	4%	0%
Colleague diagnosed	95%	4%	0%	0%
G.P diagnosed	19%	47%	33%	0%
Neurologist diagnosed	76%	14%	4%	4%
Pediatrician diagnosed	14%	23%	57%	4%
Psychologist diagnosed	33%	42%	23%	0%
Other diagnosed	52%	28%	19%	0%

Table 4.8 Frequency table showing the valid percentage of diagnosis of patients younger than 5 years old

4.6.2. Diagnosis of patients between the ages of 5- 9 Years

	Never	Sometimes	Often	Always
Diagnosed patient self	81%	14%	4%	0%
Colleague diagnosed	95%	4%	0%	0%
G.P diagnosed	33%	38%	28%	0%
Neurologist diagnosed	76%	19%	4.%	0%
Paediatrician diagnosed	33%	19%	47%	0%
Psychologist diagnosed	38%	38%	23%	0%
Others diagnosed	0%	0%	0%	0%

Table4.9 Frequency table illustrating the valid percentage of diagnosis of patients 5-9 years old

4.6.3. Diagnosis of patients 10-14 years old

	Never	Sometimes	Often	Always
Diagnosed patient self	81%	14%	4%	0%
Colleague diagnosed	95%	4%	0%	0%
G.P diagnosed	33%	38%	28%	0%
Neurologist diagnosed	76%	19%	4. %	0%
Pediatrician diagnosed	33%	19%	47%	0%
Psychologist diagnosed	38%	38%	23%	0%
Others diagnosed	0%	0%	0%	0%

Table 4.10 Frequency table illustrating the valid percentage of diagnosis of patients 10-14 years old

4.6.4. Diagnosis of patients aged 15-18years

	Never	Sometimes	Often	Always
Diagnosed patient self	90%	4%	4%	0%
Colleague diagnosed	95%	4%	0%	0%
G.P diagnosed	52%	23%	23%	0%
Neurologist diagnosed	81%	14%	4%	0%
Pediatrician diagnosed	57%	19%	23%	0%
Psychologist diagnosed	47%	28%	23%	0%
Other diagnosed	76%	14%	9%	0%

Table 4.11 Frequency table showing the valid percentage of diagnosis of patients younger than 15-18 years old

4.6.5. Diagnosis of patients 18 years and older

	Never	Sometimes	Often	Always
Diagnosed patient self	85%	14%	0%	0%
Colleague diagnosed	95%	4%	0%	0%
G.P diagnosed	47%	28%	23%	0%
Neurologist diagnosed	81%	9%	9%	0%
Pediatrician diagnosed	71%	14%	14%	0%
Psychologist diagnosed	47%	38%	9%	4%
Other diagnosed	76%	14%	9%	0%

Table 4.12 Frequency table showing the valid percentage of diagnosis of patients 18 years or older

4.7 Referral:

4.7.1 Referral to other practitioners: Patients younger than 5 years old

	Never	Sometimes	Often	Always
Referred to Homoeopath	76%	19%	4%	0%
Referred to Gen. Practitioner	95%	4%	0%	0%
Referred to Neurologist	81%	9%	4%	4%
Referred to Paediatrician	52%	38%	9%	0%
Referred to Psychologist	66%	23%	9%	0%
Referred to Other	57%	42%	0%	0%

Table 4.13 Frequency Table showing referrals in patients younger than 5 Years old

4.7.2 Referral of patients: 5-9 Years old

	Never	Sometimes	Often	Always
Referred to Homoeopath	71%	23%	4%	0%
Referred to Gen. Practitioner	95%	4%	0%	0%
Referred to Neurologist	81%	9%	9%	0%
Referred to Paediatrician	57%	33%	9%	0%
Referred to Psychologist	57%	33%	9%	0%
Referred to Other	42%	47%	9%	0%

Table 4.14 Frequency Table showing referrals in patients 5-9 Years old

4.7.3. Referral of patients: 10-14 years old

	Never	Sometimes	Often	Always
Referred to Homoeopath	85%	9%	4%	0%
Referred to Gen. Practitioner	95%	4%	0%	0%
Referred to Neurologist	85%	9%	4%	0%
Referred to Paediatrician	66%	23%	9%	0%
Referred to Psychologist	57%	33%	9%	0%
Referred to Other	66%	33%	0%	0%

Table 4.15 Frequency Table showing referral of patients aged 10-14 years

4.7.4 Referral of patients: 15-18 Years

	Never	Sometimes	Often	Always
Referred to Homoeopath	81%	14%	4%	0%
Referred to Gen. Practitioner	95%	4%	0%	0%
Referred to Neurologist	85%	9%	4%	0%
Referred to Pediatrician	71%	19%	9%	0%
Referred to Psychologist	57%	33%	9%	0%
Referred to Other	71%	28%	0%	0%

Table 4.16 Frequency Table showing referral of patients aged 15-18 years

4.7.5. Referral of Patients: 18 years and older:

	Never	Sometimes	Often	Always
Referred to Homoeopath	85%	9%	4%	0%
Referred to Gen. Practitioner	95%	4%	0%	0%
Referred to Neurologist	85%	0%	14%	0%
Referred to Pediatrician	76%	14%	9%	0%
Referred to Psychologist	57%	38%	4%	0%
Referred to Other	61%	33.%	4%	0%

Table 4.17 Frequency Table showing referral of patients aged 18 years and older

4.8.1. Treatment options: For patients 5 years and under

	Never	Sometimes	Often	Always
Simplex remedy	9%	19%	19%	52%
Complex Remedy	38%	38%	19%	0%
Vitamins	14%	19%	28%	38%
Dietary Changes	4%	4%	14%	76%
Herbal Remedies	19%	33%	23%	23%
Bach Flower Remedies	66%	19%	9%	4%

Table 4.18 Frequency Table showing valid percentage of treatment options for patient 5 years and younger

4.8.2: Treatment options for patients 5-9 Years of age

	Never	Sometimes	Often	Always
Simplex Prescription	14%	9%	19%	57%
Complex Prescription	38%	38%	23%	0%
Vitamin Prescription	14%	19%	28%	38%
Dietary Changes	9%	4%	14%	71%
Herbal Prescription	14%	14%	33%	38%
Bach Flower Remedies	61%	28%	4%	4%

Table 4.19 Frequency Table showing valid percentage of treatment options for patients 5-9 Years

4.8.3: Treatment options for patients 10-14 years

	Never	Sometimes	Often	Always
Simplex remedy	28%	14%	14%	42%
Complex Remedy	52%	23%	23%	0%
Vitamins	28%	19%	14%	38%
Dietary Changes	19%	9%	4%	66%
Herbal Remedies	19%	23%	23%	33%
Bach Flower Remedies	61%	23%	9%	4%

Table 4.20 Frequency Table showing treatment options of patients 10-14 Years

4.8.4: Treatment options for patients 15-18 years

	Never	Sometimes	Often	Always
Simplex Prescription	42%	9%	4%	42%
Complex Prescription	57%	23%	19%	0%
Vitamin Prescription	33%	19%	14%	33%
Dietary Changes	33%	9%	4%	52%
Herbal Prescription	33%	14%	23%	28%
Bach Flower Remedies	71%	19%	4%	4%

Table 4.21 Frequency Table showing treatment options for patients aged 15-18 Years

4.8.5: Treatment options for patients 18 years and older

	Never	Sometimes	Often	Always
Simplex Prescription	38%	14%	9%	38%
Complex Prescription	57%	23%	19%	0%
Vitamin Prescription	33%	19%	14%	33%
Dietary Changes	28%	9%	9%	52%
Herbal Prescription	28%	19%	23%	28%
Bach Flower Remedies	71%	14%	9%	4%

Table 4.24 Frequency Table showing treatment options for patients 18 Years and older

MEMORANDUM OF AGREEMENT

Between

MALL SPACE MANAGEMENT CC
(Registration No. 1999/027025/23)
Hereinafter referred to as **MSM**

And

(Registration No. _____)
Hereinafter referred to as the "Convenor"

Herein represented by _____
(Identity No. _____)
Who warrants that he/she is duly authorised hereto

RECORDING

The parties have agreed that the Convenor will stage a promotion/exhibition ("the event") at Liberty Midlands Mall, ("the Centre") Sanctuary Road, Pietermaritzburg, upon the following terms and conditions:-

1.	PARTICULARS OF PROMOTION		
	1.1	Name of event:	MICABELLA
	1.2	Description of event:	KIOSK EXHIBITION
	1.3	Location of event:	KIOSK 3 ENTRANCE 3
		Contact person:	ITAY HARAZI
		Contact number:	083 771 6728
	1.4	Duration of event:	27 MARCH – 30 APRIL 2012 (AFTER 6PM)
	1.5	Set up date:	26 MARCH 2012 (AFTER 6PM)
	1.6	Break down date:	30 APRIL 2012 (AFTER 6PM)
	1.7	Number of exhibitions:	1 MONTH (AFTER 6PM)
	1.8	Deposit: (payable upon signature)	FULL PAYMENT
	1.9	Hire charge: (payable in terms of clause 2)	R22 800 INCL VAT (TWENTY TWO THOUSAND EIGHT HUNDRED RAND)
	1.10	The booking is reserved until 23/01/2012. Should this signed contract not be returned to Mall Space Management Offices, Liberty Midlands Mall, by the date stipulated in this clause, then the parties agree that the booking in respect of the event will automatically terminate.	
	1.11	The Convenor shall at its cost unless specifically arranged with MSM, provide all the promotional equipment and advertising material required to stage the event including but not limited to tables, chairs, stanchions, screens and posters. It is agreed that MSM shall not be liable for any loss or damage of whatsoever nature and howsoever caused to the said promotional equipment. It is further stipulated that posters may not be greater than 890mm in length and 630mm in width or less than 841mm in length and 594mm in width (A1 size).	
		INITIAL _____	

2. HIRE CHARGE

- 2.1 The Convenor agrees to remit in full the hire charge referred to in clause 1.9 as determined by MSM at its sole discretion, to MSM, 42 (forty two) days prior to the commencement date stipulated in clause 1.4. Should the event be cancelled by the Convenor within 14 days prior to the commencement date, for any reason whatsoever, then, in that event, MSM reserves the right to demand and/or retain payment of the full hire charge which the parties agree shall be a genuine pre-estimate of the damages suffered by MSM as a result of such a cancellation.
- 2.2 Any booking made within 42 days of the commencement date stipulated in clause 1.4 must be paid in full immediately upon signature
- 2.3 Only electronic fund transfers; bank certified cheques or cash payments will be accepted.
- 2.4 These payments are to be made in favour of:

MALL SPACE MANAGEMENT CC; First National Bank Bedford Gdns; Acc. No.62009707920; Bank Code 252-155

and proof thereof delivered by hand, telefax or e-mail to the domicilium address (specified in clause 16), 42 days prior to the commencement date.

3. RELOCATION

MSM reserves the right to change the location of the event, where the operation of the Centre as a whole necessitates such a move. MSM will endeavour to relocate the event to a position of equivalent exposure and will refund the Convenor any difference in the hire charges applicable to the old and new locations.

4. SUBMISSION OF PLANS

The Convenor agrees to provide the plans of the event detailing the exact location of any exhibits and the layout and overall appearance of any promotion. MSM undertakes to ensure that the plans are approved at least 14 (fourteen) days prior to the set up date stipulated in clause 1.5. No event will be permitted to take place unless such plans have been approved. Should the Convenor not comply with the provisions of this clause then, in such event, MSM reserves the right to cancel the event 14 days prior to the scheduled set up date specified in clause 1.5.

5. BUILD-UP OF EVENT

- 5.1 It is agreed that, unless otherwise specified in clauses 1.5 and 1.6, all set building of any exhibits and promotional material will be undertaken only on the set up date, and dismantled on the break down date, or on such alternative days to be agreed with the MSM, in writing. Build-up or break-down of exhibitions may be carried out during normal trading hours at the discretion of Centre Management, however no vehicles whatsoever will be allowed into the Centre during normal trading hours
- 5.2 The Convenor agrees that it will not use any construction materials that are flammable, toxic, and potentially injurious or in anyway represent a safety or health hazard, and no electrical points, cables or fittings may be left exposed and accessible to the public. The Convenor shall also ensure that only silver duct tape is used for the taping of electrical and other cables. MSM shall be entitled to call for a certificate from a qualified electrician at the cost of the Convenor certifying all electrical work required for the event to be safe.

6. LICENSES

- 6.1 The Convenor warrants that in any instance where the type of promotion activity requires either the permission of or the granting of a license from any licensing, third party or local authority, such action is the responsibility of the Convenor and written proof of such approval shall be presented to MSM prior to the scheduled date of the event.
- 6.2 The Convenor warrants that all requirements and regulations in regard to artists, music and performing rights will be complied with, and the Convenor will be held responsible for any claims against MSM with regard to artists, music, performing rights and similar claims.
- 6.3 The Convenor undertakes to obtain all necessary consents and/or releases which may be required by MSM from third parties whose names, likenesses, testimonies, scripts, musical compositions or similar materials or rights are used in advertising/ promotion or any other materials prepared in terms of this agreement and the Convenor warrants that such written consents shall be obtained prior to the use of the advertising/promotion or other materials.

INITIAL _____

7. MANNING OF THE EVENT

The Convenor agrees that the event is to be fully operational during the minimum trading hours of the Centre in force during the period of the promotion. Accordingly, the event must be manned from 09h00 to 18h00 on Monday to Saturday and on Sundays from 09h00 to 17h00. However, should the event be of such a nature that a security service is required; the Convenor shall provide at its cost a security arrangement to police the event day and/ or night from set up date to break down date specified in clauses 1.5 and 1.6. It is specifically recorded that the Convenor shall ensure that all security guards so employed shall be made fully acquainted with the security procedure of the Centre and, shall in the event of any emergency; follow all directions given by the Centre Management and its security staff. Should the Convenor wish to dismantle the event at the end of each day, and then set up again the following morning, the Convenor agrees to remove at its cost ALL promotional equipment from the given location, including all tables, chairs and screens etc.

8. ADVERTISING

- 8.1 The Convenor shall provide MSM with a copy of any leaflet, poster and other advertising material to be approved by MSM at least 4 (four) weeks prior to the scheduled date of the event. Any such leaflet, poster and other advertising material may only be distributed from within the promotional area.
- 8.2 Posters to A1 size (83.7cm x 59 cm) referred to in 1.12 for the event must be supplied by the Convenor to MSM for display in the poster boxes in and around the Centre at least 1 (one) week prior to the scheduled date of the event. The posters to be used as well as the cost relating thereto (as specified in clause 1.13) shall be paid by the Convenor to MSM by no later than 2 (two) weeks preceding the scheduled date from which the poster space has been booked.

9. SERVICES

The Convenor agrees that where the event, in the opinion of MSM, consumed an abnormal amount of power, water or other supplied service then in that event MSM may, in its sole discretion, levy an additional charge to the Convenor.

10. EXEMPTION FROM LIABILITY

- 10.1 The Convenor hereby indemnifies and holds MSM its agents, directors and servants harmless against:
- 10.1.1 any damages to the property, whether movable or immovable, including any consequential damage directly flowing from damage to property;
 - 10.1.2 any liability in respect of any claims which may be made against MSM, arising out of damage to property, whether movable or immovable, of the Convenor, the tenants of shopping centre or of any third parties, including any consequential damage directly or indirectly flowing from physical damage to any such property;
 - 10.1.3 liability in respect of the death of or injury to any person, wherever the damage, loss, injury or death is due to or arises out of whether directly or indirectly, as a result of the staging of a promotional activity.
 - 10.1.4 The Convenor indemnifies MSM against legal proceedings or expenses (including attorney and own client costs) which the Convenor may incur as a result of claims and/or proceedings relating to defamation, invasion of privacy, piracy, and plagiarism, misappropriation of ideas or concepts, infringement of advertising or intellectual property rights resulting from any act or otherwise of the Convenor.
- 10.2 In the event of the MSM being in a position to provide the Convenor with any form of overnight or temporary storage space, it is agreed by the parties that MSM shall not be liable for any loss or damage of whatsoever nature and howsoever caused to the promotional equipment.

11. CONVENOR'S OBLIGATIONS

The Convenor agrees to maintain at all times a high standard of exhibition/promotion which is in the opinion of MSM, of a level commensurate with the image of the Centre. Without derogating from the generality of the above, the following rules as stipulated in the attached "Annexure 1" shall be strictly observed by the Convenor:

INITIAL _____

12. BREACH

Should the Convenor fail to pay any amount due in terms of this agreement to MSM or commit or permit the commission of a breach of any of the conditions contained herein, whether or not such breach goes to the root of this contract, MSM shall be entitled but not obliged (notwithstanding any previous waiver or conduct on the part of the MSM that would otherwise stop it or anything contrary herein contained) to cancel this agreement forthwith in writing. If this agreement is cancelled MSM shall be entitled: -

- 12.1 to retain all and monies paid by the Convenor to MSM in respect of the event as a genuine pre-estimate on the damages suffered by MSM in terms of clause 2 of this agreement, MSM reserving the right to take any other Legal action it deems necessary;
- 12.2 the Convenor shall immediately remove all its equipment from the promotional area within two hours of such notification, failing which MSM shall be entitled to remove such equipment at the cost of the Convenor and the Convenor shall have no claim whatsoever either for damages or otherwise against MSM; and
- 12.3 to elect that any other agreement between the Convenor and MSM for any future event to be held in the centre shall be regarded as having being duly cancelled and be of no further force or effect.

13. INSURANCE

The Convenor -

- 13.1 Hereby warrants that it has and will maintain, at its cost, insurance cover in respect of: -
 - 13.1.1 public liability insurance of at least R5 million per occurrence in respect of third party and property claims, and
 - 13.1.2 loss or damage caused by all risk of whatsoever nature and will, if called upon by MSM to do so, furnish written proof of such insurance cover.
- 13.2 will have no claim or right of action against MSM, its directors, servants or agents ("the principals") for damage, loss or otherwise arising out of or by reason of any permission, stipulation or direction given, being varied or revoked by the principals or through any other cause whatsoever, nor shall the principals be responsible for any personal injury which may be sustained in or about the Centre to the Convenor, its directors, servants, agents, customers or any other person to whom such injury may be caused.

14. WHOLE AGREEMENT

This document constitutes the sole record of the agreement between the parties, and neither party shall be bound by any express or implied term, representation, warranty, promise or the like not recorded herein. No addition to variation or agreed cancellation of this agreement shall be of any force or effect unless in writing and signed by or on the behalf of the parties.

15. NON-WAIVER

No indulgence granted to the Convenor shall constitute a waiver of any of the rights of MSM who shall not thereby be precluded from exercising any rights against the Convenor which may have risen in the past or which arises in the future.

INITIAL _____

16. DOMICILUM

The parties choose domicilium citandi et executandi for service of any notice, payment of any amounts due, the serving of any process and for any other purpose arising from this agreement as follows:

THE CONVENOR

MALL SPACE MANAGEMENT CC

First Floor, Twin Towers East, Sandton City
 Telefax: 011-883-7028
 E-mail: admin@mallspacemanagement.co.za

18 INVOICING DETAILS

Order Number _____

Company: _____

Co Registration No : (If sole proprietor kindly supply I.D. document) _____

VAT Number: _____

Attention: _____

Telephone: _____ Fax: _____

Physical Address: _____

Postal Address: _____

Email Address: _____

This done and signed at _____ on the _____ day of _____ 2012.

WITNESSES

1 _____

2 _____

SIGN: _____

For and on the behalf of the Convenor

This done and signed at _____ on the _____ day of _____ 2012.

WITNESSES

1 _____

2 _____

For and on the behalf of MALL SPACE
 MANAGEMENT CC.

CONVENOR'S OBLIGATIONS

The Convenor agrees to maintain at all times a high standard of exhibition/promotion by strictly observing the following rules in accordance with the requirements referred to in clause 11;

- 11.1 no banners shall be permitted without prior permission from MSM;
- 11.2 no display material shall be permitted to exceed a height restriction of 1.8 metres, nor shall it be attached to any pillars, walls or shop windows;
- 11.3 The Convenor shall ensure that at all times during the event that no part of the event or the persons manning the event shall extend beyond the boundaries of the exhibition area;
- 11.4 all signage shall be printed or professionally sign written - no hand written signs shall be permitted;
- 11.5 all tables shall be covered either in exhibit branded table cloth, or the Convenor's branded table cloth in keeping with the high standard of the event;
- 11.6 no exhibition or material display shall obscure the visibility of, or access to, any shops sited in the proximity of the promotional area. Screens shall not form a blocking wall;
- 11.7 the Convenor agrees that no money be exchanged in the promotional area (unless specific arrangements are made with MSM and MSM's approval thereto is confirmed in writing);
- 11.8 the Convenor agrees that cooking demonstrations are not permitted in the promotional area. However, food samples may be given if prepared under conditions stipulated by the relevant local authority;
- 11.9 no alcohol may be consumed in the promotional area (launches, cocktail parties and the like must be discussed with and approved by MSM in writing);
- 11.10 use any audiovisual equipment of whatsoever nature in a manner which would constitute a nuisance to any tenants, patrons or the management of the Centre;
- 11.11 the Convenor agrees that in the event of any large equipment, display material or vehicles or any item of excessive weight required to be brought into the centre, the Convenor shall advise MSM at least 7 (seven) days in advance of the date and time of the event to allow the MSM to arrange access to the centre or to arrange approval by a structural engineer;
- 11.12 the Convenor shall supply a list of the names and addresses of any exhibitors taking part in the event at least 14 (fourteen) days prior to the scheduled date thereof, together with a copy of the standard contract between the Convenor and any such exhibitor relating to the event. Such list of participants must be approved by MSM in writing, and MSM reserves the right to exclude participants notwithstanding any contract entered into between the Convenor and participant. The contract between the Convenor and participant must include the requirement that the participant is aware of and accepts all the conditions of this agreement between MSM and the Convenor. MSM shall be entitled to distribute questionnaires to all participating exhibitors requesting their response to the event in order to maintain or improve the standard of any future events to be held in the Centre;
- 11.13 the promotion displays are to conform to the plans/proposals approved by MSM and no variation will be permitted without the prior written approval of MSM;
- 11.14 only promotional activities as described in 1.2 will be permitted. Any promotional activities not included therein will not be permitted and MSM shall be entitled to terminate forthwith any promotional activity, and request that the Convenor forthwith vacate the promotional area, should the Convenor be in breach of clause 1.2.
- 11.15 The Convenor shall at all times abide by the House Rules of the Centre.

INITIAL _____