Coll. Antropol. **26** (2002) 1: 137–147
UDC 616.895-052:615.852
Original scientific paper

Psychiatric Patients' Experiences in Complementary and Alternative Medicine (CAM), and in Religious Support – A Pilot Study

O. Kozumplik and V. Jukić

Department of Integral Psychiatry, Psychiatric Hospital »Vrapče«, Zagreb, Croatia

A B S T R A C T

In the Psychiatric Hospital »Vrapče« an investigation on a 200 patient sample was carried out in the year 2000. The purpose of the investigation was to analyze the examinees' experiences of complementary and alternative medicine (CAM) and religious support. 35.5% of the examinees had had previous experiences of CAM and religious support. The examinees born in towns used CAM methods and religious support significantly more often. The schizophrenic patients used CAM methods and religious support significantly more frequently than the patients with affective and anxiety disorders. Non-significantly more often CAM methods and religious support were utilized by women, examinees between 21 and 30 years of age, persons who graduated from junior college, those who live in cohabitation and patients of Islamic religion. Patients consulted priests most often. Significantly more often patients did not pay for the CAM treatments and religious support and non-significantly more often patients considered CAM therapy and religious support to be successful. Non-significantly more often patients consulted CAM practitioners and religious practitioners without being previously advised by their relatives or friends. Relatives of the patients advised them to consult CAM practitioners and religious practitioners significantly more often than the friends of the patients did. Considering the possible missed benefits and harm effects of CAM treatment as well as of the interaction between utilization of CAM methods/religious support and conventional treatment, this problem should be given full attention. Further investigations are required.

Received for publication February 10, 2002

Introduction

Definition of CAM

CAM refers to a broad group of therapeutic approaches that have been difficult to describe with a single definition. Casilleth (1998) explained CAM as treatments used to promote wellness, those used alongside conventional care, and those used to replace conventional treatments[1]. This definition is perhaps not completely acceptable in our environment, mostly due to hesitation of the dominant health care system to accept and acknowledge different alternative approaches. A more acceptable and appropriate is that of the World Health Organization (WHO) in »General guidelines for methodologies on research and evaluation of traditional medicine« (2000). In this document WHO defines traditional medicine as »the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness«. In the same document WHO states that the terms »complementary medicine« or »alternative medicine« are used interchangeably with traditional medicine in some countries and refer to a broad set of health care practices that are not a part of that country's own tradition and are not integrated into the dominant health care system.

CAM utilization in the world today

The popularity of CAM is growing, not only in the countries of the far East, but also in the highly developed western countries. Investigations conducted in the USA and Australia showed that a high percentage of the population utilizes CAM methods[2]. The prevalence of CAM utilization (vitamins, minerals, or biological CAM remedy) is high in Sweden too, especially among women and educated people[3]. During the last decade in the USA and Sweden, an increase in utilization of CAM methods was registered[2,3]. The CAM methods are becoming more popular in the United Kingdom as well[4].

In different parts of the world, traditional healers deal with the problem of mental illness. In Israel, psychiatric disorders of Bedouins are treated by Dervishes[5]. In Malaysia, psychiatric patients seek help from traditional healers, bomohs[6]. In Germany, psychiatric patients of Turkish origin seek help from traditional magic faith healers, Hocas[7].

Influence of traditional beliefs regarding cause of mental illnesses on the choice of treatment

In countries of Asia and Africa and among people originating from those countries, traditional beliefs concerning the cause of mental illnesses have a strong influence on the therapeutic process. Such beliefs strongly influence not only the patients' understanding of mental illness, but also that of the patients' families. Therefore, such beliefs should be understood and considered in order to carry out successful treatments[7–9]. Research carried out among Bedouins in Israel has shown that the greater the extent of traditionalism in Bedouin society, the more prevalent the belief in supernatural powers as a cause of illness, and the higher the rate of consulting traditional healers[10]. Although Ethiopian immigrants in Israel utilize Israeli Western medical clinics and services, in some cases they seek help from traditional healers for health problems whose causes are related to Ethiopian cultural concepts and beliefs[11]. Research carried out in a rural Ethiopian community has shown that working in close connection with traditional healers would give the primary health care worker a better opportunity

to gain acceptance from the community and to modify certain harmful practices[12]. There have been similar examples in Western countries. In a psychiatric clinic in Switzerland, an investigation was carried out among protestant out-patients who described themselves as religious. The investigation showed that 37.6% of these believed in the influence of evil spirits as a possible causation of their problems, labeling this as 'occult bondage' or 'possession', while 30.3% sought help through prayers and exorcism[13].

Clinical research on CAM methods

A number of investigations have focused on analyzing the effects of some CAM methods in order to establish their biological background[14,15]. The aim of a study done at the Faculty of Medical Sciences in Huston, Texas, in 1996, was to test a framework of relaxation or stress reduction as a mechanism of touch therapy. It was concluded that the findings suggest both biochemical and physiological changes in the direction of relaxation[14]. Investigations of some CAM methods have offered contradictory results[16–18]. An investigation conducted in Canada has shown that aromatherapy is no more effective than placebo in reducing anxiety[16]. However, an investigation done in Japan has shown that aromatherapy was an effective method of treating depression and anxiety in chronic hemodialysis patients[17].

Beneficial and potential harmful effects of CAM and religious practice

Coexistence of two or more medical systems is present in all countries. In many cases efforts are being made, supported by the WHO, toward integration of different medical systems[19]. In certain cases western medicine accepts CAM. In rural parts of Africa psychiatrists face difficulties while treating diseases of traditional cultural aetiology, characteristic for Africans. Because traditional healers are highly successful in treating such patients, they are consulted regarding treatment[20]. Examples of collaboration between conventional and alternative medicine exit in the West, too. In the Swiss region Baselland, the psychiatric outpatient service offered, besides conventional psychotherapy and several different complementary methods, the possibility of spiritual healing, and evaluated it by scientific means. The purpose was to determine whether cooperation between a spiritual healer and a public institution was feasible. The research proved this kind of cooperation to be feasible and effective[21]. Results of some other investigations also indicated the feasibility of collaboration between conventional and CAM medicine, utilization of CAM methods in conventional medicine and making CAM practitioners part of the team during the process of treatment is feasible[22,23]. Certain CAM methods are already recognized and utilized by the conventional medical system. Acupuncture has been incorporated as a treatment component in numerous addiction treatment programs in the United States[24]. Interest in meditation as a relaxation method has increased with the awareness of the influence of stress on human psychology and the recognition of stress in the aetiology of somatic diseases, a group of so-called psychosomatic diseases. Numerous studies have proven the effectiveness of herbal products, among others in the therapy of mental diseases (i.e. Hypericum perforatum and S-Adenozilmetionin in therapy of depression)[4].

On the other hand, the efficiency of CAM methods has for the greater part not been proved scientifically. People use these methods partly because CAM practitioners devote time to their patients and listen to their concerns, and also because of CAM's holistic approach[25]. The lack of

criterion is especially manifested in the situations when patients take CAM products along with conventional medications, which can lead to serious harmful interactions and side effects[4]. The frequency of consuming CAM products along with conventional medications has been investigated in several studies, and the results vary between 24–73%[4]. Beside herbal medications, there are other examples of CAM adverse effects. Chiropractic treatment can cause headache, fatigue[26,27], or, in a small number of cases, manipulation of the lower spine can result in cauda equina syndrom[28]. Cases of hepatits, HIV, pneumothorax, endocarditis, and other problems have been reported after acupuncture treatments[29].

Another issue is that patients do not consult their physicians regarding CAM treatment, but take CAM products as recommended by relatives, friends, other patients, and under the influence of public media and the Internet[4].

Studies connect CAM utilization with different socio-demographic factors[3,30, 30–33], diagnosis[6,30] and belief in magical, supernatural causes of diseases[13,33]. The majority of CAM users are female, middle-aged, educated, and with higher income[4]. Investigations have shown that CAM users seek a holistic approach to health, and see a mind-body connection to illness and health. CAM is used preventively and curatively, often to treat chronic conditions that do not respond adequately to conventional therapy (arthritis, pains in neck and back, depression, anxiety, headache, etc.), and in the case of malignant diseases[4]. Furthermore, the annual expenditure on CAM treatments has been investigated in some countries[34,35]. Basically, in this research we have focused on CAM methods and religious support traditionally present in our culture, primarily different types of spiritual healing and herbalism, but also allowing other outcomes when determining the prevalence of different CAM methods utilization. Although highly topical in the world, very little attention has been paid to this subject in Croatia, especially concerning the economic dimension of CAM utilization, so far not investigated in Croatia. Getting a better insight into possible missed benefits and potential harmful effects of CAM treatment and religious support is of immense importance, considering primarily the number of CAM and religious consultation today.

Aims of research

The aims of this research were:

1. To determine the proportion of the examinees who had previous experiences of complementary and alternative medicine and religious support;
2. To determine the distribution of CAM methods and religious support utilization, in relation to different demographic characteristics and diagnoses of psychiatric patients;
3. To determine the prevalence of different CAM methods and religious support utilization;
4. To determine the frequency of different advice to patients given by priests and to determine the most frequent advice from the priests of different confessions;
5. To determine the proportion of patients who paid for the CAM treatments and religious support and to asses any differences between proportions of payers and non-payers is significant
6. To determine the proportion of the examinees who considered CAM therapy and religious support efficient, out of those who utilized CAM methods and religious support;
7. To determine who advised the examinees to seek help from CAM practitioners and religious practitioners, and to what extent.

Subjects and Methods

In the year 2000 a research project was carried out on a sample of 200 patients (100 males, 100 females) in the Psychiatric Hospital »Vrapče«. The investigation took three months. The patients were interviewed when they were able to answer the questions, considering their cognitive abilities. Only those who agreed to answer the questions after being acquainted with content and purposes of the questionnaire were included in the research. The patient's diagnosis was not a selection criterion. In the case of more than one diagnosis per patient, the leading one was included in the statistical analysis. The patients were questioned by means of a semi-structured interview. In order to confirm the answers, patients' medical documentation was consulted as well as statements of the medical staff. A questionnaire was made for the investigation purposes, consisting of questions dealing with problems relevant to the subject of work. The questions were related to the socio-demographic characteristics (sex, age, education, marital status, background, confession) and the experience of examinees regarding use of CAM methods and religious support (type of CAM/religious practitioner, advice to patients given by priests, who advised the examinees to seek CAM/religious consultation, expenditure on consultations, opinions of examinees on advice/therapy effect). A distinction was made between religious/spiritual practices and those seen as being more within the medical domain. Answers to questions were subjected to statistical analysis by using the SAS 6.12 program. The distribution frequency difference was tested by the test of proportion, chi-square test, and Fishers exact test[36]. The examinees who did not answer questions were not taken into account during the analysis. In the interest of an unbiased approach we did not expect responders to answer all the questions.

Results

Utilization of CAM methods and religious practice

Methods of alternative medicine and religious support had been used by 35.5% of the examinees. Of these examinees, 79% utilized religious practices and 21% used different CAM methods. Women utilized CAM methods and religious support more than men, but not significantly (38% vs. 33%, $p = 0.460$) (Table 1). No significant difference was found in the ages of those examinees which utilized CAM and religious support ($p = 0.249$). The CAM practitioners and religious practitioners were consulted more frequently by the examinees between 21 and 30 years of age (Table 1). No significant difference was found regarding education. The examinees who graduated from a junior college used CAM methods and religious support more often than the rest of the patients ($p = 0.232$) (Table 1). Also, no significant difference was found regarding the marital status of those who utilized CAM methods and religious support ($p = 0.09$). More often the CAM practitioners and religious practitioners were consulted by the examinees who lived in cohabitation (Table 1). The patients born in towns utilized CAM methods and religious support significantly more often (42.11% vs. 22.39%, $p < 0.01$) (Table 1). Patients of Islamic religion used the CAM methods and religious support more often than the examinees of Catholic and Orthodox religion, but not significantly ($p = 0.247$) (Table 1). Patients with schizophrenia utilized CAM methods and religious support significantly more often than the patients with diagnosis of affective and anxiety disorders ($p < 0.05$) (Table 1). The percentage of patients with other diagnoses was very low, so these patients were not considered in the testing.

Most often patients sought help from priests ($p < 0.001$). The frequency of con-

TABLE 1
DISTRIBUTION OF CAM METHODS AND RELIGIOUS SUPPORT UTILIZATION REGARDING DIFFERENT DEMOGRAPHIC CHARACTERISTICS AND DIAGNOSES OF PSYCHIATRIC PATIENTS

		No. of consultations	No. of examinees
Gender	Male	33	100
	Female	38	100
	Total	71	200
	χ^2=0.546; df=1; p=0.460		
Age (yrs)	<20	3	9
	21-30	15	29
	31-40	21	54
	41-50	18	56
	51-60	10	30
	>60	4	22
	Total	71	200
	χ^2=6.636; df=5; p=0.249		
Education	Unfinished primary school	6	20
	Primary school	20	41
	High school	33	112
	Junior college	6	11
	College/University	6	13
	Total	71	200
	χ^2=5.593; df=4; p=0.232		
Marital status	Married	15	59
	Single	37	82
	Divorced	11	37
	Widow/er	5	17
	Cohabitation	3	5
	Total	71	200
	χ^2=8.056; df=4; p=0.09		
Place of birth	Country	15	67
	Town	56	133
	Total	71	200
	χ^2=7.565; df=1; p=0.006		
Religion[a]	Catholic	59	165
	Orthodox	3	11
	Muslim	4	6
	Total	66	182
	χ^2=2.803; df=2; p=0.247		
Diagnosis[b]	F20-29[c]	52	125
	F30-39[d]	5	26
	F40-49[e]	4	18
	Total	61	169
	χ^2=6.35; df=2; p=0.041		

[a] because of a very small sample size examinees who stated to be members of other confessions or atheists were not taken into consideration;
[b] because of a very small sample size examinees with other diagnoses were not taken into consideration;
[c] Schizophrenia and other psychotic disorders;
[d] Affective disorders;
[e] Anxiety disorders

sultations was as follows: priests 69.77%, herbalists 9.3%, magic healers 8.14%, bioenergists 8.14%, acupuncturists 3.49%, and exorcists 1.16% (Table 2).

TABLE 2
TYPES OF CAM AND RELIGIOUS PRACTITIONERS CONSULTED BY EXAMINEES

CAM practitioner	No. of consultat.	%
Priest	60	69.77
Herbalist	8	9.30
Magic healer	7	8.14
Bioenergyst	7	8.14
Acupuncturist	3	3.49
Exorcist	1	1.16
Total	86	100

χ^2=177.576; df=5; p<0.001

Advice given by priests

Patients were asked to indicate the type of advice received from priests. The precentages receiving different types of advice were as follows (Figure 1 and Table 3): prayer (47.06%), confession (24.71%), to consult a physician (12.94%), »writing« or »holy relics« (8.24%), to pay for mass (4.71%), exorcism (2.35%) (the examinees who were advised by priests, but who would not say what the advice was, were omitted from the analysis). Catholic priests most often suggested prayer (26.75%), Orthodox priests most often suggested confession (36.36%), and Islamic priests most often gave »writing« or »holy relics« (28.57%).

TABLE 3
ADVICE TO EXAMINEES GIVEN BY PRIESTS

Advice	No.	%
Praying to God	40	47.06
Confession	21	24.71
Consult a physician	11	12.93
»Writing« or »holy relics«	7	8.24
Pay for mass	4	4.71
Exorcism	2	2.35
Total	85	100

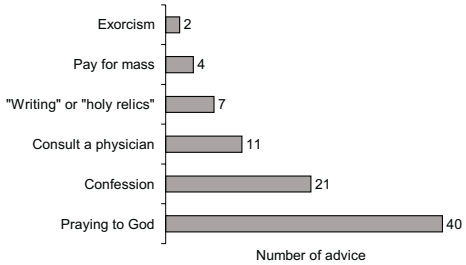

Fig. 1. Advice to examinees given by priests.

Expenditure on consultations and opinions of examinees on advice/therapy effect

Significantly more frequently patients did not pay for the CAM treatment and religious support (30.99% vs. 69.01, p < 0.001) (Table 4). A higher number of patients considered CAM therapy and religious support to be successful, but not significantly (52.11% vs. 17.89%, p = 0.484) (Table 5).

TABLE 4
EXPENDITURE ON CONSULTATIONS

Paying to consultants	No.	%
Yes	22	30.99
No	49	69.01
Total	71	100

Test of proportion, p<0.001

TABLE 5
OPINIONS OF EXAMINEES ON ADVICE/THERAPY EFFECT

Advice/therapy effect	No.	%
Successful	37	52.11
Not successful	34	47.89
Total	71	100

Test of proportion, p=0.484

Social support

Most patients consulted CAM practitioners and religious practitioners more often without being previously advised (53.95% vs. 46.05%, p = 0.332). Relatives advised patients to consult CAM practitioners and religious practitioners significantly more often then the friends (77.14% vs. 22.86%, p < 0.001) (Table 6).

TABLE 6
WHO ADVISED EXAMINEES TO CONSULT CAM PRACTITIONERS AND RELIGIOUS PRACTITIONERS

Adviser	No.	%
Nobody (examinee himself)	41	53.95
Relatives or friends	35	46.05
Total	76	100
Test of proportion, p=0.332		
Relatives	27	77.14
Friends	8	22.86
Total	35	100
Test of proportion, p<0.001		

Discussion and Conclusions

The results of this research have shown that 35.5% of the examinees utilized CAM methods and religious support; 79% utilized religious practices, and 21% used different CAM methods. Surveys among the general population in the United States, the United Kingdom, Canada, and Australia have suggested lifetime prevalence rates of greater than 60%, and annual rates between 15% and 50%[4].

The patients were selected on the ground of their cognitive abilities and entered the investigation voluntarily after being informed about the content and the purpose of the questionnaire. They were able to understand and answer the questions and were also willing to do so. The patient's diagnosis was not a selection criterion. In the case of more than one diagnosis per patient, the leading diagnosis was included in the statistical analysis. These selection criteria reduced the chance for bias. We were able to get a better insight into the reliability of the answers by consulting the patients' documentation as well as the medical staff. This, as well as the selection criteria, reduced the chance for confounders to a certain minimum. In the interest of an unbiased approach we did not expect the responders to answer all the questions. The number of non-responders is very low, so they were not included into the statistical analysis (Table 1).

Among the examinees there was no significant difference regarding sex, age, education, marital status, and religion. More often CAM methods and religious support users were women, examinees between 21 and 30 years of age, persons who graduated from junior college, examinees living in cohabitation, and Muslims. The CAM practitioners and religious practitioners were significantly more often consulted by patients with schizophrenia and by those born in towns.

The relation of socio-demographic factors and diagnosis to the use of CAM treatments in general was analyzed in earlier investigations[37–40]. A higher prevalence of CAM and religious consultations among schizophrenic patients compared to patients with other mental diseases was found by some other authors, also[13,30]. In some investigations, however, different results were obtained[41,42]. According to Muskin (2000) a high proportion of CAM users are women, middle -aged people, educated, and those with higher income[4].

In countries of Asia and Africa and among people originating from those countries, traditional beliefs concerning the cause of mental illnesses have a strong influence on the therapeutic process. Such beliefs influence not only the

patients' understanding of mental illness, but also that of the patients' family. Therefore, such beliefs should be understood and considered in order to carry out successful treatments[7–9]. This could explain the proportion of certain CAM types and religious support use in consultations.

Patients most often consulted priests, and the percentages of different consultations were as follows: priests 69.77%, herbalists 9.30%, healers 8.14%, bioenergysts 8.14%, acupuncturists 3.49%, exorcists 1.16%. Such results point to the importance of religious support for mental patients. This could be explained by the fact that schizophrenic patients (who were predominant among examinees in this study) often relate the causes of their disease to supernatural and demonic powers[31,43].

Therefore, having in mind traditional customs and beliefs, it can be assumed that the high frequency of CAM profiles and religious support is the result of traditional beliefs regarding the causes of mental illness. Similar conclusions were derived from the investigations carried out in some Asian and African countries, and in Europe[7–9,13]. This indicates the importance of recognizing such beliefs in the process of treatment. Ignorance of these facts could lead to premature discontinuation of the therapeutic process[44]. The importance of the spiritual healers' engagement in the therapeutic process was recognized in Switzerland. The efficiency of spiritual healers within the psychiatric hospital was investigated, and the results indicated the need for such collaboration[21].

Research carried out in a rural Ethiopian community showed that engaging traditional healers with medical teams leads to a better acceptance of the treatment process[12].

Advices coming from priests were as follows: prayer (47.06%), confession (24.71%), consulting a physician (12.94 %), »writing« or »holy relics« (8.24%), paying for mass (4.71%), exorcism (2.35%). Catholic priests most often suggested prayer to the patients (26.75%), Orthodox priests most often suggested confession (36.36%), while Islamic priests most often gave »writing« or »holy relics« (28.57%). It could be assumed that the obtained results come from the specific religious doctrines. Significantly more often patients did not pay for the consultations, which could be explained by the fact that the patients consulted priests most often.

Certain investigations, which analyzed the annual expenditure on CAM treatments in general, revealed that it was increasing[34,35]. It can be assumed that this is the result of growing interest in CAM[2–4].

More patients considered CAM therapy and religious support to be successful, but not significantly. Research results from South Carolina, USA, showed that the examinees considered CAM methods to be successful and would recommend it to others[45].

Most patients consulted CAM practitioners and religious practitioners more often without being previously advised to do so, but the difference was not significant. Relatives advised patients to consult CAM/religious practitioners significantly more often than friends. Research in Malaysia, cited earlier, showed that the strength of social support and the belief of patients, friends and/or relatives in supernatural causes of mental illness were closely related to the degree of traditional treatment[6].

As mentioned in the Introduction, the efficiency of CAM methods has for the most part not been proven scientifically. People use these methods partly because CAM practitioners devote time to their patients and listen to their concerns, because of CAM's holistic approach[25], but

also as a result of ineffectiveness and adverse effects of conventional treatments. Beside herbal medications, there are other examples of CAM adverse effects. Chiropractic treatment can cause headache, fatigue[26,27] or, in a small number of cases, manipulation of the lower spine can result in cauda equina syndrom[28]. The cases of hepatits, HIV, pneumothorax, endocarditis, and other problems have been reported after acupuncture treatments[29].

Considering the possible negative consequences of the CAM treatment, and the interaction between CAM/religious support and conventional treatment, this problem should be given full attention. This area has received little attention in Croatia so far. The economics of CAM utilization has been completely neglected also. Better insight into possible missed benefits and potential harmful effects of CAM treatments and religious support is therefore of immense importance, considering the number of CAM/religious consultation today. A better understanding of this subject was the main reason for the research reported here. Since the results in this research were obtained with 200 examinees, further investigation with a larger sample is necessary to increase our understanding.

REFERENCES

1. CASILLETH, B. R.: The alternative medicine handbook. (WW Norton, New York, 1998). — 2. HARRIS, P., R. REES, Complement. Ther. Med., 8 (2000) 88. — 3. NILSSON, M., G. TREHN, K. ASPLUND, J. Intern. Med., 250 (2001) 225. — 4. MUSKIN, P. R.: Complementary and alternative medicine and psychiatry. (American Psychiatric Press, Washington, DC, 2000). — 5. AL-KRENAWI, A., J. R. GRAHAM, B. MAOZ, Soc. Sci. Med., 43 (1996) 13. — 6. RAZALI, S. M., M. A. NAJIB, Int. J. Soc. Psychiatry, 46 (2000) 281. — 7. ASSION, H. J., I. DANA, F. HEINEMANN, Fortschr. Neurol. Psychiatr., 67 (1999) 12. — 8. MORRISON, E. F., K. A. THORNTON, Issues in Mental Health Nursing, 20 (1999) 443. — 9. SHARP, L. A., Soc. Sci. Med., 38 (1994) 525. — 10. ABU-RABIA, A., Coll. Antropol., 18 (1994) 215. — 11. NUDELMAN, A., Coll. Antropol. 17 (1993) 233. — 12. ALEM, A., L. JACOBSSON, M. ARAYA, D. KEBEDE, G. KULLGREN, Acta, Psychiatr. Scand., 397 Suppl. (1999) 40. — 13. PFEIFER, S., Br. J. Med. Psychol., 67 (1994) 247. — 14. WARDELL, D. W., J. ENGEBRETSON, J. Adv. Nurs., 33 (2001) 439. — 15. GARVIN, A. W., M. R. TRINE, W. P. MORGAN, Int. J. Clin. Exp. Hypn., 49 (2000) 15. — 16. WIEBE, E., Eff. Clin. Pract., 3 (2000) 166. — 17. ITAI, T., H. AMAYASU, M. KURIBAYASHI, N. KAWAMURA, M. OKADA, A. MOMOSE, T. TATEYAMA, K. NARUMI, W. UEMATSU, S. KANEKO, Psychiatry Clin. Neurosci., 54 (2000) 393. — 18. COOKE, B., E. ERNST, Br. J. Gen. Pract., 50 (2000) 493. — 19. VELTEN-SCHUBERT, E., Coll. Antropol., 17 (1993) 209. — 20. WESSELS, W. H., Aust. N. Z. J. Psychiatry, 19 (1985) 283. — 21. MESSERLI-ROHRBACH, V., J. BOSCH, Forsch. Komplementarmed. Klass. Naturheilkd., 7 (2000) 275. — 22. RUIZ, P., J. LANGROD, Am. J. Psychiatry, 133 (1976) 95. — 23. CANDELENT, T., G. CANDELENT, Hosp. Community Psychiatry, 26 (1975) 156. — 24. MARGOLIN, A., S. K. AVANTS, H. D. KLEBER, Journal of Alternative & Complementary Medicine, 4 (1998) 405. — 25. VEERAMAH, E. K., S. HOLMES, J. R. Soc. Health, 120 (2000) 42. — 26. SENSTAD, O., Y. de C. LEBOUEF, C. F. BORCHGREVNIK, Scand. J. Prim. Health Care, 22 (1996) 50. — 27. SENSTAD, O., Y. de C. LEBOUEF, C. F. BORCHGREVNIK, Spine, 22 (1997) 435. — 28. KAPTCHUK, T. J., D. M. EISENBERG, Arch. Intern. Med., 158 (1998) 2215. — 29. ERNST, E., Pain, 71 (1997) 123. — 30. CAMPION, J., D. BHUGRA, Soc. Psychiatry Psychiatr. Epidemiol., 32 (1997) 215. — 31. PFEIFER, S., Psychopathology, 32. (1999) 252. — 32. IHEZUE, U. H., Acta Psychiatr. Scand., 68 (1983) 277. — 33. AKIGHIR, A., Int. J. Soc. Psychiatry, 28 (1982) 203. — 34. EISENBERG, D. M., R. B. DAVIS, S. L. ETTNER, J. A. M. A., 280 (1998) 1569. — 35. ASHER, B. F., M. SEIDMAN, C. SNYDERMAN, Laryngoscope, 111 (2001) 1383. — 36. SOKAL, R. R., F. J. ROHLF: Biometry: The principles and practice of statistics in biological research. (W.H. Freeman and Co., San Francisco, 1969). — 37. BALIS, R., A. MAIGA, A. ABOUBACAR, Can. J. Public Health, 88 (1997) 159. — 38. BURG, M. A., R. L. HATCH, A. H. NEIMS, South. Med. J., 91 (1998) 1126. — 39. EISENBERG, D. M., R. C. KESSLER, C. FOSTER, N. Engl. J. Med., 328 (1993) 246. — 40. FULDER, S. J., R. E. MUNRO, Lancet, 2 (1985) 542. — 41. KUA, E. H., P. H. CHEW, S. M. KO, Acta Psychiatr. Scand., 88 (1993) 447. — 42. UNUTZER, J., R. KLAP, R. STURM, A. S. YOUNG, T. MARMON, J. SHATKIN, K. B. WELLS, Am. J. Psychiatry, 157 (2000) 1851. — 43. RAZALI, S. M., U. A. KHAN, C. I. HASANAH, Acta Psychiatr.

Scand., 94 (1996) 229. — 44. AL-KRENAWI, A., Int. J. Soc. Psychiatry, 45 (1999) 56. — 45. OLDENDICK, R., A. L. COKER, D. WIELAND, J. I. RAYMOND, J. C. PROBST, B. J. SCHELL, C. H. STOSKOPF, South. Med. J., 93 (2000) 375.

O. Kozumplik

Department of Integral Psychiatry, Psychiatric Hospital »Vrapče«, Bolnička c. 32, 10000 Zagreb, Croatia

ISKUSTVA PSIHIJATRIJSKIH BOLESNIKA U KORIŠTENJU ALTERNATIVNE I KOMPLEMENTARNE MEDICINE TE RELIGIJSKE POTPORE: PILOT ISTRAŽIVANJE

S A Ž E T A K

U Psihijatrijskoj bolnici »Vrapče« 2000. godine provedeno je istraživanje na uzorku od 200 pacijenata. Svrha istraživanja bila je analizirati iskustva ispitanika glede uporabe metoda komplementarne i alternativne medicine (KAM) i religijske potpore. 35,5% ispitanika koristilo je KAM metode i religijsku potporu. Ispitanici rođeni u gradu značajno su češće koristili KAM metode i religijsku potporu. Shizofreni pacijenti koristili su KAM metode i religijsku potporu značajno češće od pacijenata s afektivnim i anksioznim poremećajima. KAM metode i religijsku potporu nešto su češće koristile žene, ispitanici između 21 i 30 godina starosti, osobe koje su završile višu školu, osobe koje žive u izvanbračnoj zajednici i osobe muslimanske vjeroispovijesti. Pacijenti su se najčešće za pomoć obraćali svećenicima. Značajno češće pacijenti nisu plaćali KAM tretmane i religijsku potporu, a nešto više pacijenata smatralo je da su KAM tretmani i religijska potpora bili učinkoviti. Nešto češće pacijenti su konzultirali KAM terapeute i religijske terapute bez prethodnog savjeta rodbine ili prijatelja. Rodbina pacijenata savjetovala je pacijentima da konzultiraju KAM terapeute i religijske terapeute značajno češće nego što su to činili prijatelji pacijenata. Imajući u vidu moguće neuočene koristi i štetne učinke KAM tretmana, kao i interakcije između korištenja KAM tretmana/religijske potpore i konvencionalnog liječenja, ovom problemu trebalo bi posvetiti punu pažnju. Potrebna su daljnja istraživanja.