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**A COMPARISON STUDY OF THE PRESENTING SYMPTOMS
BETWEEN MAORI AND PAKEHA PATIENTS
DIAGNOSED WITH SCHIZOPHRENIA.**

A thesis presented in partial fulfilment of the requirements
for the degree of Master of Arts in Psychology,
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Lisa Cherrington

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ABSTRACT

The exact relationship between culture and the expression of psychopathology among different cultural groups within New Zealand has yet to be firmly established. The present study investigated the relationship between culture and presenting symptomatology of Maori and Pakeha patients diagnosed with schizophrenia. More specifically, the main aim of the study was to investigate whether differences exist between Maori and Pakeha in the expression of schizophrenia and to explore whether paranormal beliefs and cultural knowledge influence the frequency and content of specific symptoms. Three specific hypotheses were tested. First, the hypothesis that Maori and Pakeha differ in respect to levels of Maori knowledge and strength of paranormal beliefs was explored. Second, the hypothesis that Maori have higher frequencies of hallucinations, delusions of control and subcultural delusions and hallucinations was investigated. Third, the hypothesis that paranormal beliefs and cultural knowledge influence the frequency of presenting symptoms between Maori and Pakeha was explored. A total of 14 Maori and 16 Pakeha patients currently admitted to mental health services with a diagnosis of schizophrenia were interviewed using the Present Status Examination (PSE). The Test of Maori Knowledge (TMK), Revised Paranormal Belief Scale (PBS-R) and a Provisional Maori Cultural Identity Questionnaire (PMCIQ) were also administered during the interview (the latter administered only to Maori participants). The findings indicated that Maori participants experienced significantly higher frequencies of hallucinations and delusions than Pakeha participants. There were no significant differences between groups in strength of paranormal beliefs nor were paranormal beliefs found to influence the frequency with which hallucinations and delusions were reported. However, Maori participants had significantly higher levels of Maori knowledge. Moreover, the findings suggest that Maori knowledge was an influencing variable in the content and frequency of subcultural delusions and hallucinations. Limitations of the study, future research recommendations and implications of the findings for the assessment, diagnosis and treatment of Maori psychiatric patients are discussed.

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JADE OR POUNAMU?

See this taonga I wear?

Kia āta titiro e hoa

For I see

the tears of Ranginui

te wehi o Papatuanuku

I hear the korero of my tūpuna

and feel the love of my koro

Te mauri o te pounamu

Tauīwi

Jade or Pounamu?

What is it that you see?

- Lisa Cherrington

TE TIMATATANGA

INTRODUCTION

The perception of psychological disturbance or abnormal behaviour differs across cultures. Every culture has different beliefs and values regarding mental disorder, what causes it and how it should be treated. There may also be differences in the way different cultural groups experience mental disorder. The cross-cultural study of psychopathology compares behaviours and examines these different perspectives. Through comparing incidence rates, manifestations of mental disorders and the course of mental disorders across cultures, the relationship between culture and psychopathology is further explored and refined.

Schizophrenia, or the manifestations of what Western psychiatry labels as schizophrenia, is one such mental disorder that has been identified in all regions of the world (Dragnus, 1990). Approximately one percent of the world's population is affected by schizophrenia (Schizophrenia Fellowship New Zealand, 1992). Within New Zealand in the last decade there have been on average approximately 340 new cases of schizophrenia diagnosed each year. There are on average each year 2,500 readmissions to psychiatric institutions in New Zealand due to schizophrenia (calculated from statistics provided by Ministry of Health, 1993).

Whilst there has been an abundance of overseas research that has looked at the relationship between culture and schizophrenia, similar research among Maori and Pakeha groups within New Zealand is virtually non-existent. This is somewhat surprising considering the disproportionately higher number of Maori diagnosed with schizophrenia. In 1991 Maori first admission rates for schizophrenia were considerably higher than non-Maori rates. In

particular, the first admission rate for Maori males aged 15 to 19 years due to schizophrenia was 4.1 times higher than the non-Maori male rate. The first admission rate for Maori females aged 20-24 years due to schizophrenia was 3.4 times the non-Maori female rate (Department of Health, 1993). Furthermore, Maori have been found to have significantly higher rates of readmissions for schizophrenia than non-Maori (Sachdev, 1989a). In 1991 the leading cause of readmissions among Maori was due to schizophrenia (Department of Health, 1993). Although hospital admission rates do not reflect the true rate of schizophrenia within the community, the trends over the last ten years indicate that there are considerably more Maori per head of population being admitted to psychiatric institutions with a diagnosis of schizophrenia.

Given the disproportionate number of Maori as compared to non-Maori diagnosed with schizophrenia, the inevitable question to ask is why these differences exist. Are Maori more susceptible to schizophrenia? Is there a chance that Maori are being misdiagnosed with schizophrenia? Do Maori express schizophrenia in the same manner as non-Maori? Is the course and prognosis of schizophrenia the same for Maori and non-Maori? These types of questions form the basis of research into the study of psychopathology across cultures. The research that evolves provide important insights into the relationship between culture and psychopathology.

The present study is an attempt to examine one small part of the relationship between culture and psychopathology. In particular, this study focuses on the presenting symptomatology of Maori and Pakeha patients diagnosed with schizophrenia. There are two main questions to be answered and which form the basis of the present study:

- Do Maori and non-Maori express schizophrenia in the same way?
- What influence does culture play in the expression of schizophrenia?

Chapter 1 presents a literature review of the cross-cultural research that has been conducted in the area of presenting symptomatology of schizophrenia. Current theories about whether the expression of psychopathology is either different or similar across different cultures are discussed. The review emphasises that although there are differing perspectives and research to substantiate both views, certain methodological inadequacies inherent in the research enables the debate of whether the expression of schizophrenia across cultures is either similar or different to continue.

One of the criticisms of previous research into the expression of schizophrenia across cultures has been the lack of discussion about each culture's conceptualizations about mental disorder and the meaning of certain behaviours within a culture. For this reason, Chapter 2 focuses specifically on Maori concepts of mental health and illness. The chapter describes how a Maori perspective incorporates spiritual and cultural factors as vital to Maori mental health. Maori people also hold spiritual beliefs about the causes of mental illness. These beliefs are still prevalent among Maori people today. Thus, it is suggested that some of these spiritual and cultural beliefs may be influencing factors in the symptom presentation and clinical assessment of a Maori person who receives a diagnosis of schizophrenia.

This present study, therefore, investigates whether there are differences in presenting symptoms between Maori and Pakeha patients, and explores whether certain cultural beliefs account for these differences. The literature review in Chapter 3 outlines two theories that

have been put forward to explain the relationship between culture and the expression of psychopathology. The first theory postulates that cultural values, beliefs and attitudes may influence the expression of psychopathology among different cultural groups. This theory is discussed in relation to Maori beliefs and the presentation of Maori psychiatric patients. It is argued that certain Maori cultural and spiritual beliefs may influence the occurrence, frequency and content of certain symptoms such as hallucinations and delusions.

The second theory hypothesises that differences between cultures in presenting symptomatology may be attributed to the cultural beliefs, values and attitudes of the diagnostician who assesses, interprets and diagnoses a person with a suspected mental disorder. This theory is discussed in relation to the assessment of Maori patients and how misinterpretations of behaviour can occur between different cultural groups. It is suggested that differences in symptomatology may be a direct result of a clinician's interpretations of behaviour as abnormal.

In summation, the literature review argues that differences do exist in the presentation of schizophrenia across cultural groups and that these differences may be due to the cultural beliefs, values and attitudes inherent in different cultural groups. Thus, the present study compares the frequencies of presenting symptoms between Maori and Pakeha patients diagnosed with schizophrenia and explores whether cultural beliefs and knowledge influence the expression of schizophrenia among different cultural groups.

Overall, the present study seeks to help clarify the relationship culture may play in the expression of psychopathology in New Zealand. It also suggests the need for mental health

workers to be aware of the vast differences in beliefs, attitudes and values among different cultural groups. Awareness and understanding of these cultural differences, it is argued, has important implications in terms of the assessment, diagnosis and subsequent treatment of a Maori person with suspected schizophrenia.

CHAPTER 1

THE EXPRESSION OF PSYCHOPATHOLOGY ACROSS DIFFERENT CULTURES

Similarities versus Differences

There exist two major but opposing views on the expression of psychopathology among different cultures. The first view relates to the universality or commonality of psychopathology across cultures. The second view relates to the cultural relativist approach which emphasises the heterogeneity of psychopathology with each culture creating its own set of disorders.

Proponents of the universality or similarity view would argue that abnormal behaviour is a universal concept and can reliably be identified as such among different cultures. Major mental disorders such as schizophrenia occur universally with the incidence of such disorders varying little among different cultures. From the universalist view, there exists a high degree of similarity and uniformity in the expression of psychopathology across different cultural settings (Dragnus, 1980). The universal viewpoint places culture in a peripheral role in relation to its influence on psychopathology. From this perspective psychopathology is brought about by the universal stresses of living and responses to these stresses (whether they be mediated by biological, psychological or social mechanisms) are basically the same (Dragnus, 1986).

By contrast, the cultural relativist approach emphasises the cultural uniqueness of disorders and highlights the existence of differences in the presentation of psychopathology among

different cultures. Proponents of this view place culture in a central role in its influence on psychopathology. Manifestations of disturbed behaviour are linked to the unique cultural milieu of each person (Dragnus, 1980). From an extremist position, each culture is seen as creating its own disorders (Dragnus, 1986). Thus, this view maintains that differences do exist in the manifestation of psychopathology among different cultural groups.

However, research into the expression of schizophrenia across different cultures has found both similarities and differences in the way different cultures express psychopathology. According to Jablensky and Sartorius (1975), a selective emphasis on either view could find factual support.

Research supporting the similarity view of schizophrenia across cultures

One of the most promising studies to be conducted in this area is the International Pilot Study of Schizophrenia (IPSS) conducted by the World Health Organisation (WHO) (1973). The IPSS used structured diagnostic interviews in nine nations to study the nature and distribution of schizophrenia among countries that differed in socio-cultural and economic characteristics. Patients seeking psychiatric assistance in each centre were screened and on the basis of certain criteria were included in the study. These patients were interviewed using the Present Status Examination (PSE) (Wing, Cooper & Sartorius, 1974) and Past History and Social Description scales. The PSE data was then used to classify patients according to a computer diagnostic programme (CATEGO). In all, 1202 patients were examined, of whom 811 received a clinical diagnosis of schizophrenia. The most significant findings of the IPSS pertained to the 'universal' nature of schizophrenia and to the more favourable outcome for individuals with schizophrenia who came from developing countries (WHO, 1973).

In relation to the expression of schizophrenia among different cultures, the initial reports of the IPSS highlighted the uniformity of the presenting symptoms of schizophrenia across cultures. This conclusion was based on the similarity of similar clusters of symptoms across all countries and the identification of a concordant group of schizophrenics in all the centres. For example, clinical profiles of all the patients in each diagnostic group were compared between diagnostic groups and centres. These comparisons showed that a group of patients given a diagnosis of schizophrenia in one centre had a symptom profile similar to that of patients given the same diagnosis in another centre (WHO, 1973). The concordant group of patients who were identified in each of the nine centres had concordant syndromes which included lack of insight, pre-delusional signs, flatness of affect, auditory hallucinations (except in the Washington centre) and experiences of control (Sartorius, Shapiro & Jablensky, 1974). The results also indicated a high degree of homogeneity in the psychopathology of individual schizophrenic subgroups such as the group with paranoid schizophrenia.

At the same time, certain centre-specific characteristics were found among some groups of patients (Sartorius et al., 1974). Moreover, a closer analysis of the findings indicates symptom differences between various centres. For example, more of the patients in Cali than those in Washington demonstrated lack of insight (93% vs 48%), auditory hallucinations (46% vs 9%) and neurasthenic complaints (17% vs 8%). More patients in the London group than those in Agra had experiences of control (48% to 15%), distortion of perception (18% to 4%), pseudo-hallucinations (19% to 1%), derealisation (30% vs 5%) and had lower scores in incongruity (0% to 34%) and disregard for social norms (15% to 34%) (WHO, 1975). In essence, when pairs of centres were compared, there appeared to be differences between them in the frequencies with which certain symptoms were reported or recorded.

A follow-up study was carried out 2 years later where patients were recontacted and interviewed again using the same research instruments and interviewing techniques (WHO, 1979). Centre by centre comparisons of schizophrenic patients deemed psychotic at the 2nd year follow-up found that there were no significant differences among profiles, although there was a relatively low degree of similarity between Washington patient profiles and those of other national centres (WHO, 1979). Despite these findings, the overall similarity of symptomatology was emphasised.

The WHO Collaborative Study on the Determinants of Outcome of Severe Mental Disorder (DOS) was conducted in the 1980's to further some of the findings of the IPSS studies. A total of 10 countries were involved in the study. The groups consisted of people making a first in lifetime contact with any type of 'helping agency' because of symptoms of psychotic illness (Sartorius, et al., 1986). By investigating this group, it was hoped to find a representative sample of patients who had not yet been influenced by treatment and social attitudes.

Data obtained from administration of the PSE indicated overall similarity in symptomatology of patients in different centres diagnosed with schizophrenia. Comparisons were then made according to developing and developed centres. These two profiles were very similar except for three differences. First, the frequency of affective symptoms was found to be higher among patients in developed countries. Second, some Schneiderian first rank symptoms (Schneider, 1959) such as thought insertion or broadcast and primary delusions occurred with greater frequency among patients in developed centres (Jablensky, et al., 1992). Third, auditory hallucinations and particularly visual hallucinations were experienced more by

patients in developing centres than patients in developed centres. However, overall these differences were regarded by the authors as 'relatively insignificant' given the greater similarity in scores between centres among the remaining 41 symptoms that were analyzed.

The authors conclude:

Schizophrenic illnesses are ubiquitous, appear with similar incidence in different cultures and have clinical features that are more remarkable by their similarity across cultures than by their difference (Jablensky et al., 1992, p. 2).

The IPSS and DOS studies have often been cited as evidence of the universality of schizophrenia across all cultures. It would seem that there is evidence that schizophrenia is an illness that can be identified in different cultures. However, the expression of this psychopathology is not as uniform as the studies would suggest. Closer scrutiny of the results shows that there are differences, particularly when centres are compared. Furthermore, there are certain limitations inherent in these two studies that may discredit claims that the expression of schizophrenia is similar among different cultures.

Fernando (1991), in reviewing the IPSS studies points out that the validity of schizophrenia as a universally accepted construct or illness was not questioned or researched. The diagnosis of schizophrenia was made according to Western definitions and patients compared accordingly. Furthermore, as Dragnus (1980) points out indigenous conceptualizations of schizophrenia were ignored as were attempts "to relate the symptom patterns discovered to their meanings in their respective cultures" (p. 131).

Moreover, no data was obtained on the independent criterion validity of the PSE. According to Fernando (1991), the PSE was never validated for cross-cultural research and concepts of illness embodied in the PSE which were based on Western psychiatry were presumed to be applicable across all cultures. Fernando (1991) goes further to state:

The IPSS is a demonstration of how to impose Western concepts of illness on other countries. ...All through the series of WHO studies...there is an assumption that, if a system that is developed in Europe and seemingly suitable for Western cultures can be reliably applied, it is good enough for other cultures. This is a position of cultural arrogance, bordering on racism (p. 134).

One of the main aims of the WHO studies was to provide a uniform framework for exploring and reporting on schizophrenia among different countries. Through the use of standardised and reliable instruments and continuous training in the use of these instruments, the IPSS studies showed that it was possible to provide a uniform framework for the diagnosis of schizophrenia and research into schizophrenia across cultures. Indeed, the IPSS and DOS studies have improved on previous cross-cultural studies by using standardised and reliable assessment and diagnostic procedures. However, what the project demonstrated was "the ability of pretrained psychiatrists from several countries to describe and rate the disturbance of preselected patients in a similar manner" (Dragnus, 1980, p. 132). The study does not necessarily demonstrate actual uniformity of symptoms and syndromes among different cultures.

Other research that has been on a smaller scale and focused on comparisons between two groups has also found uniformity in symptomatology of schizophrenia. For example, De Hoyos and De Hoyos (1965) reviewed the medical records of black and white schizophrenics in a hospital and found no significant differences in symptomatology between black and whites when the data was analyzed through factor analysis. The authors then attempted to analyze the data by focusing on differences in the frequencies of recorded symptoms obtained from the medical records. They found a consistent pattern of fewer symptoms recorded overall for the black sample despite identical diagnoses of schizophrenia. Whites had a higher frequency of recorded passivity symptoms and non-delusional symptoms whilst blacks appeared to have a higher number of recorded hallucinations. This study has often been cited as evidence of different psychopathology among blacks and whites and in particular the trend that blacks experience a higher frequency of hallucinations. It needs to be noted that differences in the number of recorded symptoms are not an indication of symptomatological differences nor can a review of medical records provide substantial evidence for the commonality of schizophrenia because of the many biases inherent in this procedure.

Using a more reliable and structured approach, Simon, Fleiss, Gurland, Stiller and Sharpe (1973) compared the psychopathology of patients given a diagnosis of schizophrenia and depression (according to the project criteria) using a structured mental status interview. Black and white patients who were compared on the 45 scales measuring disturbed thought and behaviour were found not to differ significantly on any of the scales. The authors conclude that black and white schizophrenic patients do not differ in psychopathology.

Klein, Person, Cetingok and Itil (1978) compared patients from Turkey and Missouri admitted to hospital with a primary diagnosis of schizophrenia. The three scales used to make comparisons were the Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962), the Itil-Keskiner Psychopathological Rating Scale (Holden, Itil & Keskiner, 1968) and the Holden Seven Point Global Scale. They found no statistical differences in the symptoms and severity of illness among the two populations.

In a more recent study in which a matched diagnosis approach was used, Escobar, Randolph and Hill (1986) compared the symptomatology of Hispanic war veterans with white non-hispanic war veterans who had been given a diagnosis of schizophrenia by the project psychiatrist. Patients were matched according to socio-economic, geographic and treatment backgrounds. Symptomatology was obtained using a structured diagnostic interview, as well as the BPRS, Global Assessment Scale (GAS) (Endicott, Spitzer, Fleiss & Cohen, 1978) and Symptom Checklist 90 (SCL-90) (Derogatis, Lipman, Rickels, Uhlenhuth & Cori, 1974). They found that certain primary symptoms of schizophrenia such as hallucinations and delusions were similar among both groups. However, differences were found in relation to some of the secondary aspects of schizophrenia such as the content of delusions and hallucinations. The presence of somatic complaints was significantly higher among Hispanics (Escobar et al., 1986).

In summation, the majority of these studies emphasise the uniformity of schizophrenia across different countries and groups. However, a closer analysis reveals that differences have been noted but, because of the overall similarity, have not been addressed. Furthermore, certain

limitations within the studies means that the similarity in expression of schizophrenia cannot be automatically assumed.

Research supporting the differences view of schizophrenia across cultures

There also exists an abundance of research that supports the cultural relativist view of differences in psychopathology. This research has used a variety of different approaches such as matching diagnosis, reviewing records, clinicians impressions and interviewing significant others. However, these studies are also subject to many of the limitations inherent in those studies that have highlighted uniformity in symptomatology. A review of the research that has highlighted differences in symptomatology points to some of these limitations.

Opler (1959) administered a number of psychological tests including the Rorschach (Rorschach, 1942) and Thematic Apperception Test (Murray, 1943) to patients of Irish and Italian origin diagnosed with schizophrenia. The sample population consisted of a total of 60 patients matched for age, education, IQ and diagnosis. They found that Irish tended to have more guilt and sin preoccupations, more systematic delusions, more drinking problems and more affective troubles than Italians.

In a more recent study, Adebimpe, Klein and Fried (1981) compared Missouri black and white rural and urban schizophrenic patients using the BPRS and Itil-Keskiner Psychopathological Rating Scale. The study focused on possible variations in hallucinations and delusions among the two racial groups. Results of selected rating scale items found that auditory hallucinations occurred at a significantly higher frequency among blacks. Visual and other hallucinations (i.e. non-visual, non-auditory) were also found to be more frequent among

blacks although not at the same level of statistical significance. The results revealed no differences in the frequency of delusions. The authors conclude that the results, in line with other research finding similar differences in the frequency of hallucinations among blacks and whites, reflect the fact that many blacks, irrespective of diagnosis, experience a variety of non-schizophrenic hallucinations. The authors emphasise the need to look at the content as well as the context in which these hallucinations occur (Adebimpe et al., 1981).

Further to this study, Adebimpe, Chung-Chou, Klein and Lange (1982) compared the overall psychopathology of black and white rural and urban schizophrenic patients. Results indicated that 'important' symptoms were more severe in blacks than whites. Blacks were found to be more angry, impulsive, hallucinating, dysphoric and asocial than white schizophrenic patients. Differences in race were detected at a significant level using the Itil-Keskiner Scale but not on the BPRS. The authors postulate that such differences reflect the differentiation of emotional states which have been found to vary with the cultural background of patients (Leff, 1973).

Welner, Liss and Robins (1973) in a follow up to a chart review study they had conducted used a structured interview among black and white patients admitted to hospital. The results revealed that the frequency of 13 out of 233 possible symptoms were significantly different when black and white patients were compared. Blacks were found to have a higher frequency of delusions of reference, body change and grandeur and visual and auditory hallucinations. These differences were found despite there being no differences in the frequency of psychiatric diagnosis. According to the authors, black and white patients with the same psychiatric disorder will exhibit significantly different symptomatology. They suggest that

differences in symptomatology are characteristic more of a group rather than a psychiatric disorder. Thus, psychiatric symptoms are significantly different between black and white patients and do not necessarily reflect different psychiatric disorders.

In a more recent study, Fraberga, Mezzich and Ulrich (1988) compared symptomatology among matched samples of blacks and whites within specific diagnostic categories. Using the Initial Evaluation Form (IEF) (Mezzich, Dow & Rich, 1981) variations in symptomatology between the two groups were most pronounced in unipolar depressive disorders, but were also noticeable in schizophrenia, paranoid/other psychoses, anxiety disorders and dementia. In relation to the schizophrenic group, there was a tendency for blacks to score lower on affective items. Whites scored higher on emotional distance or coldness, flat/incongruous affect and eccentricity. No significant differences were found in psychoticism among blacks and whites.

A substudy of the WHO Determinants of Outcome of Severe Mental Disorder focused specifically on Indian and Nigerian schizophrenic patients (Katz, et al., 1988). Patients were assessed and compared using the PSE. The researchers also included in the study an investigation of the expressive quality and social behaviour of patients through interviewing family members using the Relatives Ratings of Symptoms and Social Behaviour (KAS-R) (Katz & Lyerly, 1963). Results of the PSE indicated a higher frequency among the Agra group of affective symptoms, depressed mood, morning depression and morbid jealousy. This corresponded with the main findings from family members which found that Indian patients had a more affective and self-centred orientation in their presenting symptomatology. By contrast, PSE data revealed a higher frequency of hallucinatory voices, delusions of control

and thought insertion among the Ibadan group which also related to the findings from family members that their relatives presented with more paranoid features, were more suspicious, bizarre and anxious (Katz et al., 1988). The authors attempt to relate these differences to cultural variations and themes occurring within each culture.

As has been discussed, these prospective studies used a variety of instruments to elicit information about the presenting symptomatology among different cultural groups. Whilst differences were noted, especially in the frequency of certain symptoms, the validity of these instruments among different cultural groups must be kept in mind when evaluating the results. For the most part, the instruments used in the studies are based on Western concepts of psychopathology and have not been validated cross-culturally. Furthermore, the pot-pourri of instruments used in the research highlighting differences makes it impossible to draw any definite conclusions because of the biases in each instrument. The most commonly used instruments from this review are the PSE and BPRS. Commonly cited articles in support of differences in schizophrenia such as the Opler (1959) study fail to also state the limitations of such tests as the Rorschach which were used as evidence to support the theory that differences do exist in the expression of schizophrenia across cultures.

Another approach that has been used to look at the symptomatology of different cultural groups diagnosed with schizophrenia has been to review the case records of patients diagnosed with schizophrenia and make comparisons according to the types of symptoms reported. For example, Vitols, Waters and Keeler (1963) reviewed the records of all first admissions for black and white schizophrenic patients in two psychiatric hospitals. The results indicated a higher prevalence of auditory and visual hallucinations in blacks. No differences

were found in the prevalence of delusions. Through calculating the ratio of hallucinations to delusions among black and white schizophrenic patients and non-schizophrenic patients, the authors demonstrated that the incidence of auditory and visual hallucinations as compared to delusions was still significantly higher among the black schizophrenic patients, but the ratio of hallucinations to delusions among white and black non-schizophrenic patients was the same. According to the authors, this established that differences in history taking and charting practices were not accountable for the significant differences in symptomatology among blacks and whites (Vitols et al., 1963).

Enright and Jaekle (1963) compared the symptomatology of Japanese and Filipino patients diagnosed with schizophrenic reaction, paranoid type. Data was obtained through reviewing the commitment papers of each patient. Through analyses of symptom clusters, significant differences were found. For example, Japanese schizophrenic patients tended to show more disturbances in thinking, more ideas of reference and were more passive and withdrawn. In contrast, Filipino schizophrenic patients tended to be more active and aggressive. These differences were accounted for by hypothesising that cultural factors in relation to an expressive-restrained dimension among the cultural groups were in force.

Ndetei and Vadher (1984) conducted a retrospective study comparing the frequency of hallucinations among African, West Indian, Asian and English schizophrenic patients. The clinical notes of each patient were reviewed using the Syndrome Checklist (SCL) (Wing et al., 1974) as a standardised method for noting the psychiatric symptoms. Patients were then given a diagnosis from information obtained in the SCL according to the Standard CATEGO programme (Wing et al., 1974). The results indicated a higher frequency of hallucinations

among African, Jamaicans, other Caribbeans and Asians than among English and other groups.

Murphy, Wittkower, Fried and Ellenberger (1963) used a questionnaire survey among psychiatrists from 27 countries to study the manifestations of schizophrenia in different countries. They identified a core pattern of schizophrenia from the responses of psychiatrists. However, they also found significant differences in the frequency with which certain symptoms were reported in different countries. For example, visual and tactile hallucinations were most frequently reported in Africa and the Near East, social and emotional withdrawal and flatness of affect most frequently reported in Japanese and Okinawans, catatonic negativism in India and South America, and catatonic excitement in Africa and South America. Differences in symptomatology were also found when comparisons were made according to religious affiliations and rural and urban environments. For example, delusions of destruction and religious delusions have been commonly associated with classical European descriptions of schizophrenia. Results indicated that patients belonging to high guilt evoking religions such as Christianity had higher frequencies of delusions and delusions of destruction than East Asian religions such as Buddhism and Shintoism. The authors conclude that the differences in symptomatology among cultural groups varies according to cultural, social, observational and conceptual factors (Murphy et al., 1963).

Many of the studies pointing to differences in symptomatology have a number of limitations. For example, the retrospective approach that has commonly used written records to compare symptomatology is subject to the biases of psychiatrists in how they record symptoms and what symptoms they decide to focus on. For example, a study conducted by Cooper (1975)

found that American psychiatrists focused more on positive symptoms and were more likely to rate symptoms at a higher level of abnormality than British psychiatrists. What may appear to be differences in symptomatology may merely reflect the current trend at the time that symptoms were recorded.

A prospective approach that interviews patients at the time of admission also has some limitations. Many of the studies that have found differences in symptomatology have used a variety of 'standardised' instruments. However, as in the IPSS studies, little mention is made of how constructs within the instruments were validated cross-culturally. The variety of instruments that have been used makes it impossible to draw any firm conclusions regarding the validity of statements made concerning symptom differences. However, a uniform approach to eliciting information about symptomatology has a distinct advantage over the post hoc method of reviewing records in terms of reliability and consistency.

Conclusion

In conclusion, the research into the manifestation of schizophrenia across different cultures has identified a core syndrome of schizophrenia that can be identified in a number of different cultural sites across the world. Despite the possible universality of schizophrenia, the results from research also show significant differences in the frequencies and content of certain symptoms among different cultural groups. In particular, hallucinations and delusions seem to differ in frequency among different cultural groups. Thus, in relation to the symptomatology of schizophrenia across cultures, Jablensky and Sartorius (1975) state:

Most studies indicate that the majority of clinical signs and symptoms commonly associated with schizophrenia can be found to occur in a great

variety of cultures, but the relative frequency and predominant content of some symptoms vary markedly from one culture to another (p. 118).

Before attempting to outline some of the theories that have been put forward to explain why differences exist in the expression of schizophrenia across cultures, it is important to gain an understanding of how each culture views mental health and illness. Thus the next chapter explores Maori concepts of mental health and illness.

CHAPTER 2

MAORI CONCEPTS OF HEALTH AND ILLNESS

Many cross-cultural studies, which look at the expression of psychopathology across cultures, have been criticised for not recognising or discussing indigenous conceptualizations of mental disorder and relating some of the symptom presentations of Western defined mental disorders to indigenous cultural behaviour patterns, beliefs and attitudes.

For this reason, Chapter 2 compares Maori concepts of mental health and ill health with Western concepts. As will become evident, the Maori perspective incorporates spiritual and cultural factors as being vital to Maori mental health. This holistic approach, which has often been disregarded by Western mental health professionals, reflects the different value and belief systems within each culture.

In discussing the causes of illness from a Maori perspective, it will become evident how cultural and spiritual beliefs play an important role in these theories of causation. Furthermore, many of these cultural and spiritual beliefs have been maintained and may be influencing factors in the symptom presentation of a person with a diagnosis of schizophrenia.

A Maori view of health

The Maori view of health takes a holistic approach which incorporates cultural and spiritual factors as paramount to good mental health and well-being. This perspective of health involves the concepts of Te Taha Wairua (spiritual well-being), Te Taha Hinengaro (mental well-being), Te Taha Tinana (physical well-being) and Te Taha Whanau (family well-being)

(Ngata, 1985; Durie, 1985a). Other aspects of Maori culture viewed as a foundation to good mental health include *te taha whenua* (land) and *te reo Maori* (Maori language).¹ As such mental health cannot be looked upon as a separate entity but rather is seen as strongly intertwined with other components that contribute to the *waiora* (well-being) of a Maori person. If one part is not being nourished, an imbalance is created and the overall *waiora* of a person is at risk.

Te Taha Hinengaro

Te Taha Hinengaro refers to the "mental and emotional dimensions of a person" (Ngata, 1985, p. 134) or the psychic aspect that is related to thoughts and feelings (Durie, 1987). These attitudes, thoughts, feelings and ways of expressing them differ from Western ways. For example, Smith (1989) discusses how traditional Maori viewed a large part of their experience as occurring or originating from outside the self. Traditional explanations of illness and emotions like fear and grief were thought to be the influence of *atua* (gods). In this context the self was not personally responsible for any emotions or suffering experienced (Smith, 1989). By contrast, Western explanations of experience look to the individual as being primarily responsible for his/her own thoughts or emotions.

Te taha wairua

Te taha wairua refers to the intangible, spiritual part or soul of a person (Mason, Ryan, Bennett & Turei, 1988). It is something that is not easily defined, something that is felt rather

¹There exist a number of other models of Maori health such as Rose Pere's *Te Wheke* (Pere, 1992). The model described here has been chosen because of its simplicity. The researcher sees both models as incorporating the main ideology of a holistic approach that acknowledges both spiritual and cultural factors in the wellbeing of a Maori person.

than seen and exists within all Maori people. Spiritual insight and well-being provides a person with a sense of knowing who one is and where he/she comes from. Moreover, it provides an important link with our tupuna (ancestors) and environment.

Te taha wairua is enhanced by cultural belonging, participation and identification with what it is to be Maori; one's Maoritanga. Knowing one's turangawaewae (place where one belongs) and whakapapa (genealogy) is strongly linked with te taha wairua. To be open to and identify with one's tupuna (ancestors) is also an important part to te taha wairua. Maori attach great importance to their tupuna. Te taha wairua is also reflected in the beliefs, values and customs Maori people have. Spiritual well-being is considered the most vital aspect of Maori health and well-being. However, it is this aspect that has most widely been ignored by Western professionals in favour of medical and scientific values (Durie, 1984).

Te taha whanau

Te taha whanau refers to the extended family network, its unity and an individual's sense of belonging to this invaluable support system. Intertwined with the intact whanau is the concept of whanaungatanga which is also an important base to one's identity and Maoritanga. Whanaungatanga refers to a sense of belonging and kinship. There also exists an awareness of the obligations and expectations within a whanau. Whanaungatanga extends not only to those belonging within the whanau but to members within the hapu and iwi. Knowing one's links and obligations binds members into a cohesive unit and provides members with physical, spiritual and emotional sustenance. Potaka-Dewes (1986) sees the mental health of Maori people as dependant on the stability and promotion of the extended family. Not only are there the transmission of whakapapa and a sense of identity, but also cultural values and beliefs.

Many western health theories and concepts go directly against the values of te taha whanau and whanaungatanga. As Durie discusses:

A popular western mental health concept in recent years has centred on the importance of the individual who is seen as a self-sufficient, self motivated and self assertive person. ...Good mental health has been equated with independence, directness and severance of generational ties. It is a peculiarly Western view which in Maori terms is the antithesis of mental health. To be "totally independent" and a "separate person" is in Maori terms, to be unhealthy (Durie, 1984, p. 8).

Maori concepts of health focus on the importance of whanau support and interdependence. An individual flourishes in relation to his/her whanau, the backbone of his/her identity and well-being.

Te taha tinana

Te taha tinana refers to the physical well-being of a person. More so in traditional times, physical and mental health were believed to be influenced and maintained by spiritual beliefs and adherence to the laws of tapu. The physical health of a person depended on the positive integrations of spiritual, mental and family well-being. However, it is the physical aspect of health that Western society has focused predominately upon, with little regard to the spiritual and cultural aspects which are viewed by Maori people as interconnected.

Te taha whenua me te reo Maori

Other aspects of Maori culture viewed as basic foundations to good mental health include te taha whenua and te reo Maori. These are aspects that provide Maori with a sense of identity

and well-being. For example, Maori people have a very strong spiritual and emotional link with the land. Maori refer to the earth as Papatuanuku, the earth mother, who nourishes us physically, spiritually and emotionally. The land is part of a Maori person's internalised identity; without it one has no firm basis with which to survive and grow.

Te reo Maori is also seen as a vital link to the well-being of a Maori person. The survival of any culture relies upon their language. The Maori language is of paramount importance in nourishing the unique identity of Maori people. With the language also comes the transmission of values and beliefs, as well as an unique style of expression.

In summary, a Maori view of mental health incorporates the mental, physical, spiritual and family dimensions of a person. If one area is not being nourished then the overall waiora of a person is at risk. This holistic perspective towards mental health highlights the different values and belief systems that exist between Maori and Western philosophies.

Maori concepts of illness

Maori explanations of illness and mental disorder centre around spiritual philosophies and supernatural causes. These views have often been pushed aside by Western professionals in favour of scientific beliefs in ill-health. Although the importance of Western medicine cannot be undermined, the belief systems of Maori in relation to ill-health and mental disorder still exist and need to be understood.

Tapu as a cause of illness

In traditional times, ill-health occurred through either accidents, or infringement of tapu, or makutu. Accidents were man-made and the causes of injury identifiable (Durie, 1977). Treatment of these types of injuries such as cuts and sprained ankles usually involved the use of rongoa which used Maori herbs and plant medicines (Beaglehole & Beaglehole, 1946).

Ill-health and sickness were attributed primarily to supernatural causes with the cause of such illnesses being an infringement of tapu. The concept of tapu has both religious and legal associations and was regarded as the main spiritual force within Maori society. Tapu was often seen as a state of being. "A tapu place, person or act demanded the respect of the community and individuals were not free to engage in casual encounters with the particular object" (Durie, 1987, p. 205).

Breaches of tapu were referred to as a hara. Examples of tapu violation include walking onto tapu burial grounds, not observing correct rituals for a particular custom or coming into a contact with a piece of the body regarded as tapu. The hara would then lead to sickness often referred to as a mate atua (Durie, 1977) or mate Maori. This was because states of tapu were connected to the direct influence of atua. "The atua were the unseen animators of the Maori world, and they were the power behind the state of tapu that could make it both efficacious and dangerous" (Sachdev, 1989b, p. 962).

The Maori spiritual religious system consisted of different types of atua ranging from Io (the supreme God), departmental gods (sons of Ranginui and Papatuanuku) to tribal and familial atua (Lyndon, 1983). Therefore, the well-being of a Maori person was dependent on support

and protection of the mauri (life principle) by atua (Walker, 1977). When a hara was committed, it was believed ancestral atua who acted as guardians for individuals and tribes, left the person and the mauri was no longer protected. Subsequently, the person was defenceless or became possessed by other destructive atua. The person would then "become ill and exhibit symptoms appropriate to the Ngau or bite of the atua he had offended. He could also be possessed by an atua and become a 'tangata porangi' or mad man" (Lyndon, 1983, p. 27).

Thus all sickness was regarded as primarily psychological (Durie, 1977) with beliefs in tapu and the consequences of infringement of the laws of tapu being the primary cause for illness.

Makutu as a cause of illness

Another identified cause of illness was through makutu. Makutu refers to the use of karakia (prayer or incantation) to affect an individual. Typically makutu would result in death, but it has also been used in less drastic ways such as preventing an individual's or a family's mana becoming too great (Lyndon, 1983). Such a makutu would involve the family becoming less productive through the generations until the makutu was removed (Lyndon, 1983). It was usually tohunga (priest, expert) who had the skills to practise makutu. Typically an ohonga (something belonging to the intended victim such as hair or something he/she had touched) was obtained in order for the karakia or incantations to affect the intended victim. The ohonga represented the mauri of the victim. This in part explains Maori practise of carefully getting rid of such things as loose toe nail clippings and loose hair so that a makutu could not be put on them. The differentiation between a mate atua or makutu as the cause of illness was determined by the tohunga from whom a person was seeking assistance.

Treatment of sickness

The treatment of mate atua, mate Maori and makutu involved the services of a tohunga. If a tapu had been broken, it was then up to the tohunga to identify the hara and locate the responsible atua (Sachdev, 1989b). This involved finding out the movements of the patient prior to the onset of the problem. Special attention was also given to the patients dreams which provided information on what type of atua was involved. The karakia was usually used to appease or remove atua.

The spiritual belief systems of traditional Maori and the spiritual basis of healing were disregarded by Western society in favour of a more scientific, medical approach. Traditional Maori vehemently believed in the power of incantation and prayer by a tohunga to cure sickness. Western society viewed these incantations as 'superstitious mummery' despite the fact that Christianity brought similar practises. Their disregard for Maori belief systems is evident in the 1907 Tohunga Suppression Act which outlawed faith healing practises. This law occurred at a time when traditional healing practices were still being used in an attempt to cure diseases which were brought out to New Zealand by Pakeha. The law disregarded the importance of traditional healing approaches in relation to sicknesses that were caused by infringements of tapu, makutu and mate Maori. Undoubtedly, Western medicine has had some positive effects on the physical health of Maori people. Nevertheless, health professionals continue to disregard the importance of Maori beliefs in tapu, makutu and spirituality in curing certain sicknesses.

Beliefs in mate atua, mate Maori and makutu

Beliefs in mate atua, mate Maori and makutu, the causes and cures still exist within contemporary Maori society. Whilst many of these beliefs do not have the same degree of hold over Maori people today, "some of the beliefs have persisted, often in a modified form, and influence behaviour consciously or unconsciously" (Dansy, 1978 cited in Sachdev, 1989b, p. 967).

For example Lyndon (1983) found that beliefs in tapu, mate Maori and makutu were still prevalent in Maori society and still being transmitted to younger generations. Lyndon's study involved interviewing initially 6 informants from within her own hapu area of Ngati Hine and administering a questionnaire dealing with attitudes and beliefs towards mental illness, makutu, dreams and spirits. Subsequent group discussions were held with another group of informants who had experienced mate Maori or makutu, or who had been committed to a mental hospital. Finally, a group discussion with Maori children looking at the knowledge they had about some of these concepts was also conducted. In all, a total of 60 people were involved in discussions and interviews.

Many of Lyndon's informants still retained beliefs in tapu, mate Maori and makutu. All of them believed that mental illness could be caused by mate Maori and makutu. However, there was much reluctance to tell Pakeha professionals that the cause of illness may be due to cultural factors because of the fact that beliefs in tapu and spirits were not generally accepted by Pakeha professionals. Many of Lyndon's informants also felt that if they were to tell a Pakeha professional what they believed the cause of their illness to be they would be referred for psychiatric counselling (Lyndon, 1983).

Furthermore, all of Lyndon's informants knew of people within their extended family who had 'gone strange' or died because of mate Maori. Usually the identified cause was a transgression of tapu especially in relation to people going on to burial grounds. Lyndon (1983) concludes:

Despite nearly two hundred years of contact with the Pakeha and one hundred and forty three years of sustained contact with them, the Maori still retain many of the beliefs of their ancestors, including the belief that 'spirits' can and do, punish transgressions of tapu or that they can be used as an instrument in makutu to punish or avenge (p. 113).

Not only were beliefs in tapu, mate Maori and makutu prevalent among informants, but also beliefs in spirits and the significance of dreams as agents in warning or helping a person (Lyndon, 1983). For example, a number of beliefs prevalent among Lyndon's informants centred around the existence of a family kaitiaki (guardians) or aria (symbols of kaitiaki). Aria could appear prior to the death of a member of the family or when someone was ill. The exact significance of the aria could be determined by the way it appeared and the noise it made when it came. For example, if it appeared in an agitated manner, this was sufficient for the family member to telephone other's and take precautions when travelling (Lyndon, 1983).

Other beliefs prevalent among Lyndon's informants related to the significance of dreams as agents in warning and helping a person and beliefs in wairua (spirits) and kehua (ghosts). For example, the wairua was seen as the part that left the body when a person was dreaming. If there was danger, the wairua would then return and warn the person in a dream (Smith, 1989). The wairua would also leave when a person was very ill and nearing death. Lyndon's

informants believed in the ability of the wairua of a person nearing death to visit loved ones in some manner (Lyndon, 1983).

Conclusion

In summary, traditional Maori viewed sickness and disease as resulting from the influence of atua. Usually the cause of sickness was because of a transgression of tapu or makutu. Treatment involved the implementation of karakia usually conducted by tohunga. Today, beliefs in mate atua, mate Maori, tapu and makutu still exist among Maori to varying degrees. Other beliefs in spirits, wairua and the presence of kaitiaki are also common as highlighted in Lyndon's study.

The presence of these 'supernatural' beliefs in traditional and contemporary society has important implications in terms of the assessment and diagnosis of a Maori person with a suspected mental disorder. As stated by Lyndon (1983):

The belief and conviction that my informants have, in the ability of the atua to affect their daily lives through the intervention of dreams, visitations from the dead, the ability of the atua to punish them for transgressions of tapu and that the atua can be used by those with the mana and expertise to punish or avenge is of significance in the diagnosis of schizoid and paranoid states amongst the Maori (p. 110).

Those diagnosing Maori patients need to be aware of the fact that Maori cultural beliefs accept and even condone certain phenomena such as seeing spirits and hearing their tupuna. In many cases, these types of abilities are often a source of pride (Lyndon, 1983). As one

of Lyndon's informants reported, "I think it shows a sensitivity and that we still haven't put a closeness to our origins and to nature too far away from us" (Lyndon, 1983, p. 113).

The importance of cultural beliefs in the expression of psychopathology across cultures has not yet been established. The next chapter explores two theories which postulate that cultural beliefs, attitudes and values may influence the expression and interpretation of abnormal behaviour. These two theories are discussed in relation to Maori cultural beliefs and to the presentation and assessment of a Maori patient.

CHAPTER 3

THE RELATIONSHIP OF CULTURE TO THE EXPRESSION OF PSYCHOPATHOLOGY

Given that differences do exist in the symptomatology of schizophrenia across different cultures, the next question to ask is why these differences exist. What we are trying to understand is each person's experience of mental disorder and why one culture's experience of a mental disorder is different from another culture's experience of the same mental disorder.

There exist a number of possible cultural variables that may have an effect on the expression of psychopathology among different cultural groups. Dragnus (1980) reviews seven possible theories about the relationship between culture and the expression of psychopathology. These theories, which range from the influence of cultural themes, myths, philosophical assumptions and social stereotypes within a culture to patterns of disturbed behaviour within a culture, are seen as variables in the expression of psychopathology. However, whilst there has been a large amount of cross-cultural research that indicates a definite relationship exists between culture and psychopathology, little has been done to test, refine and research these theories.

There are two theories in particular which identify cultural beliefs, values and attitudes as variables in the expression and interpretation of psychopathology. First, differences in symptomatology among different cultures may be due to certain cultural beliefs, values and attitudes that have an influence on the occurrence, frequency and content of certain symptoms. Second, differences in symptomatology among different cultural groups may also be due to

the cultural beliefs, values and attitudes of a person who assesses, interprets and diagnoses a person with a mental disorder. Accordingly, differences that have been found in the expression of schizophrenia may be accounted for by the different beliefs and values within one culture. Moreover, these cultural variables may have an effect on how a person presents or how a person is perceived or both.

Theory 1: The occurrence, frequency and content of certain symptoms expressed by an individual is influenced by his/her cultural beliefs, values and attitudes.

Occurrence and frequency of symptoms

Differences in the occurrence and frequency of symptoms among different cultural groups may be influenced by cultural beliefs, values and attitudes. For example, cultural attitudes towards hallucinations may affect both the frequency and content of such experiences (Al-Issa, 1977). Al-Issa hypothesises that the rationality of a culture and its distinction between reality and fantasy may result in different attitudes to hallucinations. In 'rational' cultures, a distinction is made between reality and fantasy, as a result many negative attitudes are held towards hallucinatory experiences. In less rational cultures, the distinction between reality and fantasy is more flexible, and as a result more positive attitudes are held towards hallucinations:

Individuals are encouraged to observe their hallucinations, imagery and other private events. Since these experiences are positively valued in relation to individual and group activities, they tend to be frequently noticed and communicated to others. ...It is possible that in these societies the high frequency of reported hallucinations may not be because more of them occur,

but because they come more often into the public domain through self-description (Al-Issa, 1977, p. 577).

In essence, Al-Issa is hypothesising that the acceptability of hallucinatory experiences within a culture may account for the reported higher frequencies of such experiences among different cultural groups. For example, within Maori culture it is acceptable to hear voices and have visions especially in relation to our tupuna. Thus, hallucinations either of an auditory, tactile or visual nature are phenomena that are more generally accepted within Maori society and are not necessarily viewed as a symptom of mental illness. In some instances they are phenomena that are valued among and by those who experience them. Sometimes hearing voices or seeing visions was regarded as a person in communion with atua and in some instances, given the correct whakapapa, this person may have even acquired tohunga status. In other instances, a Maori person who hears voices, especially those of his/her tupuna, is seen as possessing a very special gift and spiritual connections with his/her tupuna.

Many Maori people have similar 'paranormal' or hallucinatory experiences in everyday life. For example, a number of informants in Lyndon's study often heard voices calling out to them especially when they were away from home or prior to a loved one dying (Lyndon, 1983). Sensing an absent family members presence or being able to smell the odour or perfume of that person was also experienced by a number of Lyndon's informants (Lyndon, 1983). Such hallucinatory experiences were not seen as abnormal in the psychiatric sense, but a sign of spiritual awareness and intactness.

Because of the spiritual beliefs Maori people have, there is a greater acceptability of such hallucinatory experiences. Maori spiritual beliefs are discussed and thus passed on from one generation to the next. In contrast, Western society discourages such experiences and looks upon them negatively. The non-acceptability of such experiences within a culture may be a reason why the frequency of hallucinations could be lower in a Western population. However, no data exist to date that has compared the frequencies of hallucinations among Maori and non-Maori populations in New Zealand.

Another example of the differences in the acceptability of certain phenomena and the emphasis Maori people place on spirituality can be seen in the spiritual relationship Maori have towards the land. "...Everything about the Maori is related to the environment. Trees, stone, animals, birds are all connected" (Potaka-Dewes, 1986, p. 13). Because of the close affinity Maori people have with the environment, they are also open to and can sense the mauri and wairua of Papatuanuku and the forms of life that live with her. It is because of this spiritual relationship and the belief that everything has a mauri that certain phenomena such as hearing trees talking, sensing the wairua of a river or seeing the mauri in stones is more readily accepted in Maori society. Beliefs in the mauri of everyday objects and being attuned to the wairua of the environment deviate considerably from Pakeha norms, beliefs and values. In many instances, a person presenting with such beliefs and experiences may have been diagnosed by a Western diagnostician as delusional, hallucinating and in need of psychiatric care.

However, it may be that Maori people are more likely to present with certain types of 'delusions' or 'hallucinations' because of the greater acceptability and beliefs in 'paranormal'

events. In particular, delusions of control and persecution could be symptoms that occur more frequently among Maori patients because of the beliefs that are held towards tapu and the influence of atua. Hallucinations may occur more frequently among Maori patients because of the greater acceptability of such phenomena within Maori society.

Content of symptoms

Variability in the content of symptoms among different cultural groups is largely accepted and attributed to cultural pathoplastic factors. The term pathoplastic refers to those factors which "modify the basic manifestations of mental disorders to produce different symptom profiles in different cultural groups" (Adebimpe et al., 1982, p. 888).

Most immediately, the content of certain symptoms such as hallucinations and delusions is expected to vary from one culture to the next because of the different past experiences an individual encounters within a certain socio-cultural context (Al-Issa, 1977). Cultural teachings (Murphy, H.B.M, 1967), beliefs (Murphy, J.M, 1976), values and attitudes (Al-Issa, 1977) are other variables that have been hypothesised as influencing the content of symptoms. For example, the content of religious delusions is correlated with the religious teachings of a culture and a number of studies have found such a pattern (see Maslowski, 1988; Murphy, H.B.M., 1982; Murphy, H.B.M., et al., 1963).

Al-Issa (1977) also noted that delusions and hallucinations reflect the themes, concerns and ideas of their respective cultures. Further, Lenz (1964 cited in Dragnus, 1980) traced the content of delusions through decades of hospital records in Austria. The content of delusions changed according to the technological advances and ideas of the time. For example, in 1901

delusions centring around electric current first appeared, changing to robots in 1913 and radio waves in 1924.

In the context of New Zealand studies, Beaglehole and Beaglehole (1946) alluded briefly to hallucinations among a sample population of Maori patients admitted to hospital. They found that the large majority of hallucinations related to matters of religiously phrased persecution. For example, "the Ratana crowd put him in the hospital because God made him greater than Ratana" or "wicked Maori spirits drop on him like flies, crawl up his nose, saying horrible things, trying to destroy him" (Beaglehole & Beaglehole, 1946, p. 242). Other common themes of delusions and hallucinations related to anxieties over Maori lands, Maori welfare and Maori-Pakeha relations. According to Beaglehole and Beaglehole (1946) the psychopathology of the Maori patients reflected the "overt phrasing of the inner struggles and tensions from which the Maori suffers today" (p. 243). In terms of the considerable economic and social changes occurring in New Zealand at the time of this study, particularly in relation to Maori land, health and welfare, the content of symptoms among this sample seem to reflect some of the main themes and concerns of the time.

Cultural beliefs about the origin of hallucinations may also affect the occurrence and content of such hallucinatory experiences (Al-Issa, 1977). For example, traditional Maori looked to outside forces to explain any illnesses or sicknesses that occurred. Thus, sickness was explained in terms of outside forces or atua being in control. Traditionally the beliefs in tapu governed the social and cultural life of Maori. Whilst these beliefs are not as prevalent today or adhered to as stringently as traditional Maori, beliefs in tapu and the ability of atua to influence an individual still exist today. It is these beliefs in the origins of illnesses that may

be an influencing factor in the content of certain delusions and hallucinations among Maori people.

Taking a more specific example, delusions of control which are recognised as passivity feelings commonly experienced by schizophrenic patients (Landmark, Merskey, Cernovsky & Helmes, 1990), could be an experience that occurs more frequently among Maori because of their beliefs in the ability of outside forces being in control. Because of these beliefs, Maori may be more likely to refer to atua or spirits than may a person from a culture that does not hold such beliefs.

For example, according to Beaglehole and Beaglehole (1946) many Maori sicknesses either began or ended with delusions. The reason given for is that "the phenomenon of mental disease brings a catch of anxiety and fright to the Maori... which he tries to understand in terms of a world of obscure spirits' (Beaglehole & Beaglehole, 1946, p. 241). The Beaglehole's study of a sample population of Maori patients admitted to a psychiatric hospital supported this observation that Maori people tended to relate their sickness to outside influences (Beaglehole & Beaglehole, 1946). Although this study did not focus specifically on schizophrenia, it did highlight the significant cultural content of symptoms among Maori patients who demonstrated psychosis.

Sachdev (1989a) conducted a retrospective review of the records of 12 Maori patients diagnosed with schizophrenia. The presentation of the patients was fairly typical although 7 out of 12 cases had significant cultural content:

There was a frequent reference to Maori culture by patients with the suggestion that some of their experiences were not to be considered pathological as they were acceptable as normal in Maori culture (Sachdev, 1989a, p. 535).

In particular, Sachdev (1989a) noted the content of some delusions among Maori people involved Maori spirits. As discussed by Al-Issa (1977):

Considering the schizophrenic hallucinations as random, spontaneous, and unpredictable, with unknown causation, puts them beyond the control of the psychiatrist and the individual himself. By attributing them to spirits, social expectation of their content and occurrence tends to be prescribed (p. 576).

In essence, the content of delusions and hallucinations among Maori people may be a reflection of the spiritual beliefs Maori people hold towards their land, tupuna and own being. Because of these beliefs, Maori may be more likely to refer to paranormal phenomena than a person from a culture who does not hold such beliefs. Therefore, references to mate Maori, tapu, makutu and spirits may be more common among Maori psychiatric patients than a Pakeha patient because of the fact that the Maori patient has been brought up with these beliefs. Thus, the cultural teachings and subsequent beliefs may influence the content of certain symptoms.

In summation, the content of delusions and hallucinations among Maori patients may be more likely to have a cultural flavouring because of the beliefs Maori hold towards such 'paranormal' events. Whether or not content of the symptom is founded or unfounded (i.e.

perceived as such within Maori society), the content of the symptom and the frequency with which it presents could be linked to a person's cultural beliefs and attitudes.

Theory 2: Differences in symptomatology may be a result of the cultural beliefs, values, norms and attitudes of mental health professionals.

Culture not only influences how an individual expresses his/her psychopathology, it also influences how a person is perceived. In this instance, differences in symptomatology among different cultural groups may be a result of the assessment and interpretation of behaviour by mental health professionals. The influencing variable in the assessment of a patient and subsequent differences in symptomatology may be attributed to the cultural values, beliefs and attitudes of the assessing person.

Within New Zealand, for example, mental health professionals assess the presence of symptoms and diagnose primarily on the basis of Western philosophies and definitions of abnormal behaviour. As Rosenhan (1973 cited in Murphy, 1976) points out:

The perception of behaviour as schizophrenic is relative to context, for psychiatric diagnosis betrays little about the patient but much more about the environment in which an observer finds him. The presence of psychopathology is based on culturally derived and socially engrained stereotypes as to the significance of certain symptoms such as hearing voices (p. 1019).

Occurrence and frequency of symptoms

As discussed earlier, differences exist between Maori and Pakeha in the conceptualization of mental disorders such as schizophrenia. A Maori perspective takes a holistic approach which

incorporates spiritual and cultural factors as being vital in the presentation and etiology of mental disorders. This approach has often been disregarded by Western health professionals and represents the different value and beliefs systems within each culture. These different values and beliefs may affect the interpretation of behaviour and subsequent diagnosis of a person.

It is because of these different beliefs and values that a Maori patient may be perceived by a Western diagnostician as exhibiting more delusions, more hallucinations, more social withdrawal or more severe psychopathology. For example, take the following scenario:

A Maori woman is admitted to a psychiatric ward reporting visitations from Maori spirits. She believes she has broken a tapu and because of the influence of evil atua is going to die.

A Western clinician may interpret this belief as a delusion because according to his/her own background, this belief is not plausible. According to Western norms and values, the presence of such symptoms may be an indicator of a psychotic episode. Because of the perceived hallucinations and delusions, the Maori woman may then be allocated the diagnosis of a paranoid schizophrenic.²

According to Maori norms and values, the patient may be exhibiting culturally acceptable and/or understandable behaviour. The point to be made here is that the Western clinician

²It is acknowledged that other criteria such as length of illness are typically used before a diagnosis of schizophrenia is made.

needs to be fully aware of the fact that Maori hold and accept such beliefs.³ These beliefs cannot be ignored in the assessment and treatment of the person as there may be justifiable cause to their presentation. It may not be paranoid schizophrenia but a justifiable reaction to a transgression of tapu. Appropriate treatment would then ensure the spiritual dimensions of the person were dealt with. However, the presence and severity of psychopathology is often determined by the Western mental health professional who in the majority of instances is deemed as expert.

Cultural differences between a patient and clinician, such as behavioral mannerisms, use of language and styles of relating, may be misunderstood by a clinician from another culture. As a result, certain symptoms may be perceived as being present because of the cultural values and beliefs a clinician holds about what is considered abnormal behaviour. In other words, behaviour that is defined as abnormal in one culture is not necessarily deemed that in another culture.

For example, differences in the meaning and interpretation of body language among Maori and Pakeha has important implications in terms of assessing whether disturbances of affect are present in a patient. Metge and Kinloch (1978) discuss a number of differences between Maori, Samoan and Pakeha in terms of communication. Within Maori and Samoan culture, for example, it is considered rude to look directly at others when talking to others. Within Pakeha culture, direct eye contact is considered respectful and a sign that one is listening. A

³DSM III-R includes criteria for the diagnosis of schizophrenia which acknowledges that certain cultural beliefs and experiences may be difficult to distinguish from hallucinations and delusions. "When such experiences are shared and accepted by a cultural group, they should not be considered evidence of psychosis" (American Psychiatric Association (APA), 1987, p. 193).

Pakeha clinician assessing a Maori patient may then interpret a lack of eye contact as a sign of lack of confidence, depression or perhaps rudeness or shiftiness. Even the Maori custom of ruru (handshake), hongī (greeting through pressing noses) and kihi (kiss) when meeting someone may be interpreted as inappropriate affect although it is doubtful whether many Maori would extend this practice to a person from a different culture and within a Pakeha setting. However, it is important to note that the interpretation of behaviour, especially body language is subject to the bias of the observer's own repertoire of acceptable behaviour. Thus, the observer's cultural values and beliefs influence how a person is perceived.

Perceived disturbances of affect may in some instances be a reflection of the social interaction between a psychiatrist and patient, especially if they are from different cultural backgrounds. Poor rapport may merely be a reflection of the distrust a Maori patient has towards Pakeha medicine and institutions. Indeed, the manner in which a psychiatric assessment is conducted may serve to alienate a Maori patient. For example, it is generally accepted that before starting an interview, some time is spent in gaining rapport. The manner in which this rapport is gained differs between Maori and Pakeha mental health workers. From a Maori perspective it is important to know who this person is in relation to his/her whanau and tupuna. Therefore, some time is spent in finding out where he/she is from and finding connections. In many instances it is also important to ask a Maori patient whether he/she would like a karakia to be said before the session starts. This is perceived as protecting and guiding both the patient and mental health worker. However, many assessment interviews are conducted by clinicians who are not aware that these practices could be helpful in putting a Maori patient more at ease, thereby encouraging rapport and trust. Because of the mono-cultural

manner in which an interview is conducted, the Maori patient may display certain behaviours which the interviewer perceives as disturbances of affect.

Lack of insight is a common phenomenon recognised in people with a diagnosis of schizophrenia. However, the person determining whether a person is exhibiting lack of insight is doing so based on his/her own cultural values and standards. For example, a Western clinician may determine that a Maori patient exhibits lack of insight into his/her condition because of the fact the patient does not talk about his/her thoughts and feelings in the same manner as a Pakeha patient. There are differences in the way that Maori people express thoughts and feelings. As cultural practice indicates, there is often no need to talk about one's thoughts and feelings as 'the feelings speak for themselves' in the actions of the person (Durie, 1985b).

In some instances, lack of insight may be inferred because the patient does not acknowledge that hearing voices is a problem. It could be that the Maori patient who hears voices has been brought up in an environment that has condoned and accepted such occurrences. Therefore when the clinician inquires whether the patient has had any unusual experiences lately, the Maori patient may reply no because it is not perceived as abnormal or unusual. Alternatively, a Maori patient may indeed try and conceal hearing voices, knowing fully well that the Pakeha clinician is likely to assume that he/she needs psychiatric assistance. However, to the Maori patient and the patient's family, the voices may be an acceptable phenomenon.

Studies have indicated that there exist differences in the way psychiatric observers across cultures detect and assess symptoms and in their subsequent diagnostic attribution. For

example, a number of studies have highlighted that blacks are more likely to be misdiagnosed with schizophrenia rather than bipolar disorder (Bell & Mehta, 1980, 1981; Jones & Gray, 1986; Mukherjee, Shukla, Woodle, Rosen & Olarte, 1981; Raskin, Crook & Herman, 1975). This misdiagnosis has been on the basis of clinicians focusing on the presence of hallucinations and delusions in order to diagnose schizophrenia and on the belief that such symptoms occurred only in patients who had schizophrenia (Bell & Mehta, 1980).

The misdiagnosis of black patients because of the presence of delusions and hallucinations highlights how the beliefs of the time influenced the diagnosis of black patients. It may be that blacks and whites express psychopathology in different manners but diagnosticians assume they are the same. Alternatively, it may be that blacks were experiencing something different from schizophrenia, but because of the emphasis on Western diagnostic labels and symptoms they were given the label of schizophrenia.

Among Maori patients, it may be that perceived symptoms of schizophrenia are in fact expressions of culturally defined behaviour. The construct of whakama and the behaviours associated with whakama is one such state that may be misdiagnosed by mental health workers as schizophrenia. Whakama is often referred to as ashamed or shy. It is used to describe a state of feeling and various behaviours associated with it (Metge & Kinloch, 1978). This feeling state usually occurs when a person feels dishonoured in the eyes of others. It also refers to a sense of feeling inadequate, self-doubting or inferior (Sachdev, 1990). As Sachdev (1990) discusses:

The unease that is whakama is present because the person evaluates himself to be in a disadvantaged position in the group. Something has generally happened to decrease his mana which has not been restored (p. 435).

Because whakama involves the product and expression of lowered mana it also has spiritual implications:

For Maori mana is a spiritual force or at least has spiritual implications, whakama cannot be understood purely as a psychological problem. Maori see it as an illness with a spiritual dimension, an unease which affects the whole person, body, mind and spirit (Metge, 1986, p. 78).

The behavioural manifestations of whakama include blocking, withdrawal, *pouri te ngakau*, flight and suicide (Sachdev, 1990). Blocking and withdrawal are relevant symptoms in terms of the assessment and diagnosis of schizophrenia. It may be that many of these symptoms are being interpreted as symptoms of schizophrenia because of the cultural beliefs and values of the assessing diagnostician who does not recognise different cultural conceptualizations and manifestations of illness.

Blocking is the most common manifestation of whakama in contemporary Maori society and is referred to as 'a negation of normal activity, a blocking of normal cognitive processes and, a lack of expression of affective responses' (Sachdev, 1990, p. 436). A person who is experiencing whakama may appear to have 'switched off', be dumbfounded, and say very little. Certain behavioural manifestations of anxiety such as restlessness, nervous laughter and stereotyped movements can also be seen in whakama (Sachdev, 1990).

Withdrawal is another phenomena involved in whakama. This is primarily due to the perceived loss of mana. The person who is whakama may withdraw from all social contact. Communication with others is reduced to a minimum. Usually, however, appetite and sleep remain the same (Sachdev, 1990).

The behaviours inherent in whakama are usually not considered abnormal in a psychiatric sense although 'the person suffering from it is considered to be weak and vulnerable' (Sachdev, 1990, p. 439). The manifestations of whakama highlights how different behaviours are interpreted in terms of seriousness of ill-health. Whilst the person who is experiencing whakama is considered to be undergoing some emotional turmoil, it is not considered abnormal nor is it seen as requiring hospitalization. Rather, behaviours are viewed as a socially understandable and acceptable response to a loss of mana and certain procedures are needed.

It is highly likely that many manifestations of whakama are being misdiagnosed as a psychiatric disorder. For example, Sachdev (1990) discusses how the behavioural response of withdrawal in whakama may be confused with schizophreniform illness and depression. However, differences exist in that manifestations of whakama do not typically include thought disorder and hallucinations which are commonly associated with schizophrenia. Furthermore, other motor disorders associated with schizophrenia like posturization and ambitendence are also absent (Sachdev, 1990). According to Sachdev (1990) the course of whakama also differs from other psychiatric disorders in that it tends to end abruptly without medical intervention and with no residual symptoms. The diagnosis of a person experiencing whakama as having a Western psychiatric disorder is based on ethnocentric ideologies of what symptoms are

considered indicative of a psychiatric disorder and on the belief that Western psychiatric labels fit across all cultures.

In summary, experiences identified as symptoms among different cultural groups could be attributed to the cultural beliefs, values and attitudes of a clinician assessing a patient. These cultural variables may have an effect on whether symptoms such as disturbances of affect, lack of insight, rapport, delusions and hallucinations are perceived first, as being present and second, whether such behaviour is abnormal and indicative of a mental disorder.

Conclusion

In conclusion, it has been argued that differences in the expression of schizophrenia between different cultural groups may be attributable to the cultural beliefs, values and attitudes of the identified patient and/or the person assessing the patient. It has been argued that certain Maori beliefs, values and attitudes may have an influence on the content and frequency with which certain symptoms present among Maori people. The spiritual beliefs Maori people hold towards the environment, their own being and the influence of atua, may in turn influence the likelihood and frequency with which Maori experience either hearing voices, or seeing visions, or beliefs that they are under the control of outside influences.

It has also been argued that the perception of behaviour as abnormal is subject to the influence of cultural values and beliefs. This examination has highlighted how many of the symptoms commonly recognised in schizophrenia such as hallucinations, delusions and disturbances of affect are accepted in Maori society in various contexts and are not necessarily indicative of a psychiatric disorder. However, because of the cultural values and

beliefs of the assessing diagnostician, mono-cultural interpretations of behaviour are made. Therefore, differences in the symptom presentation of different cultural groups could also be attributed to the cultural values and beliefs which mould one's perception of what is considered abnormal behaviour.

Summary

This review has looked at the literature concerning symptomatology of schizophrenia across different cultures. Whilst debate continues as to whether the expression of schizophrenia is similar or different among different cultures, this review has emphasised that although schizophrenia exists in some form across different cultures, there are certain differences in the frequency and content of symptoms.

Chapter 2 highlighted the differences that exist between Maori and Pakeha in the conceptualization of mental health and illness. Maori people hold many spiritual beliefs about their own being and causes of illness which are not accepted within Western society. It has been argued that many of these cultural beliefs, attitudes and values still exist today.

Chapter 3 of the review discussed two theories that have been put forward regarding the relationship between culture and the expression of psychopathology. The first theory hypothesises that cultural beliefs, values and attitudes influence the expression of psychopathology across cultures. It is these differing beliefs, values and attitudes that may account for differences in the occurrence, frequency and content of symptoms across cultures. The second theory postulates that cultural beliefs, values and attitudes may influence the interpretation of behaviour as abnormal and indicative of psychopathology. These variables may also account for the differences in reports of symptomatology across cultures.

The present study

The present study is based on previous overseas research that has attempted to look at whether different cultural groups experience psychopathology in the same manner and it has evolved from the lack of similar research within New Zealand. Specifically, the present study focuses on a comparison of presenting symptomatology of Maori and Pakeha patients diagnosed with schizophrenia.

The main objectives of the present study are:

1. to determine whether any differences exist between Maori and Pakeha in the symptom presentation of schizophrenia
2. to relate any differences found to cultural variables.

On the basis of the previous chapter, which argued that certain beliefs and values within Maori society may influence the content and frequency of certain symptoms, the hypotheses have been formulated to test the relationship between ethnicity, cultural variables and symptom presentation:

Hypothesis 1

That there will be differences between Maori and Pakeha in strength of paranormal beliefs and amount of Maori knowledge. More specifically, Maori participants will score higher on the Test of Maori Knowledge (TMK) and Revised Paranormal Beliefs Scale (PBS-R). It is also hypothesised that scores on two subscales of the PBS-R, Spiritualism and Traditional Religious Beliefs will be significantly higher for Maori than Pakeha participants.

Hypothesis 2

There will be differences between Maori and Pakeha in the frequency of presenting symptoms. More specifically, Maori participants will present with a higher frequency of hallucinations, delusions of persecution, control and alien forces, and subcultural delusions and hallucinations as derived from scores obtained from the PSE.

Hypothesis 3

Paranormal beliefs and Maori knowledge will be influencing variables in the relationship between ethnicity and presenting symptomatology; that is, differences in the frequencies of symptom clusters between Maori and Pakeha will vary in relation to scores on the PBS-R and/or scores on the TMK.

It is hoped that the study of symptom presentation among Maori and Pakeha will provide some insights into how these groups experience psychopathology. It is envisaged that a wider understanding of how cultures experience mental disorder and the extent to which culture affects presenting symptoms can thus be gained.

The following chapters set forth the method, findings and discussion of the present study which compared presenting symptomatology of Maori and Pakeha patients diagnosed with schizophrenia.

CHAPTER 4

METHOD

Design

In order to test the hypotheses outlined in Chapter 3, a comparative cross-sectional study was designed. Participants with a primary diagnosis of schizophrenia were interviewed using a variety of instruments aimed at eliciting information about the following:

- symptom presentation (PSE, Wing et al., 1974),
- beliefs in paranormal phenomena (Revised Paranormal Belief Scale (PBS-R), Tobacyk, 1988),
- extent of Maori cultural knowledge (Test of Maori Knowledge (TMK), Thomas, 1988), and
- extent of Maori cultural identification (Provisional Maori Cultural Identity Questionnaire (PMCIQ)).

Participants

The sample of participants given a primary diagnosis of schizophrenia was drawn from mental health services within the Mid Central Health Limited and Good Health Limited areas. These two Crown Health Enterprises (CHE) encompass the region held under the previous Manawatu-Wanganui Area Health Board which was abolished on 1 July 1993. The mental health services within the two CHE's that participated in the study included Manawaroa, Continuing Care and Northcote Community Mental Health (Mid Central Health Limited) and Lake Alice, National Security Unit, Standford House, Te Awhina and Continuing Care (Good Health Limited).

Information on the distribution of Maori and Pakeha patients diagnosed with schizophrenia within the Manawatu and Wanganui area is hard to obtain. National statistics indicate that in 1991 first admissions of patients diagnosed with schizophrenia within the Manawatu-Wanganui area totalled 20. This represented 8.3% of the total first admission population in New Zealand who received a diagnosis of schizophrenia in 1991. The number of patient readmissions with a diagnosis of schizophrenia within the Manawatu-Wanganui area accounted for 8.6% of the total readmission population diagnosed with schizophrenia (Department of Health, 1993).

These statistics are derived from data obtained from Lake Alice, Te Awhina and Manawaroa. Because the mental health data does not include information from community based programmes, the prevalence of schizophrenia within the Manawatu-Wanganui area may be under-estimated. Furthermore, on the basis of these statistics alone, it is difficult to determine how representative the sample drawn from the Manawatu-Wanganui region is of the total schizophrenia population.

The inclusion criteria for the study accepted those people who had presented to mental health services with a primary diagnosis of schizophrenia and experienced recent active symptoms prior to contact by the researcher. Participants who did not meet these initial criteria were excluded from the study. Cultural identification of each participant was determined by those who self-identified as Maori or European New Zealand. Both female and male participants were sought.

In total, 30 people were interviewed with the majority of participants coming from within the Good Health Limited Area.

Procedure

Recruiting participants

After written approval was gained from the Massey University Ethics Committee and Manawatu-Wanganui Area Health Board Ethics Committee, approval was also obtained from the Managers of the Mental Health Services for Mid Central Health Limited and Good Health Limited. Following this, the clinical managers of the mental health services within these two areas were contacted to inform and gain co-operation about the study. The researcher also attended a number of multi-disciplinary team meetings where the exact nature of the research and procedure to be used were discussed more fully.

Possible participants for the study were identified by the clinical managers of each unit. The identified patient was then approached by the manager or primary nurse and asked whether the researcher could approach him/her to talk about the study. Workers making this initial approach were briefed on what was required in the request. They were also asked not to discuss the patient's given diagnosis with the patient for ethical reasons. If participants agreed to meet the researcher, an appropriate time was made for the first meeting.

The first meeting with possible participants was conducted in the units. The researcher was introduced to the patient either by the manager or primary nurse. The researcher then informed the patient about the study and what was required as well as discussing issues of confidentiality and the patients rights when participating in the study (see Appendix A for

information sheet and consent form). If the patient agreed, an appropriate time was then made for the interview. All participants were judged able to provide informed consent.

Training Sessions

Prior to interviewing patients, the researcher completed a Comprehensive Management of Mental Disorders Course in 'Effective Assessment of Mental Disorders' run by Professor Ian Falloon, Department of Psychiatry and Behavioural Science, Auckland. Training in the administration and scoring of the PSE was undertaken.

Format of interviews/data collection

Interview sessions began by discussing the study with the participant and obtaining written consent. The researcher also identified to the patient a support person within the unit who could be contacted if concerns arose from the interview.

Demographic information was first obtained. Following this, participants were interviewed using the PSE. Participants were then required to answer two self-report questionnaires: the PBS-R and TMK. Maori participants were also asked to answer the PMCIQ. The majority of participants opted for the researcher to read out the questions to the self-report measures and write down their answers.

All interviews were conducted by the researcher. With the exception of the National Security Unit and Stanford House participants, all interviews were conducted without the presence of unit staff.

A number of the interviews were not able to be completed in one session. In this case, the interview was completed within two days of the initial interview. The length of sessions ranged from 15 minutes to an hour and a half.

Research Instruments

Four instruments were used. These included the PSE (Wing et al., 1974), PBS-R (Tobacyk, 1988), TMK (Thomas, 1988) and the PMCIQ (the latter administered only to the Maori participants).

Present Status Examination (PSE)

The PSE is a structured clinical interview which is designed to elicit and record the presence or absence of psychiatric symptoms (see Appendix B). The main purpose of the schedule is to provide a reliable and standardised method of examining the present mental status of a person and describing which symptoms and syndromes are present (Wing et al., 1974).

The PSE (9th Edition) consists of 140 rateable items with specific questions and cut off points connected to each item or symptom. The PSE also provides a comprehensive glossary of definitions outlining which criteria are needed in order for a symptom to be rated as present. Specific guidelines are also set for rating the severity of a symptom. The PSE is intended only to cover symptoms experienced one month or less prior to the interview.

According to Wing et al (1974), the PSE has maintained high levels of intra-observer reliability of ratings of individual items. The IPSS tested intra-centre reliability by having 2 psychiatrists simultaneously make ratings in every 6th interview that was conducted. Item

reliability was determined by using an intraclass correlation coefficient which ranged from 0.43 to 0.97 with a median of 0.77 (Wing et al., 1974).

Levels of inter-centre reliability using different forms of analysis were somewhat lower. Inter-centre reliability was assessed by using videotaped interviews held in different countries which were then required to be rated from psychiatrists in all centres. Intraclass correlation coefficients for inter-centre reliability ranged from .00 to .87 with a median of 0.57 and for inter-centre reliability interviews, .00 to .84 with a median of .45 (WHO, 1975).

Low levels of reliability and repeatability were found in relation to ratings made on observed behaviour between centres (WHO, 1975; Wing et al., 1974).

Based on these extensive studies WHO (1975) concluded:

1. The PSE interview can be administered satisfactorily in various cultures and in widely different psychiatric centres.
2. Intra-centre reliability among interviewers using the PSE was high. Inter-centre reliability was high enough to encourage cross-cultural comparisons of data (p. 27).

One of the major criticisms of the PSE has been the lack of research into its validity across cultures (Fernando, 1991). Many of the items and definitions of behaviour subsumed in the PSE are based on Western-European definitions of abnormal behaviour. There has been little questioning of the applicability of these constructs across cultures.

Gillis, Elk, Ben-Arie and Teggin (1982) conducted a study among 120 Xhosa speaking psychiatric patients using a Xhosa translated version of the PSE. They found a number of difficulties in relation to the translation of concepts. They also noted that many of the difficulties in administering the PSE to a different cultural group arose from the different world views that existed. Cultural beliefs among Xhosa speaking patients impacted on the types of responses they were likely to give in relation to symptoms such as thought reading and persecutory delusions. Despite these difficulties the authors conclude, "the experiential events of psychiatric disturbance as defined by the PSE exist in Xhosa speaking patients and it is a valid instrument" (p. 147).

Despite lack of research into the validity of the PSE, it has been used in numerous overseas research, in particular the International Pilot Study of Schizophrenia (WHO, 1974, 1975, 1979) and Determinants of Outcome of Severe Mental Disorders (Jablensky et al., 1992) involving 9 and 10 countries respectively. The 9th edition of the PSE represents the modifications suggested through its world wide use in research and assessment.

The primary reason for using the PSE in the present study pertained to its usage internationally in the assessment of and research into schizophrenia. The PSE has proved to be a highly efficient and standardised instrument in assessing the present mental status of psychiatric patients world-wide. In a comparative study such as the present study, the PSE was viewed as an excellent tool to aid in the description and comparison of psychopathology among different cultural groups. A further consideration in using the PSE pertained to its recognition of how cultural factors may influence the expression and definition of

psychopathology. Lopez and Nunez (1987) cited the PSE as having the highest number of references (6) to cultural factors within the 11 interview schedules they reviewed.

Revised Paranormal Belief Scale

The PBS-R (Tobacyk, 1988) is a 26 item scale which is used to measure the degree of belief in paranormal phenomena (see Appendix C). The scale provides a measure of degree of belief in seven dimensions; Traditional Religious Belief, Psi/Psychokinesis, Witchcraft, Superstition, Spiritualism, Extraordinary Life Forms and Precognition. Respondents indicate degree of belief for each of the 26 items by using a 7 point rating scale which ranges from strongly disagree to strongly agree.

Levels of reliability are reported as being high. Test-retest reliability over a four week interval of the full scale was .92, with the subscale obtaining the following levels of test-retest reliability; Precognition .81, Witchcraft .93, Extraordinary Life Forms .91, Traditional Religious Belief .95, Psi .71, Superstition .89 and Spiritualism .91 (Tobacyk, 1988).

The PBS-R was used in the present study to determine the degree of belief participants had in paranormal phenomena. Although existing reliability data are based on a non-psychiatric population (Tobacyk, 1984; Tobayck & Mitchell, 1987; Tobacyk, Miller & Jones, 1984), the PBS-R was still seen as an effective instrument in assessing paranormal beliefs.

Test of Maori Knowledge Revised

The TMK is a multi-choice questionnaire developed by Thomas (1988) as an instrument to assess an individual's knowledge of Maori language and cultural practices (see Appendix D).

In its original form it consisted of 120 items and was first administered to a New Zealand High School population. A revised version included 40 items and 3 supplementary questions inquiring about level of cultural contact. From these preliminary studies it was found that a mean score of about 12 out of 40 indicated 'real' knowledge of about two items. The University sample of first year Maori language students had a mean score of 29.69 (SD = 6.50).

The results from the study conducted among 214 Form 1 - Form 4 students revealed an alpha reliability coefficient for the scale of .88. Scores from the 40 item test were also correlated with responses to questions concerning level of contact with Maori settings. Students who had more contact with Maori settings scored higher than those students who had minimal contact. This included both Maori and Pakeha students. Differences were also noted between rural and urban students. Based on these findings Thomas (1988) concludes that the TMK is measuring knowledge of Maori culture and language, and the scores are also related to exposure to Maori cultural settings.

Provisional Maori Cultural Identity Questionnaire

The PMCIQ was developed in the present study to be used as a gauge of a Maori person's level of cultural affiliation and identification (see Appendix E). The questionnaire was developed from a Maori Health Status Questionnaire used in a pilot study and developed by the researcher to test the applicability of such a questionnaire. Certain questions used in this questionnaire were also obtained from a Maori cultural identity scale developed by Kiri and Mihi Ratima which was used for research into Maori health.

The PMCIQ includes questions about ethnic affiliation, iwi and marae affiliation, perceived competency in te reo Maori, involvement within the Maori community and identifying which aspects of a person's Maori heritage had been passed on.

Validation of the questionnaire was obtained by presenting the questionnaire at a Maori Health Researcher's hui run by Manawa Hauora where participants were also asked for feedback and suggestions about its applicability.

The primary purpose of using such a questionnaire in the present study was to find out how strongly a person identified as being Maori and participated in Maori matters. In essence, the questionnaire was used to differentiate between mere ethnic identity versus cultural identity. This difference is very important when comparisons are being made between different ethnic groups and inferences are made about cultural influences.

Data Analysis

The first process of data analysis involved recoding the data. The PSE consists of 140 symptoms which are rated according to the presence or absence of symptoms and levels of severity. For ease in the data analysis process, the data were recoded according to the presence or absence of symptoms and omitted levels of severity. Therefore, a symptom that may have been rated as severe (i.e.=3) was recoded as present (=1).

The second process of data analysis involved grouping the 140 PSE symptoms into groups of symptom clusters. These symptom clusters were derived from the syndromes outlined in the PSE manual (Wing et al., 1974) and psychopathological profiles using PSE symptoms in

the IPSS and DOS studies (Jablensky et al., 1992). See Appendix F for the specific symptoms used to form the symptom clusters for the present study.

Analysis of data was conducted using the Statistical Package for Social Sciences SPSSPC+ computer programme (Norusis, 1988). Descriptive statistics, cross-tabulations, independent t-tests, correlations and ANCOVA analyses were used in the analysis of results.

1. Descriptive statistics summarising the socio-demographic information obtained were computed. This included percentages, means and standard deviations.
2. Independent t-tests were used to test differences between groups on the TMK and PBS-R. Further t-tests were calculated to establish whether there were any significant differences in the presenting symptomatology of Maori and Pakeha participants.
3. Correlations, using Pearsons r , were used to test the strength of relationships between frequencies of symptoms and scores on the PBS-R and TMK.
4. ANCOVA's were computed to establish whether paranormal beliefs and Maori knowledge were influencing variables in the frequencies of presenting symptoms among Maori and Pakeha participants.

CHAPTER 5

RESULTS

Descriptive statistics of the sample are presented first. Also included are results from the PMCIQ which were not used in the main analyses of hypotheses but provide information on the level of cultural identity and cultural involvement of the sample of Maori participants in the present study. Finally, independent t-tests, correlations and ANCOVA analyses are presented to test the hypotheses stated in Chapter 3.

Descriptive statistics of the sample

Diagnosis

All participants had been identified prior to interviewing as having a primary diagnosis of schizophrenia.

Ethnicity

The sample consisted of 30 participants. Sixteen participants self-identified as Pakeha and 14 self-identified as Maori.

Sex distribution

There were 22 (73.3%) males and 8 (26.6%) females. Within the Maori group, males outnumbered females. There were 13 (92.8%) Maori males and 1 (7.2%) Maori female. Within the Pakeha group, the distribution was more even with 9 (56.2%) Pakeha males and 7 (43.8%) Pakeha females.

*Age distribution**Table 1 Age distribution by ethnicity*

Age	Maori	Pakeha
15 - 24	4	2
25 - 34	7	5
35 - 44	2	6
45-54	1	3
Total	<u>n</u> = 14	<u>n</u> = 16

As shown in Table 1, the majority of participants were in the 25-35 year bracket. The Pakeha sample tended to consist of older people with the average age being 36 years and 29 years for the Maori sample.

Marital status

Most of the participants were single. There were 23 (76.7%) single participants, 3 (10%) married/defacto participants and 4 (13.3%) divorced participants.

*Place of current admission**Table 2 Place of admission by ethnicity*

Place of admission	Maori	Pakeha	Total
National Security Unit	6	2	8
Continuing Care, PN	-	5	5
Standford House	2	2	4
Lake Alice, Unit 4	4	-	4
Lake Alice, Kaingaora	2	1	3
Lake Alice, Unit 2	-	3	3
Te Awhina	-	1	1
Manawaroa	-	2	2
Total	<u>n</u> = 14	<u>n</u> = 16	<u>N</u> = 30

Table 2, shows the place of current admission of participants. A reasonable proportion (26%) of the present sample came from the National Maximum Security Unit (NSU).

The majority of Maori participants were currently admitted at the Forensic units (NSU, Stanford House and Kaingaora). A total of 10 (71%) Maori participants came from the Forensic units as compared to 5 (31.25%) Pakeha participants.

Education

Table 3 Education by ethnicity

Form level	Maori	Pakeha	Total
2	1	-	1
3	2	-	2
4	3	3	6
5	8	6	14
6	-	5	5
7	-	-	-
University	-	2	2
Total	<u>n</u> = 14	<u>n</u> = 16	<u>N</u> = 30

As shown in Table 3, nearly half of the participants reached 5th form level in education. Pakeha participants attained higher levels of education than Maori participants. Seven (43.7%) Pakeha participants went further than the 5th form, whereas none of the Maori participants went further than the 5th form. Six (42.8%) Maori participants did not go on to 5th form as compared to only 3 (18.8%) Pakeha participants who did not go on to 5th form.

Provisional Maori Cultural Identity Questionnaire (PMCIQ)

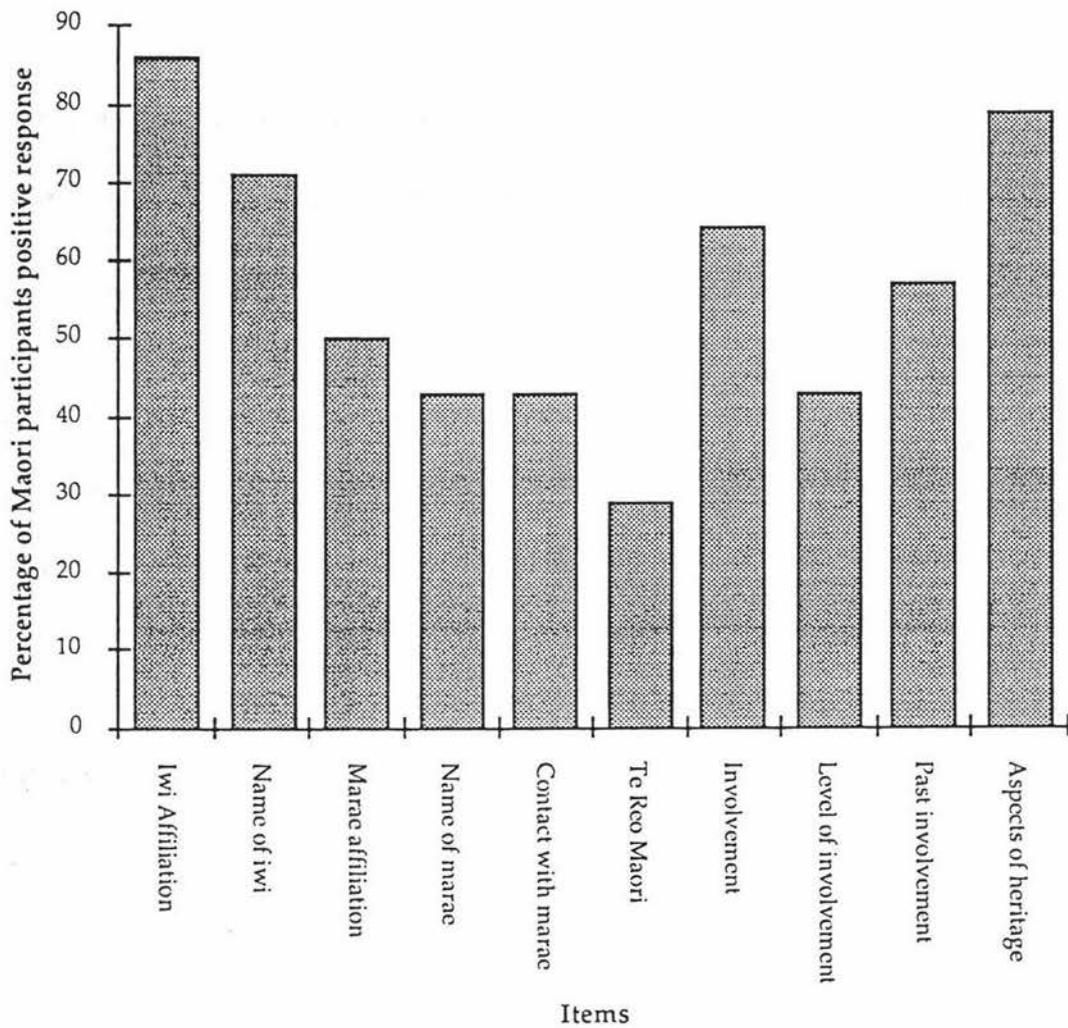


Figure 1 Percentage of positive responses on the Provisional Maori Cultural Identity Questionnaire

Results from the PMCIQ, as shown in Figure 1, indicated that the Maori sample had a high level of identification and participation in aspects of Maori culture.

Eighty-five percent reported they identified with an iwi, with 71% of participants being able to name their iwi. Only 50% of participants identified with a marae and 42% were able to

name their marae. In the last 6 months 57% had not visited their marae or any other marae whereas 43% had visited a marae between 1 to 5 times in the last 6 months.

Maori participants reported having a limited ability to korero (speak) Maori, with 71% of participants stating either that they could not korero Maori at all or that they could understand some Maori but not korero Maori.

Sixty-four percent of the participants were currently involved with the Maori community in some manner. Of these participants, 42% had moderate to extensive involvement. A large proportion of those who were involved belonged to Maori cultural groups. Over half (57%) of the Maori participants had been involved in the Maori community in the past.

The majority of participants (79%) were able to identify two or more aspects of their heritage that had been passed on to them. Whakapapa (genealogy) was the primary aspect that had been passed on to participants.

Scores on these questions were then added together. The mean score for the group was 15.64, SD = 2.65. On average, Maori participants achieved high scores on 7 out of 10 questions looking at aspects of cultural identity and involvement.

In order to test the relationship between Maori identity and involvement, and Maori knowledge, a correlation using Pearsons r was conducted. There was a significant relationship between scores on the PMCIQ and TMK ($r = .59, p < .05$).

Paranormal beliefs and Maori knowledge between Maori and Pakeha

Independent t-tests were conducted to test for differences among Maori and Pakeha scores on the TMK, PBS-R and subscales of the PBS-R. The assumptions for all t-tests were met (see West, 1991).

TMK

Maori participants had a significantly higher score on the TMK than Pakeha participants (Maori mean = 24.07, SD = 7.96; Pakeha mean = 12.44, SD = 4.58; $t(20.15) = -4.82$, $p < .001$).⁴

PBS-R

Table 4 Mean scores and standard deviations for Maori and Pakeha participants on Paranormal Belief Scale and sub-scales

Scales	Mean Maori	SD	Mean Pakeha	SD
Total Paranormal Belief	117.92	14.05	117.40	29.12
Traditional Religious	6.12	0.75	6.05	1.25
Spiritualism	4.65	1.05	4.16	2.01
Witchcraft	4.69	1.67	4.79	1.55
Precognition	4.52	1.04	4.52	1.48
Extraordinary Life	4.31	1.41	4.13	1.54
Psychokinesis	4.12	1.27	4.32	1.92
Superstition	2.87	1.27	3.75	1.76

⁴These figures are based on the separate variance estimate of t. Unless otherwise stated, figures for remaining t-tests are based on pooled variance estimates.

Table 4 shows the means and standard deviations for the total scores on the PBS-R and subscale scores. Mean scores between the two groups were similar. No significant differences were found between Maori and Pakeha on the PBS-R and subscales using independent t-tests.

Frequencies of symptom clusters between Maori and Pakeha

Table 5 Means, standard deviations and t statistic for Maori and Pakeha frequencies of presenting symptoms

Symptom clusters	Mean Maori	SD	Mean Pakeha	SD	t
Hallucinations	2.36	1.44	0.69	1.08	-3.54**
Delusions	8.21	2.63	5.71	3.07	-2.31*
Subcultural delusions and hallucinations	1.00	0.78	0.31	0.60	-2.71*
Delusions of persecution control and alien forces	1.00	1.18	0.63	0.96	-0.46
Delusions of reference	0.43	0.65	0.31	0.48	-0.56
Grandiose and religious delusions	0.64	0.84	0.12	0.34	-2.15*
Sexual and fantastic delusions	1.14	1.17	0.81	1.04	-0.82
Depressive delusions and hallucinations	0.64	0.63	0.25	0.58	-1.78
Thought disorder	0.92	0.79	1.13	1.20	0.52

* p < .05

** p < .01

Table 5, shows the means and standard deviations of symptoms rated as present between Maori and Pakeha participants for the specific symptom clusters of interest. Maori participants

had a higher mean number of symptoms rated as present in all symptom clusters except for thought disorder.

Independent t-tests revealed that Maori had significantly higher frequencies of symptoms rated as present for hallucinations ($t(28) = -3.54, p < .001$), delusions ($t(26) = -2.31, p < .05$), subcultural delusions and hallucinations ($t(28) = 2.71, p < .05$), and grandiose and religious delusions ($t(16.71) = -2.15, p < .05$).⁵

Symptom presentation, ethnicity, paranormal beliefs and Maori knowledge

Correlations using Pearsons r were conducted and revealed significant relationships between scores on the TMK and subcultural delusions and hallucinations ($r = .54, p = .001$), and nearly significant relationship for the TMK and hallucinations ($r = .30, p = .051$).

When scores on the PBS-R and two subscales Spiritualism and Traditional Religious beliefs were correlated with symptom clusters, only Total Paranormal Beliefs and thought disorder ($r = .53, p < .01$) and Spiritualism and thought disorder ($r = .51, p < .01$) were found to be significant.

ANCOVA's, taking into account the influence of hypothesised covariants (Total Paranormal Beliefs, Spiritualism, Traditional Religious Belief and Maori knowledge), were conducted. When the main effects of ethnicity were adjusted for covariants, significance levels did not change substantially for hallucinations, delusions and grandiose and religious delusions.

⁵Figures for grandiose and religious delusions based on separate variance estimate of t .

The main effect of ethnicity on subcultural delusions and hallucinations was no longer significant when adjustments were made for the TMK ($F = 1.302, p > .05$). However, the covariant relationship between TMK and subcultural delusions and hallucinations was significant ($F = 8.168, p < .01$). Significance levels did not change substantially for the remaining covariables.

CHAPTER 6

DISCUSSION

The main objective of the present study was to investigate whether there were differences between Maori and Pakeha schizophrenic patients in presenting symptomatology and whether any of these differences could be accounted for by cultural variables such as strength of paranormal beliefs and level of Maori knowledge. Differences between Maori and Pakeha in paranormal beliefs, Maori knowledge and presenting symptoms were investigated. The relationship between ethnicity, paranormal beliefs, Maori knowledge and symptom presentation was also explored.

Paranormal beliefs and Maori knowledge

In order to test whether paranormal beliefs and Maori knowledge were influencing variables in the symptom presentation of schizophrenic patients, it was necessary to test for differences between Maori and Pakeha in strength of beliefs and levels of Maori knowledge.

In support of the first hypothesis, levels of Maori knowledge were found to be significantly higher among Maori participants. However, no differences were found between Maori and Pakeha in strength of paranormal beliefs or in responses to the spiritualism and traditional religious beliefs subscales.

Of particular interest is the high level of Maori knowledge among Maori participants. A University sample of first year students taking Maori language at Waikato University who completed the TMK (Thomas, 1988) had a mean score ($M = 29.69$, $SD = 6.5$) only slightly

higher than that of the Maori participants in the present study ($M = 24$, $SD = 7.5$). Similarly, the mean score obtained by the Maori participants was double that of a sample of Maori urban 11 to 16 year old students ($M = 12.33$, $SD = 4.45$) (Thomas, 1988).

Taking into account the lower levels of education among the Maori participants, it would seem that this 'knowledge' was not gained through the education system (as possibly in the University sample), but elsewhere. Information obtained from the PMCIQ indicated that over half of the Maori sample were currently involved with the Maori community in some manner and that nearly half of the participants had moderate to extensive involvement despite their current admission. The primary form of involvement seemed to come from participation in Maori cultural groups. This supports a common speculation among Maori health workers in relation to Maori prisoners (and perhaps to Maori psychiatric patients) that Maori begin to learn about their Maoritanga (including knowledge) whilst incarcerated or admitted.

Thomas (1988) also found that levels of Maori knowledge were positively correlated with amount of cultural contact. Cultural contact variables in his study included attending marae activities, taking Maori language or culture courses and being a member of a Maori cultural group. Similar findings were found in the present study. A positive correlation was found between level of cultural identity and involvement (as derived from the PMCIQ), and amount of Maori knowledge. This would suggest that Maori knowledge may be a tentative indicator of the extent to which a Maori person identifies and is involved with his/her Maoritanga.

In the present study, results from the TMK and PMCIQ provide a picture of the level of Maori knowledge and identification of Maori participants. This sample of Maori participants

had a high level of knowledge about Maori culture and language together with a high level of cultural identity and involvement.

Results from the PBS-R indicate that both Maori and Pakeha participants were uncertain or only slightly believed in paranormal phenomena. Indeed, participants had similar scores on all subscales. The extent of participants' beliefs on the majority of subscales averaged in the uncertain to slightly agree category. The exceptions were first, traditional religious belief where the strength of belief averaged in the moderately agree category and second, superstition which averaged from slightly disagree to moderately disagree. These results were unexpected as it was originally thought that patients with schizophrenia would have reported stronger beliefs in paranormal phenomena because of their disordered thought processes.

However, Clarke (1993) assessed paranormal beliefs by using the PBS-R among first year introductory psychology students at Massey University. Significantly, the subjects in his study had lower levels of paranormal beliefs than the present sample. Moreover, in the present study, traditional religious belief and beliefs in witchcraft, superstition and spiritualism were substantially higher among both Maori and Pakeha participants than among the student population.

Contrary to the stated hypothesis, Maori participants did not have stronger paranormal beliefs than Pakeha. One possible reason for this could have been due to inability of the PBS-R to tap into traditional Maori cultural beliefs. Tobacyk (1988) argues that this scale is valid for Western cultures. Although New Zealand may be regarded as a Western nation, Maori beliefs are Polynesian and may not be fully represented in the PBS-R. For example, the spiritualism

subscale includes statements on astral projection, reincarnation, communication with the dead and the ability of the spirit to leave the body. The latter two statements apply more to Maori concepts of spiritualism than the first two. Take also, for example, the traditional religious belief scale which incorporates beliefs about the existence of the soul, the devil, God and heaven and hell. These concepts differ from traditional Maori religious beliefs which centre around tapu and the influence of atua. Failure to find differences between Maori and Pakeha in the strength of paranormal beliefs may have been due to the inadequacy of the PBS-R to reflect specific Maori cultural beliefs which were the basis for the hypothesis.

Despite the lack of beliefs in paranormal phenomena and failure to find differences in strength of beliefs between Maori and Pakeha (as derived from the PBS-R), information obtained from the interview indicates that Maori participants held certain cultural beliefs that Western society would define as paranormal. All Maori participants were asked whether they knew about tapu, mate Maori and makutu. They were then asked whether they believed in any of these concepts and, if so, if they knew anyone who had been affected by them. Nearly all (93%) of the participants knew about tapu, mate Maori and makutu and were able to explain what these concepts meant. Furthermore, the majority of participants (78%) believed in tapu, mate Maori and makutu. Four (28%) participants knew people who had been affected by tapu, mate Maori and makutu. Three (21%) believed that they themselves had been affected by makutu.

These results indicate a high degree of belief about tapu, mate Maori and makutu among the Maori participants. In noting the high degree of belief in Maori phenomena among Maori participants, one needs to keep in mind that Pakeha participants may well have held similar

beliefs. However, they were not questioned about these concepts in the interview. Despite this, it is the researchers contention that Maori cultural beliefs are not adequately represented in the PBS-R and this may be a reason why Maori did not report stronger spiritual, traditional religious and overall paranormal beliefs.

Presenting symptoms between Maori and Pakeha

The results of the present study support the second hypothesis that there would be differences in the frequencies of presenting symptoms between Maori and Pakeha. Maori participants had significantly higher frequencies of hallucinations, delusions, grandiose and religious delusions, and subcultural delusions and hallucinations. The complementary proposition that delusions of persecution, control and alien forces (DPCA) would occur more frequently with Maori participants was not supported.

Hallucinations

A number of overseas studies looking at the symptomatology of black and white schizophrenic patients have reported a higher frequency of hallucinations among blacks than whites (Adebimpe et al., 1981, 1982; Vitols et al., 1963). The DOS studies which used the PSE also reported a higher frequency of hallucinations among schizophrenic patients from developing countries than from developed countries (Sartorius et al., 1986). These findings and the findings of the present study suggest that hallucinations occur at a higher frequency in cultures where Western values and beliefs are not fully ingrained. This trend may be attributable to the greater acceptability of such phenomena in these cultures. It is unfortunate that while much of the overseas research has found differences in the frequencies of certain

symptoms, it has failed to elaborate and to further investigate possible reasons for these differences.

Delusions of persecution, control and alien forces

Originally, the DPCA symptom cluster was hypothesised as containing symptoms that related to certain Maori belief patterns but which Western society might regard as delusional. For example, beliefs about tapu could be interpreted as delusions of persecution. It is possible that beliefs about the influence of atua and other outside forces might also be interpreted as delusions of control and alien forces. Although there were no significant differences in the frequencies of this symptom cluster in the present study, closer analysis of the participants' responses suggests a substantial amount of cultural content. For example, in answer to the question 'Do you feel under the control of some force or power other than yourself?' (item 74, delusions of control), all of the Maori participants who said yes (4 out of 14), referred to the influence of Maori spirits and gods. In contrast, among the Pakeha sample who stated that they were under the control of a force or power (3 out of 16), 2 participants referred to God, one to hypnotism and the other to the voices as being forces that were controlling them.

Grandiose and religious delusions

The higher frequency of grandiose and religious delusions among Maori participants was an unexpected finding. Out of the total Maori and Pakeha sample, 40% reported that they were religious people. Differences between Maori and Pakeha became evident when intense religious belief was taken into consideration for ratings of religious delusions. Whilst over half of the Pakeha participants (56%) believed in God, their beliefs did not seem delusional. By contrast, Maori reports about their religious affiliation and beliefs had a more delusional

content that was not judged as intense religious belief. Such examples included 'God made me do bad man things' or 'the voices speak to Satan'.

At the same time, there are some difficulties in differentiating between delusion and intense religious belief and, consequently, there may be errors in drawing the line between normality and abnormality. However, if so, the level of error should have been consistent throughout all the interviews. Therefore, based on the criteria outlined in the PSE and the interviewer's standards of 'ordinary religious beliefs', Maori experienced more religious delusions.

None of the participants experienced delusions of grandiose identity (item 77). In relation to ratings on grandiose abilities (item 76), five (35%) Maori participants believed they had special powers, in contrast to one Pakeha participant who believed he had special powers. Only one of the Maori participants referred to Maori spiritual powers.

It is not clear why Maori would experience a higher frequency of religious delusions than Pakeha. Overseas research suggests a pattern exists between types of religious affiliations and frequencies of religious delusions (Murphy et al., 1963). It may be that religious beliefs are related to Maori spiritual beliefs in some manner. However, no differences were found between Maori and Pakeha in the spiritual and traditional religious beliefs subscale of the PBS-R.

Subcultural delusions and hallucinations

The results of the present study supported the hypothesis that Maori would experience a greater frequency of subcultural delusions and hallucinations. The higher frequencies of

subcultural delusions and hallucination indicates that there was a significantly higher amount of cultural content among Maori participants' responses. This is similar to the findings of Sachdev (1990) who found a significant amount of cultural content in the symptom content of Maori schizophrenic patients.

There are two items within the PSE that deal with the possibility of subcultural delusions and hallucinations. Dissociative hallucinations (item 64) asks the respondent whether he/she can carry on a two-way conversation with the voices/spirits/presence and what their explanation is? Ratings are then made according to whether the person belongs to a subcultural group or religious sect where such experiences might be sanctioned. Under subculturally influenced delusions (item 83) the examiner is instructed to 'question as appropriate'. In the present study, the examiner questioned Maori participants by asking about specific cultural phenomena (as suggested by Swartz, Ben-Aire and Teggin, 1985). As discussed previously, questions focused on the concepts of tapu, mate Maori and makutu, and the participants' beliefs and understanding of these concepts. Ratings were then made based on the content of the whole interview. Examples of subcultural delusions and hallucinations included the ability to see or hear tupuna, Maori spirits and being affected by makutu. These types of reports were rated positively signifying that the 'delusions' or 'hallucinations' a participant may have reported could easily be a belief that was shared by his/her subcultural group and was not necessarily regarded as abnormal.

In noting the higher frequencies of subcultural delusions and hallucinations among Maori, it must again be kept in mind that the same questions were not asked of the Pakeha participants.

This may have had an influence on the findings. For example, the researcher did have some

difficulty in assessing any subcultural beliefs among Pakeha participants. The interviewer asked Pakeha participants whether they had been brought up with, or held, any special beliefs. There was some difficulty in identifying particular Pakeha beliefs that could have been used under this section to bring out any specific beliefs. Despite this, ratings were still based on the content of the whole interview and very few Pakeha referred to matters that may have been typical of any type of religious sect or subcultural group.

Presenting symptoms, ethnicity, paranormal beliefs and Maori knowledge

Overall, the results of the present study did not support the third hypothesis that paranormal beliefs and cultural knowledge would be influencing variables in the symptom presentation of Maori and Pakeha schizophrenic patients. This suggests that beliefs about paranormal events and Maori knowledge do not influence the frequency with which hallucinations and delusions are experienced and reported.

However, Maori knowledge was found to be a mediating variable in the relationship between ethnicity and subcultural delusions and hallucinations (see Barron and Kenny, 1986 for criteria for mediating variables). When the influence of Maori knowledge on the main effects of ethnicity and subcultural delusions and hallucinations was controlled, the relationship between ethnicity and subcultural delusions and hallucinations was no longer significant. This indicates that Maori knowledge, which is significantly higher among Maori, influences the frequency with which a person would present with subcultural delusions and hallucinations.

A positive correlation was also found between Maori knowledge and level of Maori identity and participation. Taking this into consideration, one could postulate that Maori knowledge

is a tentative indicator of level of cultural involvement.⁶ Therefore, it may be that a Maori person who is involved with their taha Maori (as derived from amount of cultural knowledge and involvement) is more likely to present with symptoms that reflect cultural beliefs and themes.

In summation, although cultural knowledge may not affect the frequency with which delusions and hallucinations are experienced, there does seem to be a relationship between levels of Maori knowledge and the tendency for the content of hallucinations and delusions to reflect Maori cultural beliefs.

Limitations of research and future research recommendations

There are a number of possible reasons that may explain why paranormal beliefs and Maori knowledge did not account for the differences in symptom presentation between Maori and Pakeha. These include: the inadequacy of the PBS-R to represent Maori beliefs; the inappropriateness of the TMK to fully represent levels of cultural identity; and the fact that other confounding variables such as diagnosis and chronicity of illness were not controlled for in the present study. These factors will be discussed as well as suggestions for future research.

As discussed earlier, the PBS-R may not truly reflect specific Maori cultural beliefs. The lack of validity from a Maori perspective may explain why there were no specific differences

⁶Originally, it had been hoped to use the PMCIQ as the instrument to assess whether level of cultural identity was an influencing variable in symptom presentation. However, because of its lack of psychometric validity and inapplicability to Pakeha participants, it was not used. Maori knowledge was a variable that both Maori and Pakeha participants could be assessed on easily.

between Maori and Pakeha in strength of paranormal beliefs. This too would account for the failure to identify paranormal beliefs as an influencing variable in the relationship between ethnicity and frequencies of symptoms.

Further research needs to develop an instrument that can adequately assess the strength of both Pakeha and Maori paranormal beliefs. It may be that the PBS-R is more suitable for Pakeha than Maori. Lyndon (1983) developed an excellent questionnaire that, in hindsight, would have been very useful in the present study in assessing Maori participants' cultural beliefs. Lyndon's questionnaire was originally designed to find out the prevalence of beliefs in tapu, mate Maori, makutu, dreams and visitations and the affect these beliefs had on attitudes to mental illness. This questionnaire could be adapted by providing a scale in which participants rate the degree of belief on statements specific to Maori culture.

In the present study the TMK was used to measure one small part of cultural identity: Maori knowledge. The main purpose of using the TMK was to try and provide more information about the ethnic groups by bringing in a factor thought to associate with levels of Maori cultural identity. In other words, cultural identity as a whole was the variable of interest. However at the time of the study there existed no validated assessment instruments focusing specifically on cultural identity for both Maori and Pakeha. It is acknowledged that the TMK cannot fully reflect the level of a person's cultural identity and involvement despite the fact that it is correlated with cultural contact (Thomas, 1988), cultural identity and involvement (present study) and found to be a mediating variable in the relationship between ethnicity and subcultural delusions and hallucinations. The inability of the TMK to fully reflect cultural identity (acknowledging also that this was not its intended purpose) may in part explain why

Maori knowledge failed to account for differences in the frequencies of the other symptom clusters between Maori and Pakeha.

A cultural identity measure needs to be developed that can be used in cross-cultural studies such as the present study. Research that compares different ethnic groups and hopes to relate differences to cultural variables needs to have instruments that measure level of cultural identification and involvement. Ethnicity does not assume that an individual holds the beliefs, values and practices specific to that cultural group. For example, Olson (1993) developed a Maoritanga measure which assessed a Maori person's level of cultural knowledge, cultural behaviours, personal identity, social identity and cultural identity. Scores on this measure were then used to divide his participants into acculturated, partially acculturated and enculturated Maori. These groups were then compared on a number of health issues. Olson (1993) argues that levels of acculturation and enculturation need to be taken into consideration when researching Maori health.

Whilst Olson's Maoritanga measure would have been ideal for the Maori participants in the present study, a measure is also needed for Pakeha which assesses their levels of cultural identity. Future research that hopes to investigate whether cultural variables, such as level of cultural identity, influence the frequencies of presenting symptomatology among Maori and Pakeha needs to include measures that assesses both Pakehatanga and Maoritanga.

Certain limitations of the present study may also be a factor in the failure to support the hypothesis that paranormal beliefs and Maori knowledge would account for the differences in presenting symptoms. In the present study, the course of the disturbance and levels of

chronicity were not adequately controlled. DSM III-R identifies three phases of schizophrenia which include a prodromal phase, an active phase and a residual phase. Patients are further classified according to the course of the disturbance which includes subchronic, chronic, subchronic with acute exacerbation, chronic with acute exacerbation and in remission (APA, 1987). It may be that the Maori participants interviewed in the present study were at a different stage of the schizophrenic illness in terms of levels of chronicity than Pakeha participants. This may account for the higher frequencies of hallucinations and delusions among Maori. Supporting this explanation is the fact that the majority of Maori participants (71%) were currently admitted in acute and maximum security units (Unit 4, Lake Alice and NSU). In contrast, only two (12.5%) Pakeha participants were in similar units.

However, it may be that Maori patients typically experience more severe psychopathology than Pakeha patients. It has been noted that Maori are less likely to present to health services because of illness. It is not until the illness reaches a severe stage that Maori are forced to go to hospital (Pomare & de Boer, 1988). This may in part explain the current trends in the present study which revealed that Maori participants were in more acute wards.

Future research into the frequencies of hallucinations and delusions between Maori and Pakeha patients would need to control for chronicity of illness. Originally, this study had hoped to interview first admission patients with a diagnosis of schizophrenia. However, this involved a number of difficulties. Patients admitted for the first time are not usually given a diagnosis of schizophrenia. Hence, the criteria of this study were then changed to include patients in an acute state. As the study progressed, the difficulties in trying to find patients in a current acute state who would agree to participate became evident. Further difficulties

were encountered in completing the interview and self-report questionnaires. The criteria were then further modified to include patients with a diagnosis of schizophrenia experiencing recent active symptoms. Future research into this area would need to be aware of the difficulties in finding participants able to complete interview and self-report questionnaires. Further research would also need to control for levels of chronicity, for example, by interviewing only those classified as subchronic with acute exacerbation as outlined in the DSM III-R criteria.

Another confounding variable that was not controlled in the present study was the types of secondary diagnosis. The criteria for acceptance into the study was a primary diagnosis of schizophrenia. It was noted that a number of the participants within the present study also had secondary diagnoses, particularly drug and alcohol abuse and dependence. Current trends within Maori mental health suggest an increase in the number of drug abuse and drug psychosis admissions. In 1991 alcohol and drug dependence accounted for the highest proportion (28%) of all first admissions. There was a substantial increase from 1981 to 1991 of 20 to 24 year old Maori and non-Maori of both sexes first admissions due to drug abuse (Department of Health, 1993). In 1991 the Maori rate for drug psychoses admissions was disproportionately higher than non-Maori rates (Department of Health, 1993). There has also been an increase in readmission rates for Maori due to alcohol and drug abuse. Bridgman (1993) reports that from 1986 to 1991 there has been a five fold increase in the readmission rate for drug psychosis among Maori (Bridgman, 1993).

The incidence of drug dependence and abuse among the Maori sample could be a factor in the higher frequencies of hallucinations and delusions in the present study. Five (35.7%) Maori participants reported that the reason they had to come to hospital was because of their

drug taking behaviour, primarily marijuana and alcohol. These five participants also highlighted drugs as being the problem that most affected them. In contrast, none of the Pakeha participants reported drug taking behaviour as being a reason for their admission and instead referred to aspects of their schizophrenic illness such as hearing voices. This would suggest that a number of Maori participants may have experienced drug induced psychosis and the higher frequency of hallucinations and delusions may be related to their drug taking behaviour.

Another limitation of the present study relates to the modifications made to data in the data analysis process. Data was recoded according to the presence or absence of symptoms. Because of this, important information was lost in relation to the severity of symptoms. For example, the options for rating delusions ranged from 0 = absent, 1 = partial delusions and 2 = full delusions. In the present study, scores on partial and full delusions were recoded to one value representing the presence of delusions. Future research using the PSE should accommodate levels of severity into the analysis of results. By analyzing severity of symptoms with levels of acculturation and enculturation, a wider understanding can be gained about the relationship between culture and the expression of psychopathology.

Finally, the results of the present study need to be interpreted with caution because of the small sample size. Further research needs to investigate differences in symptomatology among Maori and Pakeha using larger samples in order to increase the validity and generalisation of results to the rest of the schizophrenic population within New Zealand.

CHAPTER 7

CONCLUSION

In conclusion, the results of the present study have found that Maori schizophrenic patients experience a higher frequency of delusions and hallucinations than Pakeha schizophrenic patients. This suggests that there are differences in the way Maori and Pakeha patients experience mental disorder. In particular, Maori schizophrenic patients were more likely to refer to cultural themes and beliefs when reporting their current symptoms. There is also some evidence to suggest that higher levels of Maori knowledge and identification with Maori culture is associated with the likelihood for a person to refer to cultural themes and beliefs.

The hypothesis that paranormal beliefs and/or Maori knowledge would account for the higher frequencies of hallucinations and delusions among Maori was not supported by the present study. However, levels of Maori knowledge were found to have an affect on the frequencies of subcultural delusions and hallucinations. Reasons for the failure to support the hypothesis may include the failure of the TMK and PBS-R to reflect cultural beliefs and identity, and the failure to control confounding variables such as levels of chronicity and secondary diagnoses of patients.

Summary of Research Recommendations

1. The relationship between severity of presenting symptoms and levels of cultural identity needs to be explored further. This would enable researchers to make comparisons between ethnic groups in relation to severity of symptoms and levels of cultural identity. Further research would need to:

- a) develop a cultural identity measure that assesses levels of Maoritanga and Pakehatanga. Olson's Maoritanga measure would be suitable for Maori participants.
 - b) incorporate the PSE's levels of severity of presenting symptoms into the main analyses.
 - c) investigate all symptoms within the PSE to see if there were differences in any other presenting symptomatology between Maori and Pakeha.
2. In order to investigate more fully whether cultural beliefs influence the expression of schizophrenia future research would need to:
- a) develop a more suitable measure of cultural beliefs for Maori and Pakeha. Lyndon's cultural beliefs questionnaire provides an excellent base for which to develop a Maori cultural beliefs measure.
3. The present study found differences in the frequencies of hallucinations and delusions among Maori and Pakeha schizophrenic patients. However, the researcher identified two confounding variables that may have had an influence on the findings. Future research would need to control for chronicity of illness and secondary diagnoses of participants.
4. The present study highlights the value of having Maori researchers who are aware of and understand Maori cultural beliefs and practices. Future research in to Maori mental health needs to be implemented by Maori in order that concepts are fully understood and that the research is carried out in an appropriate manner.

Practical implications

The findings of the present study have important implications in terms of the assessment, diagnosis and treatment of *turoro wairangi* (psychiatric patients). The study has highlighted the inadequacy of Western based assessment instruments to reflect Maori concepts and beliefs. Many of these beliefs and concepts need to be investigated with Maori patients in order that alternative causes of a patient's current presentation can be at least recognised and addressed. However, it may be that assessing beliefs about *tapu*, *mate Maori* and *makutu* in the form of questionnaires is not culturally appropriate because of the spiritual nature of these concepts. At the least, what is needed are Maori health workers who fully understand these concepts and can question Maori patients and their families in an appropriate manner.

In the present study, Maori participants presented with a higher frequency of delusions and hallucinations than Pakeha participants. Western psychiatry has placed much emphasis on the presence of delusions and hallucinations for the diagnosis of schizophrenia. However, mental health workers need to be aware that such phenomena are acceptable within Maori society and not necessarily abnormal. The acceptability of certain 'delusions' and 'hallucinations' within Maori society may account for the higher frequencies of perceived delusions and hallucinations among Maori in psychiatric settings. Furthermore, the tendency for Maori patients to present with more delusions and hallucinations may account for the disproportionately higher rate of Maori admissions with a diagnosis of schizophrenia.

Maori also presented with a significantly higher amount of cultural content, especially in relation to delusions and hallucinations. This suggests that there may be cultural influences in their presenting illness. Mental health workers assessing and diagnosing Maori patients

need to be aware of Maori beliefs in tapu, mate Maori and makutu. If a Maori patient reports cultural themes and beliefs, this area cannot be ignored. Mental health workers need to accept and understand that a person's presentation may also be caused by spiritual influences.

By recognising the spiritual beliefs inherent among Maori people and addressing these beliefs in an appropriate manner, more effective treatment can be provided for *turoro wairangi*. The implementation of a Maori perspective in treatment does not discount any Pakeha intervention. Maori health incorporates a holistic framework which does account for Western based philosophies that focus on physical health (*Te taha tinana*). However, treatment programmes which work solely to control symptoms or reduce chemical imbalances (as in Western medicine) may be ineffective from a Maori perspective. The treatment of our *turoro wairangi* needs to combine Western medicine and our Maori form of healing which addresses the physical, mental, family and spiritual dimensions of the patient. It is this researcher's belief that one framework (i.e. Western or Maori) does not discount the other.

Finally, it is hoped that this study has helped to increase people's understanding of the different values and beliefs systems that exist between Maori and Pakeha and how these beliefs may impact on the presentation of Maori patients. Further research is needed in order to increase our understanding of how a person's experience of mental disorder might differ from culture to culture. By increasing this knowledge and understanding, a better service in terms of assessment, diagnosis and treatment can be provided to both Maori and Pakeha *turoro wairangi*.

TE POUNAMU

*Kua tae mai te wā
ki te huaki o tātou whatu
Titiro, titiro, titiro
i te māia
te mātauranga
te āhua
o te pounamu.*

*The time has come
to open our eyes
see
the courage
the wisdom
the being
of the pounamu.*

- Lisa Cherrington

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Information Sheet and Consent Form

Appendix A



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**FACULTY OF
SOCIAL SCIENCES**

1001

**DEPARTMENT OF
PSYCHOLOGY**

PRESENTING SYMPTOMS AND CULTURE STUDY

INFORMATION SHEET

My name is Lisa Cherrington and I am currently conducting research as a requirement for a M.A. in Clinical psychology at Massey University under the supervision of Malcolm Johnson and Professor Mason Durie.

We are interested in people like yourself who have presented to mental health services with symptoms similar to those which you are experiencing. The main aim of the study is to find out specifically the types of thoughts and problems you are currently experiencing and to compare this with people from a different ethnic group. We hope that this study will help us to understand the effect of culture on these symptoms.

If you choose to participate in the study, I will be asking you some questions about what has been happening to you in the last month. This questionnaire has been used with people from a wide variety of backgrounds. It is envisaged this will take between one to two hours. After that, you will be asked to answer two questionnaires. One is about some of your beliefs and the other one is about Maori culture.

All individual information will remain entirely confidential and will not be released to anyone other than myself, Malcolm Johnson or Professor Mason Durie. The information that you give us will be collated anonymously and it will not be possible to identify you in any reports that are prepared from the study.

If you would like some time to think about participating in this study or would like to consult someone else, please feel free to do so.

If you do agree to take part, please feel free to ask any questions about the study that may occur to you during your participation. If you have any other queries or concerns about the study I can be contacted at Massey University ph 3569099 through the Psychology Department. Furthermore, if at any time during the study you feel the need to discuss any personal concerns that might arise, _____ is available for you to talk too.

If you so wish, we will also send you a summary of the findings from the study when it is completed.

Your rights are not affected by signing the following consent form. It is simply a record that given your present understanding of the study you agree to take part. If during any of the interview process you wish to withdraw from the study or not answer any of the questions you are free to do so.

Thank-you for your time.

Lisa Cherrington



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**FACULTY OF
SOCIAL SCIENCES**

1994

**DEPARTMENT OF
PSYCHOLOGY**

PRESENTING SYMPTOMS AND CULTURE STUDY

CONSENT FORM

I have read the information sheet for the study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researchers on the understanding that it is completely confidential and that my identity will not be revealed in any written or verbal reports about the study.

I wish to participate in this study under the conditions set out on the information sheet.

I AGREE/DO NOT AGREE TO TAKE PART IN THIS STUDY

Signed: _____ (participant) ____/____/____ (date)

Witness: _____ (witness) ____/____/____ (date)

I have discussed with _____ the aims and procedure involved in this study.

Signed: _____ ____/____/____

Lisa Cherrington

PRESENT STATE EXAMINATION (9th Edition)

Office Use
only

ID
(1) (2)

I. INTRODUCTION

Introduce self, describe purpose of interview and explain about any recording equipment. The purpose of the introductory section is to obtain an overall picture of the symptomatology in the subject's own words.

****** To begin with, I should like to get an idea of the sort of problems that have been troubling you during the past month.
What have been the main difficulties?
Record the main symptoms spontaneously mentioned.

Means of exploration if subject gives inadequate information:

<i>If subject's statement too brief</i>	Can you tell me more about that?
<i>If subject has no more to add</i>	What else has been troubling you?
<i>If statements are difficult to understand</i>	Can you explain what you mean?
<i>If subject is vague</i>	Could you give an example of ...?
<i>If no other response forthcoming</i>	Why did you come to the hospital?

RATE PATIENT'S ACCOUNT OF SYMPTOMS

- 0= Subject responds adequately.
- 1= Account somewhat inadequate but interview can proceed.
- 2= Account seriously inadequate but interview proceeds in an attempt to rate some subjective responses, as well as behaviour, affect and speech.
- 3= Impossible to continue with interview. Only behaviour, affect and speech sections.

(see 140)

REASONS FOR INADEQUACY (TICK AS MANY AS APPROPRIATE).

Denial or guardedness	—	Inattention	—
Patient mute, stuporous	—	Irrelevance	—
Replies to brief	—	Refusal	—
Poverty of content of speech	—	Other (specify)	—
Incoherence	—		

IF (1) OR (2) CARRY ON WITH SECTION 2, UNLESS SUBJECT MENTIONS OR HINTS AT DELUSIONS OR HALLUCINATIONS → SECTION 15

CUT OFF

*Current treatment, if subject not seen in hospital or clinic.
Rate the following if sufficient information has already emerged.
If not, use the suggested question:
May I ask if you are seeing a doctor for your nerves?
Or specify if psychosomatic complaints.*

What kind of doctor is he?
Your own G.P.? A private doctor? Psychiatrist?
0= No doctor
1= GP
2= Private doctor other than GP
3= Psychiatrist
4= Hospital out-patient (other than psychiatric)
5= Other paramedical specialist, or osteopath
6= Other specify

Are you attending for treatment any person who is not medically qualified, e.g lay therapist, herbalist, acupuncture, faith healer, Christian Science, church which forbids medical advice?
What were you complaining of at the time?

Specify type of treatment

Complaint

2. HEALTH, WORRYING, TENSION

** Is your physical health good?
(Does your body function normally?)

** Do you feel you are physically ill in any way?
(What is that like? How serious is it?)

1. RATE SUBJECT'S OWN SUBJECTIVE EVALUATION OF PRESENT PHYSICAL HEALTH (*irrespective of whether physical disease is present*).

- 0= Feels physically very fit.
- 1= Feels no particular physical complaint but does not say positively feels fit.
- 2= Feels unwell but not seriously incapacitated.
- 3= Feels seriously incapacitated by physical illness.

** What does your doctor say is wrong?
(Have you had a physical illness recently, colds, influenza, etc?)

2. RATE PRESENCE OF PHYSICAL ILLNESS OR HANDICAP (*taking results of recent investigations and physical state examination into account*).

- 0= No physical illness or handicap present.
- 1= Mild but significant physical illness or handicap (influenza or limp).

2= More serious physical illness or handicap present but not incapacitating or threatening to life (deafness or duodenal ulcer).

3= Physical illness or handicap present which is incapacitating or threatening to life (e.g blindness or carcinoma).
Specify illness, disabilities and duration:

3. RATE PSYCHOSOMATIC SYMPTOMS

** Have you worried a lot during the past month?
(What do you worry about?)

PROBE: (Money, housing, children, health, work, marriage, relatives, friends, neighbours, other)
(How much do you worry? Are you a worrier?)

If any indication of worry use further probes:

** What is it like when you worry?

(What sort of state of mind do you get into?)
(Do unpleasant thoughts constantly go round and round in your mind?)
(Can you stop them by turning your attention to something else?)

4. RATE WORRYING: *A round of painful thought which cannot be stopped and is out of proportion to the subject worried about*
1= Symptom definitely present during past month, but of moderate clinical intensity or intense less than 50% of the time
2= Symptom clinically intense more than 50% of past month.

** Have you had headaches, or other aches or pains during the past month?
(What kind?)

5. RATE ONLY TENSION PAINS, e.g. 'band around head', 'pressure', 'tightness in scalp', 'ache in back of neck', etc, not migraine.
1= Symptom definitely present during past month, but of moderate clinical intensity, or intense less than 50% of the time.
2= Symptom clinically intense more than 50% of past month.

** Have you been getting exhausted and worn out during the day or evening, even when you haven't been working very hard?

6. RATE TIREDNESS OR EXHAUSTION: *Do not include tiredness due to flu etc = 9.*
1= Only moderate form of symptom (tiredness) present; or intense form (exhaustion) less than 50% of the time
2= Intense form of symptom (exhaustion) present more than 50% of the past month.

** Have your had difficulty relaxing during the past month?
(Do your muscles feel tensed up?)

7. **RATE MUSCULAR TENSION:** *Do not include a subjective feeling of nervous tension which is rated later.*
 1= Symptom definitely present during past month, but of moderate clinical intensity, or intense less than 50% of the time.
 2= Symptom clinically intense more than 50% of past month.

 (9)

** Have you been so fidgety and restless that you couldn't sit still?
 (Do you have to keep pacing up and down?)

8. **RATE RESTLESSNESS**
 1= Only moderate form of symptom (fidgety, restless) present; or intense form (pacing, can't sit down) less than 50% of the time.
 2= Intense form of symptom (pacing, etc) present more than 50% of past month

** Do you tend to worry over your physical health?

9. **RATE HYPOCHONDRIASIS:** *Overconcern with possibility of death, disease or malfunction. Re-rate at end of interview if subject constantly reverts to hypochondriacal preoccupation. Consider ratings of symptoms (1) and (3).*
 1= Symptom present during past month, but not (2).
 2= Subject constantly reverts to hypochondriacal preoccupations during interview.

** Do you often feel on edge or keyed up or mentally tense or strained?
 (Do you generally suffer with your nerves?)
 (Do you suffer from nervous exhaustion?)

10. **RATE SUBJECTIVE FEELING OF 'NERVOUS TENSION':** *There is no need for autonomic accompaniments for this symptom to be rated present.*
 1= Symptom definitely present during past month, but of moderate intensity, or tense less than 50% of the time.
 2= Intense form of symptom present more than 50% of the past month.

 (12)

** Do you find that a lot of noise upsets you?
 (Do noises sometimes seem to penetrate, or go through your head?)

RATE HYPERSENSITIVITY TO NOISE
 1= Moderate degree during past month.
 2= Severe degree during month.

3. AUTONOMIC ANXIETY

In this section, rate only subjective anxiety with autonomic accompaniments, either free-floating or situational. Do not include worrying or nervous tension. Do not include anxiety due to e.g. persecutory delusions, except in the special item (no. 13).

CHECK LIST of autonomic accompaniments:

- | | |
|---------------------------|--------------|
| Blushing | Dry mouth |
| Butterflies | Giddiness |
| Choking | Palpitations |
| Difficulty getting breath | Sweating |
| Dizziness | Trembling |

- ** Have there been times lately when you have been very anxious or frightened?
(What was it like?)
(Did your heart beat fast?) *Ask for other autonomic symptoms.*
(How often in the past month?)

11. RATE FREE-FLOATING AUTONOMIC ANXIETY: *Exclude if due to delusions. Exclude if purely situational.*

- 1= Symptom definitely present, with autonomic accompaniment, during past month, but of moderate clinical intensity, or intense less than 50% of the time.
2= Symptom clinically intense more than 50% of the time.

 (13)

- ** Have you had the feeling that something terrible might happen?
(That some disaster might occur but you are not sure what? Like illness or death or ruination?)
(Have you been anxious about getting up in the morning because you were afraid to face the day?)
(What did it feel like?)

12. RATE ANXIOUS FOREBODING WITH AUTONOMIC ACCOMPANIMENTS

- 1= Symptom definitely present, with autonomic accompaniment during past month, but of moderate clinical intensity, or intense less than 50% of the time.
2= Symptom clinically intense more than 50% of the time.

13. RATE AUTONOMIC ANXIETY DUE TO DELUSIONS, *etc and if necessary defer to end of interview.*

- 0= No anxiety due to delusions or hallucinations.
1= Subject complains of anxiety but no evidence of anxiety on examination.
2= Clearly anxious or frightened because of delusions or hallucinations.

CUT OFF IN NO EVIDENCE OF ANXIETY OR IF ANXIETY DUE ONLY TO DELUSIONS → SECTION 4

CUT OFF

- Have you had times when you felt shaky, or your heart pounded, or you felt sweaty, and you simply had to do something about it?
(What was it like?)
(What was happening at the time?)
(How often during the past month?)
EXAMPLES:

14. RATE PANIC ATTACKS WITH AUTONOMIC SYMPTOMS: *A panic attack is intolerable anxiety leading to some action to end it, e.g. leaving a bus, phoning husband at work, going in to see a neighbour, etc.*
1= One to four panic attacks during month.
2= Panic attacks five times or more.

 (16)

- Do you tend to get anxious in certain situations, such as travelling, or being alone, or being in a lift or train?
(What situations? How often during the past month?)
EXAMPLES:

CHECKLIST:

- Crowds (shop, street, theatre, cinema, church)
- Going out alone; being at home alone
- Enclosed spaces (hairdresser, phonebooth, tunnel)
- Open spaces, bridges
- Travelling (buses, cars, trains)

15. RATE SITUATIONAL AUTONOMIC ANXIETY

- 1= Has not been in such situations during the past month but aware that anxiety would have been present if the situation had occurred.
- 2= Situation has occurred during the past month and patient did feel anxious because of it.

(17)

What about meeting people, e.g. going into a crowded room, making conversation?

CHECKLIST:

- Speaking to an audience
- Eating, drinking or writing in front of other people
- Parties

16. RATE AUTONOMIC ANXIETY ON MEETING PEOPLE

- 1= Has not been in such situations during the past month but aware that anxiety would have been present if the situation had occurred.
- 2= Situation has occurred during the past month and patient did feel anxious because of it.

Do you have any special fears, like some people are scared of feathers or cats or spiders or birds?

CHECKLIST:

- Heights, thunderstorms, darkness
- Animals or insects of any kind
- Dentists, injections, blood, injury

17: RATE ONLY SPECIFIC PHOBIAS, NOT GENERAL SITUATIONAL ANXIETY

- 1= Has not been in such situations during the past month but aware that anxiety would have been present if the situation had occurred.
- 2= Situation has occurred during the past month and patient did feel anxious because of it.

(19)

Do you avoid any of these situations (specify as appropriate) because you know you will get anxious?
(How much does it affect your life?)

18. RATE AVOIDANCE OF ANXIETY-PROVOKING SITUATIONS

- 1= Subject tends to avoid such situations whenever possible.
 - 2= Marked generalisation of avoidance has occurred during the past month, e.g. subject has not dared to leave the house or has gone out only if accompanied.
- Describe anxiety symptoms and list phobias.*

4. THINKING, CONCENTRATION, ETC.

** Can you think clearly or is there any interference with your thoughts?

** Do your thoughts tend to be muddled or slow?
(Can you make up your mind about simple things quite easily?)
(Make decisions about everyday matters?)

19. RATE SUBJECTIVELY INEFFICIENT THINKING (if due to intrusion of alien thoughts, rate 9).

- 1= Symptom definitely present during the past month, but of moderate clinical intensity or intense less than 50% of the time.
- 2= Symptom clinically intense more than 50% of the past month.

** What has your concentration been like recently?
(Can you read an article in the paper or watch a T.V. programme right through?)
(Do your thoughts drift off so that you don't take things in?)

20. RATE POOR CONCENTRATION

- 1= Only moderate form of symptom present during the past month (e.g. can read a short article, can concentrate if tries hard); or intense less than 50% of the time.
- 2= Symptom clinically intense (cannot attempt to read or concentrate) more than 50% of the past month.

** Do you tend to brood on things?
(So much that you even neglect your work?)

21. RATE NEGLECT DUE TO BROODING

- 1= Symptom has caused moderate impairment to work or social relationships
- 2= Marked impairment

** What about your interests, have they changed at all?
(Have you lost interest in work, or hobbies, or recreations?)
(Have you let your appearance go?)

22. RATE LOSS OF INTEREST continuing during the last month.

- 1= Symptom definitely present during the past month, but of moderate clinical intensity or intense less than 50% of the time.
- 2= Symptom clinically intense more than 50% of the past month.

** Have you become interested in new things at all?
IF EVIDENCE OF EXPANSIVE MOOD OR IDEAS → SECTION 9.

IF ODD IDEAS, EXPLORE FURTHER. PROCEED TO SECTION 15 IF APPROPRIATE.

** Have you suffered any lapses of memory recently? (PROBE ONLY)
IF EVIDENCE OF DISASSOCIATION OR ORGANIC MEMORY LOSS - SECTION 16
ANSWERS TO THESE QUESTIONS MAY SUGGEST THAT OTHER TYPES OF THOUGHT DISORDER ARE PRESENT, IF NOT, CUT OFF → SECTION 5

CUT OFF

IF ANY EVIDENCE OF THOUGHT DISORDER:
 Are you in full control of your thoughts?
 Can people read your mind?
 Is any thing like hypnotism or telepathy going on?
 IF NECESSARY, PROCEED TO SECTION 13

5. DEPRESSED MOOD

** Do you keep reasonably cheerful or have you been very depressed or low spirited recently?
 Have you cried at all?
 (When did you last really enjoy doing anything?)

23. RATE DEPRESSED MOOD: *N.B. When rating clinical severity of depression remember that deeply depressed people may not necessarily cry. See definition in glossary.*

1= Only moderately depressed during past month, or deep depression for less than 50% of the time and tending to vary in intensity.
 2= Deeply depressed for more than 50% of the past month, and tending to be unvarying in intensity.

 (25)

** How do you see the future?
 (Has life seemed quite hopeless?)
 (Can you see any future?)
 (Have you given up or does there still seem some reason for trying?)

24. RATE HOPELESSNESS *on subject's own view at present.*

1= Hopelessness of moderate intensity but still has some degree of hope for the future (irrespective of time during month).
 2= Intense form of symptom (patient has given up hope altogether).

USE JUDGEMENT ABOUT WORDING.

** Have you felt that life wasn't worth living?
 (Did you ever feel like ending it all?)
 (What did you think you might do?)
 (Did you actually try?)

25. RATE SUICIDAL PLANS OR ACTS

1= Deliberately considered suicide (not just a fleeting thought) but made no attempt.
 2= Suicidal attempt but subjects life never likely to be in serious danger, except unintentionally.
 3= Suicidal attempt apparently designed to end in death (i.e. accidental discovery or inefficient means).
N.B. examiner should judge clinically whether there was intent to end life or not. If in doubt assume not.

 CUT OFF

26. IF EVIDENCE OF BOTH DEPRESSION AND ANXIETY, RATE ANXIETY OR DEPRESSION PRIMARY.

If subject suffers from both anxiety and depression, and both have been rated as present, try to decide which is primary. Which seems worse, the depression or the anxiety? (Use patients own terms).

 (28)

0. Anxiety is primary. Depression appears to be entirely explicable in terms of the limitations placed on the subject by the symptoms of anxiety, e.g. being unable to leave the house, travel, meet people, etc, or being afraid of heart disease because of palpitations.
1. Anxiety and depression both present but seemed independent of each other or if not it is not possible to decide whether one of them is primary.
2. Depression is primary. Anxiety is either a result of the depression (e.g. subject is frightened because of a morbid or suicidal ideas) or it takes the form of fears of catastrophe, forebodings about illness or death, preoccupation that something awful is going to happen. Panic attacks and situational anxiety if present, are secondary to depression.

Is the depression worse at any particular time of day?

27. RATE MORNING DEPRESSION (*particularly on waking*).

0= No depression.

1= Not specially marked in mornings.

2= Specially marked in mornings.

6. SELF AND OTHERS

** Have you wanted to stay away from other people?

(Why?)

(Have you been suspicious of their intentions? Of actual harm?)

28. RATE SOCIAL WITHDRAWAL

1= Only passive form of symptom i.e. subject does not seek company but does not refuse it if offered; or, if active withdrawal, less than 50% of the month.

2= Actively avoids company (refuses it if offered). Actively withdraws in this way for more than 50% of the month.

 (30)

** What is your opinion of yourself compared to other people?

(Do you feel better, or not as good, or about the same as most?)

(Do you feel inferior or even worthless?)

29. RATE SELF-DEPRECIATION

1= Some inferiority, not amounting to feeling of worthlessness. If subject considers self to be worthless, this intense form of the symptom is present less than 50% of the time.

2= Subject considers self to be completely worthless. Symptom present more than 50% of the month.

** How confident to you feel in yourself:

(For example, in talking to others, or in managing your relations with other people?)

30. RATE LACK OF SELF-CONFIDENCE WITH OTHER PEOPLE: Consider only competence in social relationships, not competence at mechanical work, etc.

- 1= Moderate lack of self-confidence, or intense lack of less than 50% of the month.
2= Intense lack of self-confidence more than 50% of the month.

 (32)

** Are you self-conscious in public?

(Do you get the feeling that other people are taking notice of you in the street or the bus or a restaurant?)

(Do they ever seem to laugh at you or talk about you critically?)

(Do you consider people really are looking at you, or is it perhaps the way you feel about it?)

31. RATE SIMPLE IDEAS OF REFERENCE (NOT DELUSIONS)

- 1= Marked self-consciousness only (irrespective of time during month).
2= Feels that people are criticising or laughing at self but can be reassured.

 (33)

IF NO EVIDENCE OF GUILT, CUT OFF → SECTION 7.

(IF EVIDENCE OF MISINTERPRETATIONS, DELUSIONS OF REFERENCE OR PERSECUTION → SECTION 15B, 15C.)

CUT OFF

IF EVIDENCE OF GUILT:

Do you have the feeling that you are being blamed for something, or even accused? What about?

32. RATE GUILTY IDEAS OF REFERENCE. Do not include justifiable blame or accusation. Exclude delusions of guilt.

- 1= Subject feels blamed but not accused (irrespective of time during month).
2= Subject feels accused of some sin or misdemeanour. Not delusional.

IF DELUSIONS OF REFERENCE MAY BE PRESENT → SECTION 15B

Do you tend to blame yourself at all?

(If people are critical, do you think you deserve it?)

33. RATE PATHOLOGICAL GUILT ONLY

- 1= Subject feels over-guilty about some peccadillo (irrespective of time during month).
2= Subject feels to blame for everything that has gone wrong even when not his/her fault, but not delusional.

IF DELUSIONS OF GUILT MAY BE PRESENT → SECTION 15G.

Do you blame anyone else for your troubles?

IF DELUSIONS OF PERSECUTION → SECTION 15C.

7. APPETITE, SLEEP, RETARDATION, LIBIDO

** What has your appetite been like recently?

(Have you lost any weight during the past three months?)

34. RATE LOSS OF WEIGHT DUE TO POOR APPETITE

Do not include changes due to physical illness.

1= Less than 7lbs (3.2kg).

2= 7lbs (3.2kg) or more.

** Have you had any trouble getting off to sleep during the past month?

(How long do you lie awake?)

(What happens if you take sleeping tablets?)

(How often does it happen?)

35. RATE DELAYED SLEEP

1= One hour or more delay (irrespective of sleeping tablets).

2= Two hours or more delay (irrespective of sleeping tablets).

(In either case, 10 or more nights during the month).

** Do you seem to be slowed down in your movements, or to have too little energy recently? How much has it affected you?

(Do things seem to be moving too fast for you?)

36. RATE SUBJECTIVE ANERGIA AND RETARDATION

1= Marked subjective listlessness and lack of energy.

2= Marked retardation and underactivity (irrespective of time during month).

IF NO APPETITE OR SLEEP DISTURBANCE AND NO DEPRESSION, CUT OFF → SECTION 8.

CUT OFF

IF SLEEP DISTURBANCE OR DEPRESSION:

Do you wake early in the morning?

37. RATE EARLY WAKING *(One hour before usual).*

1= One hour or more before ordinary time.

2= Two hours or more before ordinary time.

(In either case, ten or more nights during month)

Has there been any change in your interest in sex?

38. RATE LOSS OF LIBIDO WITHIN PRESENT EPISODE OF ILLNESS AND PERSISTING DURING PAST MONTH

1= Marked loss of interest and performance.

2= Almost total loss of libido.

Does the depression or tension get worst before the start of the monthly period?

39. RATE PREMENSTRUAL EXACERBATION

0= No definite exacerbation.

1= Marked exacerbation.

8. IRRITABILITY

* Have you been very much more irritable than usual recently?

(How do you show it?)

(Do you keep it to yourself, or shout, or even hit people?)

40. RATE IRRITABILITY

- 1= Keeps irritation to him/her self.
 2= Shows anger by shouting or quarrelling.
 3= Shows anger by hitting people, throwing or breaking things.

 (42)**9. EXPANSIVE MOOD AND IDEATION**

- ** Have you sometimes felt particularly cheerful and on top of the world, without any reason?
 (Too cheerful to be healthy?)
 (How long does it last?)

41. RATE EXPANSIVE MOOD: *not ordinary high spirits.*

- 1= Moderately expansive mood (euphoria with marked element of inappropriateness or excitement, whether recognised by subject or not), present during past month and persistent for hours at a time. *Do not include transient high spirits. Not necessarily described by subject.
 2= Intense form of symptom (elation or exaltation) definitely present during past month and persistent for hours at a time. Described by subject.

- ** Have you felt particularly full of energy lately, or full of exciting ideas?
 (Do things seem to be going to slowly for you?)
 (Do you need less sleep than usual?)
 (Do you find yourself extremely active but not getting tired?)
 (Have you developed new interests recently?)

43. RATE SUBJECTIVE IDEOMOTOR PRESSURE

- 1= Subjective equivalent of flight of ideas. Images and ideas flash through the mind, each suggesting others, at a faster rate than usual. State persists for hours at a time. * Definitely occurred during the past month.
 2= As (1) but accompanied by very high energy output and activity which does not seem to make subject tired at the time. Definitely occurred during past month and persisted for hours at a time.*
 * *If symptom was more transient but very intense or frequently repeated, it may still be included.*

 (44)

IF NO EVIDENCE OF EXPANSIVE MOOD AND IDEATION, CUT OFF → SECTION 10.

CUT OFF	<input type="checkbox"/>
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IF EVIDENCE OF EXPANSIVE MOOD AND IDEATION:

- Have things seemed super-efficient at work, or as though you had special powers or talents quite out of the ordinary?
 Have you felt specially healthy?
 Have you been buying any interesting things recently?

43. RATE GRANDIOSE IDEAS AND ACTIONS

- 1= Subjective feeling of superb health, exceptionally high intelligence, extraordinary abilities, etc. Persistent for hours at a time. * Symptom occurred at some time during the month.
- 2= Grandiose ideas have been translated into action during the month e.g. overspending, gambling, etc., under the influence of grandiose ideas and expansive affect. *Do not include compulsive gambling unless clearly of this type.*

 (45)

(→ GRANDIOSE DELUSIONS, SECTION 15D IF NECESSARY.)

10. OBSESSIONS

These symptoms are usually experienced as occurring against conscious resistance (see definition).

- ** Do you find that you have to keep on checking things that you know you have already done?
(Like gas taps, doors, switches, etc)
(Do you have to touch or count things many times or repeat the same action over and over again?)
(What happens when you try to stop?)

44. RATE OBSESSIVE CHECKING AND REPEATING

- 1= Symptom of moderate intensity or if severe, present less than 50% of the time.
- 2= Symptom present in severe degree, more than 50% of the past month.

 (46)

- ** Do you spend a lot of time on personal cleanliness, like washing over and over even though you know you are clean?
What about tidiness?
(Do you get worried by contamination with germs?)
(Do you have other rituals?)
(What happens when you try to stop?)

45. RATE OBSESSIVE CLEANLINESS AND SIMILAR RITUALS

- 1= Symptom of moderate intensity or if severe, present less than 50% of the time.
- 2= Symptom present in severe degree, more than 50% of the past month.

- ** Do you find it difficult to make decisions even about trivial things?
(Do you constantly have to question the meaning of the universe?)
(Do you get awful thoughts coming into your mind even when you try to keep them out?)
(What happens when you try and stop?)

46. RATE OBSESSIVE IDEAS AND RUMINATION

- 1= Symptom of moderate intensity or if severe, present less than 50% of the time.
- 2= Symptom present in severe degree, more than 50% of the past month.

11. DEREALISATION AND DEPERSONALISATION

- ** Have you had the feeling recently that things around you were unreal?
(As though everything was an imitation of reality, like a stage set, with people acting instead of being themselves?)
(What was it like? How do you explain it?)

47. RATE DEREALISATION

- 1= Moderately intense form of symptom definitely occurred during the past month, and persisted for hours at a time. Things appear artificial, people appear lifeless and seem to act rather than being themselves.
2= Intense form of symptom occurred during the past month and persisted for hours at a time, e.g. whole world appears like a gigantic stage set, with imitation instead of real objects and puppets instead of people. (If delusional, do not rate here but symptom 90.)

 (49)

- ** Have you yourself felt unreal, that you were not a person, not in the living world?
(Or that you were outside yourself, looking at yourself from outside?)
(Or that you look unreal in the mirror?)
(Or that some part of your body did not belong to you?)
(How do you explain it?)

48. RATE DEPERSONALISATION

- 1= Moderately intense form of the symptom definitely occurred during the past month and persisted for hours at a time. Subject feels himself unreal, a sham, a shadow.
2= Intense form of symptom definitely occurred during the past month and persisted for hours at a time. Subject feels he/she is dead, not a person, living in a parallel existence, a hollow shell, even that he/she does not exist. (if delusional, do not rate here but symptom 90.)

12. OTHER PERCEPTUAL DISORDERS (NOT HALLUCINATIONS)

- ** Do you ever get the feeling that something odd is going on which you can't explain?
(Or that familiar surroundings seem strange? How do you explain it?)

49. RATE DELUSIONAL MOOD: *The subject feels that his/her familiar environment has changed in a way which puzzles him/her and which he/she may not be able to describe clearly. The feeling often accompanies delusion formation.*

- 1= Symptom definitely present. No delusions have actually been formulated, though patient may feel that various delusional explanations are possible.
2= Full delusional elaboration has occurred.

 (50)

- ** Does your imagination sometimes play tricks on you?

** Is there anything unusual about the way things look or sound, or smell, or taste?
(Does your body function normally?)
(Is your own appearance normal?)

CONTINUE BELOW CUT-OFF IN NECESSARY, EVEN IF (49) NOT PRESENT.

IF NO PERCEPTUAL ABNORMALITY → SYMPTOM 54.

CUT OFF

IF THERE IS ANY HINT OF PERCEPTUAL ABNORMALITY, CONTINUE BEYOND CUT OFF POINT AND ALSO CONSIDER LATER SECTIONS. RATE ONLY BASIC EXPERIENCE, NOT DELUSIONAL ELABORATION.

In what way? Do sounds seem unnaturally clear or loud or things look vividly coloured or detailed?
(How do you explain this?)

50. RATE HEIGHTENED PERCEPTION: *e.g. subject intensely aware of cracks in a wall, details of a wallpaper pattern, colours in a picture. Sounds heard with exceptional clarity, music appears particularly beautiful.*
1= Subject unable to describe the symptom precisely, but examiner thinks it is likely to have been present at some time during the past month.
2= Subject briefly describes the symptom. Definitely present at some time (even if only briefly) during the the past month.

(52)

** Do things seem dark or grey or colourless?
(How do you explain it?)

51. RATE DULLED PERCEPTIONS: *The reverse of symptom (50). Things look, sound and taste dull, flat, colourless and uninteresting.*
1= Subject unable to describe the symptom precisely, but examiner thinks it is likely to have been present at some time during the past month.
2= Subject briefly describes the symptom. Definitely present at some time (even if only briefly) during the past month.

(53)

Does the appearance of things or people change in a puzzling way: e.g. distorted shapes or size or colour?
(How do you explain it?)

52. RATE CHANGED PERCEPTION
1= Subject unable to describe the symptom precisely, but examiner thinks it is likely to have been present at some time during the past month.
2= Subject briefly describes the symptom. Definitely present at some time (even if only briefly) during the past month.

Do you think your own appearance is normal?
(Conviction that nose is too large, teeth misshapen, body crooked, etc. Ask questions here if convenient but rate symptom (89).)

Does your experience of time seem to have changed?
(Does it go too fast or too slowly, or do you seem to live through experiences exactly as you have had them before?)

53. RATE CHANGED PERCEPTION OF TIME, INCLUDING *DEJA VU*

- 1= Subject unable to describe the symptom precisely, but examiner thinks it is likely to have been present at some time during the past month.
- 2= Subject briefly describes the symptom. Definitely present at some time (even if only briefly) during the past month.

Do you feel that you have lost your emotions in some way?
(That you are empty of all feeling, incapable of reacting emotionally?)
(Is this a definite change, or have you always been like that?)
(How do you explain it?)

 (56)54. RATE LOST EMOTIONS: *Rate only subjective loss of affect, i.e. subject can remember being able to react emotionally, though this might have been months or even years ago.*

- 1= Symptom definitely present during the past month but less than 50% of the time.
- 2= Symptom present more than 50% during past month.

13. THOUGHT READING, INSERTION, ECHO, BROADCAST

IF QUESTION HAS NOT BEEN COVERED IN SECTION 4 ASK:

- ** Can you think quite clearly or is there any interference with your thoughts?
(Are you in full control of your thoughts?)
(Can people read your mind?)
(Is anything like hypnotism or telepathy going on?)

IF NO EVIDENCE OF THOUGHT READING, etc., CUT OFF → SECTION 14.

CUT OFF

IF ANY EVIDENCE, ASK QUESTIONS BELOW:

(These symptoms are often recorded as false positives. The examiner must be satisfied that the subject is not simply assenting to a question he does not understand, but genuinely recognises the experience and can describe it so that the examiner recognises it). It is particularly important to know the relevant sections of the Instruction manual well before rating these symptoms.

Are thoughts put into your head which you know are not your own?
(How do you know they are not your own?)
(Where do they come from?)

55. RATE THOUGHT INSERTION: *Include only thoughts recognised as alien. Do not include delusional elaboration, only basic experience. (Exclude hallucinations.)*

- 1= Symptom described clearly, but subject thinks it may be due to 'own unconscious thoughts' etc., i.e. not certainly alien.
- 2= Symptom described clearly and thoughts described as alien, i.e. inserted into mind from elsewhere (even if subject does not know from where). Not hallucinations.

Do you ever seem to hear your own thoughts spoken aloud in your head, so that someone standing near might be able to hear them?
(Are thoughts broadcast, so that other people know what you are thinking?)
(How do you explain it?)

56. RATE THOUGHT BROADCAST

- 1= Hears own thoughts 'spoken' aloud but not broadcast. Subject must really hear them aloud in his/her head. If in doubt rate (8) or (0).
 2= Thoughts transferred or broadcast so that others can share subject's thoughts even when they are not in the same room. (Do not include 'thoughts being read' unless this is an explanation of thought broadcast. The subject must actually experience his/her thoughts being available to others.)

 (5)

Do you ever seem to hear your own thoughts repeated or echoed?
 (What was it like? How do you explain it?)
 (Where does it come from?)

57. RATE THOUGHT ECHO OR COMMENTARY

- 1= Thought echo. If any doubt rate (8) or (0).
 2= Subject experiences alien thoughts related to his/her own thoughts, i.e. associations or comments on his/her own thoughts. Not hallucinations.

Do you ever experience your thoughts stopping quite unexpectedly so that there are none left in your mind, even when your thoughts were flowing freely before?
 (What was it like?)
 (How often does it occur? What is it due to?)

Do your thoughts ever seem to be taken out of your head, as though some external person or force were removing them?
 (Can you give an example?)
 (How do you explain it?)

58. RATE THOUGHT BLOCK OR WITHDRAWAL

- 1= Thought block. Do not include if due to anxiety or lack of concentration; only if it occurs totally unexpectedly when thoughts are flowing freely. One single occasion is not sufficient for rating. Be very critical in rating this symptom.
 2= Delusional explanation that thoughts are withdrawn.

Can anyone read your thoughts?
 (How do you know? How do you explain it?)

59. RATE DELUSION OF THOUGHTS BEING READ: Only if subject does not mean that people can infer his thoughts from his actions. (do not include subject reading thoughts of other people → 76).

- 1= 'Partial' delusion. Subject entertains the possibility that thoughts might be read but is not certain about it. Exclude if subcultural explanation.
 2= Full delusion. Exclude if subcultural explanation. The term 'thought reading' is commonly used to mean the ability to tell what someone is thinking from the way they behave - this use should be excluded.

 (6)**14. HALLUCINATIONS****USE JUDGEMENT ABOUT WORDING**

** I should like to ask you a routine question which we ask of everybody. Do you ever seem to hear noises or voices when there is no one about, and nothing else to explain it?
 (Do you ever seem to hear your name being called?)

** Is that true of visions or other unusual experience, which some people have?
(Touch, smell, taste, temperature, pain, etc.)

IF NO EVIDENCE FOR HALLUCINATIONS OF ANY SENSE, CUT OFF → SECTION 15.

CUT OFF

IF EVIDENCE FOR NON-AUDITORY HALLUCINATIONS ONLY → SUBSECTIONS 14B AND 14C

14A. AUDITORY HALLUCINATIONS

IF ANY EVIDENCE THAT AUDITORY HALLUCINATIONS MIGHT BE PRESENT:

Do you hear noises like tapping, or music? (What is it like?)

Does it sound like muttering or whispering?

Can you make out the words?

60. RATE NON-VERBAL AUDITORY HALLUCINATIONS

1= Music, tapping, car engines, etc. Do not include tinnitus.

2= Muttering, whispering, but subject cannot make out any words at all.

(

What does the voice say?

(Write down examples of typical verbal hallucinations)

(If accusatory: Do you think that it is justified? Do you deserve it?)

Do you hear your name being called?

61. RATE VERBAL HALLUCINATIONS BASED ON DEPRESSION OR ELATION OR VOICE CALLING SUBJECT

Content is congruent with mood; e.g. 'He's dirty', in context of depression, or 'Go to Westminster', in elated subject who thinks he is Prime Minister. Include voice calling subject (e.g. calling name) or saying single words only. Be careful to distinguish from delusions of reference in which people whom the subject can see are thought to be talking about him.

RECORD EXAMPLES:

1= Voice calling name, or single words only.

2= Other verbal hallucination; congruent with depressed mood.

3= Other verbal hallucinations; congruent with elated mood.

)

Do you hear several voices talking about you?

Do they refer to you as 'he' or 'she'?

(What do they say?)

(Do they seem to comment on what you are thinking, or reading, or doing?)

62. RATE VOICE(S) DISCUSSING SUBJECT IN THIRD PERSON OR COMMENTING ON THOUGHTS OR ACTIONS (NOT BASED ON DEPRESSION OR ELATION)

Do not include muttering or whispering if subject cannot make our words. Exclude 'dissociative' hallucinations (symptom 64). Do not include voice calling name or affectively based verbal hallucinations (symptom 61). There may be one voice commenting on subject's thoughts or actions, or several voices discussing the subject in the third person.

- 1= Hears a voice or voices commenting on thoughts or actions in third person (e.g. 'Now he's going to bed' or 'why would he think a thing like that?'). (2) not present.
- 2= Hears voices talking about him/her in third person (e.g. 'I think he's a homosexual, don't you?' 'Yes, he wears a pink pullover, that's a sign of it'). (1) may also be present.

Do they speak directly to you?
 (Are they threatening or unpleasant?)
 (Do they call you names?)
 Do they give orders? (Do you obey?)

63. RATE VOICES SPEAKING TO SUBJECT (NOT BASED ON DEPRESSION OR ELATION)

Include voice(s) speaking directly to subject, whether accusing, threatening, giving orders or giving information. Exclude voice(s) calling name or based on depression or elation (symptom 61), or commenting on subject's thoughts or actions (symptom 62). Exclude 'dissociative' hallucinations (symptom 63).

- 1= Pleasant, supportive or neutral voices, not based on affect. No hostile voices.
- 2= Hostile, threatening or accusing voice(s), thought to be undeserved and not based on affect.

N.B. If single isolated words, even with neutral affect, include under 61(1).

Can you carry on a two-way conversation with - ?
 (You can reply and then - replies to you, and you reply again, just as in an ordinary conversation?)
 (Do you see anything or smell anything at the same time as you hear the voice?)
 (Who is it that you are talking to?)
 (What is the explanation?)
 (Do you know anyone else who has this kind of experience?)

64. RATE 'DISSOCIATIVE' HALLUCINATIONS (VERBAL AND/OR OTHER)

The subject can hold a two-way conversation with a presence (variously described as a person, ghost, spirit, god, etc.) which may also be sensed in other ways, e.g. visually or by touch or smell. Often connected with people with whom the subject has strong affective ties. Visual hallucinations can occur alone. There is usually a strong subcultural colouring, e.g. the subject belongs to a religious sect or to a subcultural group which sanctions hallucinatory experiences, or the subject has been under the influence of someone who is involved with such practise. Exclude hypnagogic hallucinations.

RECORD EXAMPLES:

- 1= 'Dissociative' hallucinations present. Subject belongs to subcultural group or sect in which such experiences are sanctioned.
- 2= 'Dissociative' hallucinations present. Subject does not belong to subcultural group as in (1). If not known, rate (1).

65. Are there voices in your mind or can you hear them through your ears?

Scoring:

- 1= Subject hears both pseudo-hallucinations (within mind) and true hallucinations (through ears).
- 2= Subject hears pseudo-hallucinations only.
- 3= Subject hears true hallucinations only.

How do you explain the voice?
RECORD EXPLANATION:

14B. VISUAL HALLUCINATIONS

IF QUESTION HAS NOT BEEN COVERED IN SECTION 12 OR 14A, ASK:

** Have you had visions or seen things other people couldn't see?

IF NO EVIDENCE HERE OR ELSEWHERE FOR VISUAL HALLUCINATIONS CUT OFF → SECTION 15.

CUT OFF

IF ANY EVIDENCE OF VISUAL HALLUCINATIONS:

With your eyes or in your mind?

What did you see?

Were you half asleep at the time?

Has it occurred when you were fully awake?

Did you realise you were 'seeing things'?

Did the vision seem to arise out of a pattern on the wallpaper or a shadow?

How do you explain it?

66. RATE VISUAL HALLUCINATIONS: *in clear consciousness including pseudo-hallucinations. Exclude 'dissociative' visual hallucinations (symptom 64).* (6)

1= Formless visual hallucination - flashes of light, shadows, etc.

2= Formed visual hallucinations - people, objects like a 'fiery cross', faces, etc.

67. RATE DELIRIOUS VISUAL HALLUCINATIONS

IF QUESTIONS HAVE NOT BEEN COVERED IN PREVIOUS SECTIONS:

** Is there anything unusual about the way things feel, or taste, or smell?

** Does your body function normally?

IF NO EVIDENCE FRO OTHER HALLUCINATIONS CUT OFF → SECTION 15A.

CUT OFF

IF ANY EVIDENCE FOR OTHER HALLUCINATIONS:

Do you sometimes notice strange smells that other people don't notice?

(What sort of thing?)

(How do you explain it?)

68. RATE OLFACTORY HALLUCINATIONS: *Exclude delusion that patient himself smells.*

- 1= Simple olfactory hallucination. Not delusionally elaborated. Subject smells oranges, death, a burnt smell, scent, etc., which other people cannot smell. Can offer no explanation.
2= Delusional elaboration in addition, e.g. gas being put into room.

 (70)

Do you seem to think that you yourself give off a smell which is noticed?
(What is the explanation?)

69. RATE DELUSION THAT SUBJECT SMELLS: *Do not include simple preoccupation with body odour, e.g. in anxious subject who sweats a lot.*

- 1= Subject irrationally thinks he gives off a smell but is not certain. Not sure that others have noticed it but thinks it possible
2= Subject sure that he gives off a smell and that others have noticed it and react accordingly.

Do you ever feel that someone is touching you, but when you look there is nobody there?
(Have you noticed that food or drink seems to have an unusual taste recently?)

70. RATE OTHER HALLUCINATIONS AND DELUSIONAL ELABORATION: *Exclude hypochondriacal and nihilistic delusions rated in (90) and (91).*

- 1= Sensation of touch, food tastes burnt etc, but subject puzzled by the experience. No delusional elaboration.
2= Delusional elaboration in addition, e.g. fantasy lover, food poisoned, etc.

 (72)

15. DELUSIONS

Delusions may be of two kinds, primary and secondary. Both kinds are rated together in the following symptoms except where specified. For example, primary delusions are specifically rated in symptom (82). They are defined here for convenience.

Primary delusions are based upon experiences in which a subject suddenly becomes convinced that a particular set of events has a special meaning (e.g. a subject undergoing a liver biopsy suddenly felt he had been chosen by God). The delusion cannot be explained and it is not shared by other members of the subject's cultural or social group.

Secondary delusions are delusional elaborations of primary delusions or other basic phenomena such as derealisation, depersonalisation, perceptual distortions, hallucinations, thought echo, mood changes, etc.

Above cut-off questions, likely to elicit delusions if present, are included in many of the preceding sections. There may also be evidence in the case-record or in the subjects spontaneous account.

IF NO EVIDENCE AT ALL THAT DELUSIONS ARE PRESENT, CUT OFF → SECTION 16

RECORD IF ANY PSYCHOTIC PHENOMENA PRESENT, OTHER THAN DELUSIONS, USE JUDGEMENT AS TO WHETHER TO PROCEED BEYOND CUT OFF.

CUT OFF

IF ANY EVIDENCE FOR DELUSIONS, ASK ALL QUESTIONS NOT IN BRACKETS, AND ANY FURTHER QUESTIONS WHICH SEEM INDICATED.

RATING OF PARTIAL AND FULL DELUSIONS

In general, all delusions are rated as follows:

- 1= Partial delusions, which are expressed with doubt, or as possibilities which the subject entertains but is not certain about. This rating should not be used if it is clear that full delusions have been present during the month, or if the subject has acted as if fully deluded.
2= Full delusions have been present at sometime during the month. Fully convinced. No insight.

A useful question to elucidate the difference between partial and full delusions is as follows:

Even when you seem to be most convinced, do you really feel in the back of your mind that it might well not be true, that it might be your imagination?

15A. DELUSIONS OF CONTROL

The subject's will is replaced by that of some external agency. A simple statement that the radio is controlling the subject is not sufficient. (This statement alone should be rated 8.) The subject must describe a replacement of will by some other force.

Do not include feeling that life is planned and directed by fate, or that the future is present already in embryo, or that subject is not very strong willed, or that voices give subject orders. Do not conclude simple identification with God or being under God's direction. Do not include subcultural or hysterical possession states or multiple personality (→ 100).

Do you feel under the control of some force or power other than yourself?

(As though you were a robot or a zombie without a will of your own?)

(As though you were possessed by someone or something else?)

(What was it like?)

(Does this force make your movements for you without your willing it, or use your voice, or your hand-writing? Does it replace your personality? What is the explanation?)

71. RATE DELUSIONS OF CONTROL

1= Partial delusions

2= Full delusions

 (73)**15B. MISINTERPRETATIONS, MISIDENTIFICATION AND DELUSIONS OF REFERENCE**

Do not include simple self-consciousness or feeling that subject attracts comment, even if critical. These are rated under symptom 31. There must be elaboration: e.g. someone crosses his knees in order to indicate that the subject is homosexual; or the whole neighbourhood is gossiping.

Delusional misinterpretations, etc. This is an extension of the delusion of reference, so that not only do people seem to refer to subject, but situations appear to be deliberately created to test him (exclude situations of medical treatment), or objects appear to have special meanings.

Do people seem to drop hints about you or say things with a double meaning, or do things in a special way so as to convey a meaning?

Does everyone seem to gossip about you?

(Do people follow you about or check up on you or record your movements?)

(How do they do it? Why?)

(Are there people about who are not what they seem to be?)

72. RATE DELUSIONS OF REFERENCE

1= Partial delusions

2= Full delusions

 (74)

Do things seem to be specially arranged?
 (Is an experiment going on, to test you out?)
 (Do you see any reference to yourself on TV or in the papers?)
 (Do you ever seem to see special meanings in advertisements, or shop windows, or in the way things are arranged?)
 (How do you explain this?)

73. RATE DELUSIONAL MISINTERPRETATION AND MISIDENTIFICATION

- 1= Partial delusions
 2= Full delusions

(75)

15C. DELUSIONS OF PERSECUTION

Is anyone trying to deliberately harm you, e.g. trying to poison you or kill you?
 (How? Is there an organisation like the Mafia behind it?)
 (Is there any other kind of persecution? How do you explain this?)

74. RATE DELUSIONS OF PERSECUTION

- 1= Partial delusions
 2= Full delusions

(76)

15D. EXPANSIVE DELUSIONS

Do you think that people are organising things specially to help you?

75. RATE DELUSIONS OF ASSISTANCE

- 1= Partial delusions
 2= Full delusions

Is there anything special about you? Do you have special abilities or powers?
 (Can you read people's thoughts?)
 (Is there a special purpose or mission to your life?)
 (Are you especially clever or inventive? How do you explain this?)

76. RATE DELUSIONS OF GRANDIOSE ABILITIES

- 1= Partial delusions
 2= Full delusions

(Are you a very prominent person or related to someone prominent, like Royalty?)
 (Are you very rich or famous?)
 (How do you explain this?)

77. RATE DELUSIONS OF GRANDIOSE IDENTITY: *(exclude religious identification).*

1= Partial delusions

2= Full delusions

 (79)**15E. DELUSIONS CONCERNING VARIOUS TYPES OF INFLUENCE AND PRIMARY DELUSIONS**

Are you a very religious person?

(Specially close to Christ or God?)

(Can God communicate with you? How?)

(Are you yourself a saint?)

(How do you explain this?)

78. RATE RELIGIOUS DELUSIONS: *Including delusional religious explanations of other experiences. Exclude intense religious belief or purely subcultural beliefs.*

1= Partial delusions

2= Full delusions

 (80)

How do you explain the things that have been happening (SPECIFY)

Is there anything like hypnotism, telepathy, or the occult going on?

What is the explanation?

79. INCLUDE DELUSIONAL EXPLANATIONS IN TERMS OF PARANORMAL PHENOMENA: *e.g. hypnotism, telepathy, magic, witchcraft, etc. Exclude purely subcultural beliefs → 83.*

1= Partial delusions

2= Full delusions

Is anything like electricity or X-rays or radio waves affecting you?

(In what way? What is the explanation?)

80. INCLUDE DELUSIONAL EXPLANATIONS IN TERMS OF PHYSICAL FORCES: *e.g. radio, television, X-rays, electricity, transmitters, microphones, machines of various kinds.*

1= Partial delusions

2= Full delusions

81. DELUSIONS OF ALIEN FORCES PENETRATING OR CONTROLLING MIND (OR BODY). *Include any delusion, whether rated elsewhere or not, which involves an external force penetrating the subject's mind or body, e.g. rays turn liver to gold, alien thoughts pierce skull or are inserted into mind, hypnotism makes patient levitate, a spirit speaks with subjects's voice, a radio transmitter has been implanted into brain and broadcasts thoughts or controls actions, etc.*

1= Partial delusions

2= Full delusions

 (83)

Choose a likely delusion and ask:

How did it come into your mind that this was the explanation?

(Did it happen suddenly? How did it begin?)

82. **RATE PRIMARY DELUSIONS:** *Based upon experiences in which subject suddenly becomes convinced that a particular set of events has a special meaning (see definition, pg 214). Not based on mood or explanation of other abnormal experiences.*

- 1= Partial delusions
2= Full delusions

 (84)

15F. OTHER DELUSIONS

Examiner should question as appropriate.

83. **RATE SUBCULTURALLY INFLUENCED DELUSIONS:** *Include only subjects who belong to small groups with definitely idiosyncratic beliefs; small sects, tribes, 'secret societies', etc.*

- 0= No significant influence. For example, an English subject believing he is influenced by TV would be rated (0) since, although the delusion depends in TV being available in England, it is not in any way specific to a small subcultural group.
- 1= One or more of the delusions rated early could easily be no more than a belief shared by other members of the subject's subcultural group, e.g. the Pentecostal church with the gift of tongues. Voodoo, witchcraft, communicating with God, are other examples of beliefs which may be taken quite literally by groups of people who are not clinically deluded. Rate (1) if subject holds such beliefs without elaborating them further.
- 2= As (1), but because of excitement, expansiveness, depression, confusion, intellectual retardation, etc., the subject holds the beliefs with exceptional fervour and conviction, or elaborates them further. Such a subject might well be regarded as abnormal by other members of his own sect or group.
- 3= More specific delusional states, e.g. Koro, Witigo, etc.
Do you have any reason to be jealous of anybody?)

84. **MORBID JEALOUSLY**

- 1= Partial delusions
2= Full delusions

 (86)

85. **DELUSION OF PREGNANCY**

- 1= Partial delusions
2= Full delusions

86. **SEXUAL DELUSIONS:** *Any delusion with sexual content, e.g. fantasy lover, sex changing, etc. Do not include an untrue claim that subject is married or has children.*

- 1= Partial delusions
2= Full delusions

Have you had any unusual experience or adventures recently?

87. **RATE FANTASTIC DELUSIONS, DELUSIONAL MEMORIES, DELUSIONAL CONFABULATIONS, FANTASTIC DELUSIONS:**

- Confabulation: Subject makes up delusions on the spot. Very rare.*
Delusional memories: Subject seems to be describing actual memories. Describes the same delusions time and again. Not confabulations. Rare, e.g. 'I came down to earth on a silver star'
Fantastic delusions: The commonest of the three, e.g. England's coast melting.
- 1= Partial delusions
2= Full delusions

15G. SIMPLE DELUSIONS BASED ON GUILT, DEPERSONALISATION, HYPOCHONDRIASIS, ETC.

These symptoms often appear to be based on a depressed mood and are relatively consistent and unelaborated. Do not include more bizarre elaborations of any of them, e.g. having a metal nose = symptom 87, not 89. Having been turned into another specified person = possibly symptom 71, not 90. Liver turned to lead by X-rays = symptoms 80 and 81, not 91. England's coast melting = symptom 87, not 92.

Do you feel you have committed a crime, or sinned greatly, or deserve punishment?
(Have you felt that your presence might contaminate or ruin other people?)

88. RATE DELUSIONS OF GUILT

- 1= Subject has brought ruin to family by being in present condition, or thinks that symptoms are a punishment for not doing better, etc. Does not elaborate as in (2).
- 2= Subject says has sinned greatly or committed some terrible crime or brought ruin upon the world. May feel deserving of punishment, even of death or hell-fire, because of it.

(90)

(Do you think your appearance is normal?)

89. RATE SIMPLE DELUSIONS CONCERNING APPEARANCE: *(Nose too large, teeth misshapen, body crooked, etc.)*

- 1= Strong feeling that there is something wrong with appearance; subject looks old or ugly or dead, skin cracked, teeth misshapen, nose too large, body crooked, etc. Can be reassured temporarily. There may be only one limited preoccupation.
- 2= Subject acts accordingly (plastic operations, etc.)

(Is anything the matter with your brain?)

90. RATE DELUSIONS OF DEPERSONALISATION: *subject has no head, does not exist, hollow instead of a brain, etc.*

- 1= Unable to think, no thoughts in head, feels as though he has no brain or as though it does not function at all.
- 2= Symptom more intense. Subject has no head, no brain, does not exist.

(Is anything the matter with your body?)

91. RATE HYPOCHONDRIACAL DELUSIONS: *Subject has incurable cancer, bowels are stopped up, insides are rotting, etc.*

- 1= Subject feels body is unhealthy, rotten, diseased, but without the force of (2)
- 2= Subject has incurable cancer, bowels are stopped up or rotting away, etc.

(Do you have the feeling that something terrible is going to happen? What?)

92. RATE DELUSIONS OF CATASTROPHE: *World is about to end, some catastrophe has happened or will occur, everything is evil and will be destroyed.*

- 1= Subject feels sense of impending doom; something awful will happen. Non-specific but out of proportion to circumstances.
- 2= Delusional conviction that world is about to end or some other enormous catastrophe is about to occur or has occurred. World is dirty, decayed, rotten: i.e. further delusional elaboration of (1).

15H. GENERAL RATINGS OF DELUSIONS AND HALLUCINATIONS

(Include both partial and full delusions.)

CONSIDER BOTH DELUSIONS AND HALLUCINATIONS IN FOLLOWING RATING

93. RATE SYSTEMATISATION OF DELUSIONS

- 0= No delusions or hallucinations.
- 1= Delusions and hallucinations not elaborated into a general system affecting much of the subject's experience. Include encapsulated delusions or isolated hallucinations.
- 2= Some systematic elaboration, but substantial areas of the subject's experiences are not affected.
- 3= Subject interprets practically all his/her experience in delusional terms.

94. RATE EVASIVENESS

- 0= No attempt at concealment suspected.
- 1= Examiner suspects that there may be either delusions or hallucinations in the background, but the subject is not concealing much of the psychopathology.
- 2= Examiner suspects that there is a considerate preoccupation with delusions (even a delusional system) or hallucinations, but the subject tries to conceal them.
- 3= No concealment but other delusions or hallucinations probably present. Not elicited because of poor intelligence and education or incoherence or muteness, etc.

95. OVERALL RATING OF PREOCCUPATION WITH DELUSIONS AND HALLUCINATIONS

- 0= No delusions or hallucinations.
- 1= No delusions or hallucinations definitely rated but examiner suspects that they may be present.
- 2= Preoccupied with past delusions or hallucinations only. Not actively deluded or hallucinated at present.
- 3= Delusions or hallucinations definitely present but subject is not preoccupied with them for much of the time. Can turn attention to other things without difficulty.
- 4= Delusions or hallucinations present and take up most of the subject's attentions. Preoccupied to the exclusion of many other matters.
- 5= Patient can hardly discuss anything but delusions.

(97)

96. RATE ACTING OUT DELUSIONS

(Rate from case-record, etc).

- 0= No delusions or hallucinations.
- 1= Subject able to keep delusions or hallucinations to himself, or to confide them only to a few trusted people (sympathetic relatives, friends, doctors, etc.). He does not express them in public nor act upon them. Does not talk out loud to voices.
- 2= Subject has acted upon delusions or hallucinations during past month, or expressed them in public (i.e. outside the small circle of people who would be expected to be sympathetic). This has not however, resulted in severe social disturbance or a social crisis.
- 3= As (2) but acting out, or public expression, has resulted in severe social disturbance or a social crisis.

16. SENSORIUM AND FACTORS AFFECTING

** Have you had any lapses of memory recently?
 (Have there been any periods in which you completely forgot what happened?)
 (What was it like?)
 (How do you explain it?)

97. RATE FUGUES, BLACKOUTS, AMNESIA LASTING MORE THAN ONE HOUR: *irrespective of aetiology.*

- 1= less than 12 hours.
- 2= 12-24 hours.
- 3= more than 24 hours.

** What medicines or drugs do you take?
 (Do you take anything for your nerves or your mood?)
 (Obtain list of drugs)

(Who prescribes?)

98. RATE DRUG ABUSE DURING MONTH

- 1= Cannabis.
- 2= Amytal, etc.
- 3= LSD, amphetamine etc.
- 4= Cocaine, heroin, etc.

** May I ask about your drinking habits? How much do you usually drink each day?
 (Is alcohol in any way a problem for you? In what way?)

CHECKLIST: During the past month have you:
 had family problems because of drinking?
 missed work because of drinking?
 had morning shakes or other withdrawal symptoms?
 had blackouts for several hours?
 heard voices or seen visions?

99. RATE ALCOHOL ABUSE DURING PAST MONTH

- 1= Agrees alcohol has been a problem, but not (2).
- 2= Any check-list item applies.

 (101)

100. RATE DISSOCIATIVE STATES DURING PAST MONTH: *Narrowing of consciousness which serves an unconscious purpose and is commonly accompanied or followed by a selective amnesia, e.g. trance, possession state, fugue, hypersomnia, stupor, etc. Do not include if caused by drugs, alcohol, epilepsy, etc.*

- 1= Present during month, not at examination.
- 2= Present at examination.

101. RATE CONVERSION SYMPTOMS *e.g. paralysis, anaesthesia, blindness, tremor, seizures, etc. if mentioned during interview.*

- 1= Present during month, not at examination.
- 2= Present at examination.

102. RATE CLOUDING OR STUPOR AT EXAMINATION

- 1= Clouding: Inadequate comprehension of external impressions, with perplexity, and impairment of attention and orientation.
- 2= Stupor: Subject appears comatose but there is no clouding or impairment of consciousness.

IF ANY SUSPICION OF POOR MEMORY OR DISORIENTATION:

May I ask one or two standard questions we ask of everybody?
 How old are you?
 Can you tell me the year and the month?
 What is the name of the Prime Minister of New Zealand?

103. RATE ORGANIC IMPAIRMENT OF MEMORY *(see glossary).*

- 1= Mild.
- 2= Moderate.
- 3= Severe.

17. INSIGHT

** Do you think there is anything the matter with you?
 (What do you think it is?)

(Could it be a nervous condition?)
 (What do you think the cause is?)

(Why did you need to come to hospital?)

(Do you think *(specify delusions or hallucinations)* were part of a nervous condition?)

104. IF PSYCHOTIC SYMPTOMS (i.e. SYMPTOMS FROM SECTIONS 12-15):

- 0= Full insight (in intelligent subject, able to appreciate the issues involved).
- 1= As much insight into the nature of the condition as social background and intelligence allow.
- 2= Agrees to a nervous condition but examiner feels that subject does not really accept the explanation in terms of a nervous illness (e.g. gives delusional explanation, the result of persecution, or rays, etc.)
- 3= Denies nervous condition entirely.
- 9= Psychotic illness not present.

105. IF NEUROTIC SYMPTOMS (i.e. SYMPTOMS FROM SECTIONS 1-11 ONLY):

- 0= Full insight (in intelligent subject, able to appreciate the issues involved).
- 1= As much insight into the nature of the condition as social background and intelligence allow.
- 2= gives physical explanation for neurotic symptoms
- 3= Denies neurotic symptoms entirely
- 9= Neurotic illness not present

** Of all the problems you have told me about, which one affects you most?
 How much does it interfere with your work or your relationships with other people?

(Have you actually been out of work, or unable to do the housework, or go shopping, travelling etc. during the past month?)

(Have the symptoms impaired your efficiency in any other way?)

106. RATE SOCIAL IMPAIRMENT DUE TO NEUROTIC CONDITION

- 0= No neurotic or psychotic symptoms present.
- 1= Neurotic symptoms present but little diminution of subject's efficiency or interference with everyday activities.
- 2= Neurotic symptoms interfere with subjects efficiency to a moderate extent but are not incapacitating, e.g. subject neglects housework or can't enjoy leisure activities or social relationships, or finds work efficiency reduced because of worry, tension, irritability, depression, anxiety, etc. Subject does not however, stop work altogether or completely neglect household.
- 3= Subject severely incapacitated by neurotic symptoms: had to have at least a week off during past month; was housebound for a week or more; was actively withdrawn from all social relationships, etc. The subject does not have to be totally incapacitated for the whole month for this rating to be made, but impairment has to be very severe.
- 8= Examiner unsure.
- 9= Psychotic condition present.

(If both psychotic and neurotic condition, rate whichever shows more impairment).

 (10)

107. RATE SOCIAL IMPAIRMENT DUE TO PSYCHOTIC CONDITION

- 0= No neurotic or psychotic symptoms present.
- 1= Psychotic symptoms present but little diminution of subject's efficiency or interference with everyday activities.
- 2= Psychotic symptoms interfere with subject's efficiency to a moderate extent but are not incapacitating, e.g. subject neglects housework or can't enjoy leisure activities or social relationships, or finds work efficiency reduced because of worry, tension, irritability, depression, anxiety, etc. Subject does not however, stop work altogether or completely neglect household.
- 3= Subject severely incapacitated by psychotic symptoms: had to have at least a week off during past month; was housebound for a week or more; was actively withdrawn from all social relationships, etc. The subject does not have to be totally incapacitated for the whole month for this rating to be made, but impairment has to be very severe.
- 8= Examiner unsure.
- 9= Neurotic condition and no psychotic condition present.

FINAL QUESTION

** Have there been any other things lately that I haven't covered?
Specify:

Note here any points that seem to be important or unusual about the subject or the interview which are not covered in the schedule.

Reconsider schedule to make sure that all the obligatory questions have been asked. Also consider whether behaviour, affect and speech ratings can be made or whether further observation or examination is necessary. IF NOT, THIS IS THE END OF THE INTERVIEW

18-20 BEHAVIOUR, AFFECT AND SPEECH

RATINGS

- 0= Symptom absent.
 1= Present in fairly severe degree, or very severe but intermittent during interview.
 2= Present in very severe degree and almost continuous during interview.
 8= Examiner not sure.
 9= Subject not examined, or examination not appropriate.

N.B. If in doubt, rate (0). A rating of (1) means there is no doubt about the symptom being present in fairly severe form.

BEHAVIOUR DURING INTERVIEW

108. SELF-NEGLECT (*cleanliness, shaven, make-up, state of hair and clothes*). (11)
109. BIZARRE APPEARANCE (*secret documents openly displayed, special clothes or ornaments with symbolic significance, etc. Do not include mannerisms or posturing = symptom 116*).
110. SLOWNESS AND UNDERACTIVITY (*sits abnormally still, walks abnormally slowly, delay in performing movements*).
111. AGITATION (*fidgery, restlessness, pacing, frequent unnecessary movements*).
112. GROSS EXCITEMENT AND VIOLENCE (*throws things, runs or jumps about, waves arms widely, shouts or screams*).
113. IRREVERENT BEHAVIOUR (*sings, facetious, silly jokes, flippant remarks, unduly familiar*).
114. DISTRACTIBILITY (*stops talking or changes subject due to distraction by trivial noises or events outside the room or turns attention to furniture, etc.*)
115. EMBARRASSING BEHAVIOUR (*making sexual suggestions or advances to interviewer; loss of social restraint - scratches genitals, passes loud flatus, etc.*)
116. MANNERISMS AND POSTURING (*odd, stylised movements or acts, usually idiosyncratic to the patient, often suggestive of special meaning or purpose: assuming and maintaining uncomfortable or inappropriate postures*).
117. STEREOTYPIES, etc. (*constant repetition of movements or postures such as rocking, rubbing, nodding, grimacing: no special significance*).
118. BEHAVES AS IF HALLUCINATED (*non-verbal: as though hears voices or visions: lips move soundlessly looks around, giggles to self - not just from embarrassment, shyness etc.*).
119. CATATONIC MOVEMENTS
- (Negativism: does the opposite of what he/she is asked.
 Ambitendence: begins to take proffered hand, then withdraws; etc.
 Echopraxia: imitates examiner's movement.
 Flexibilitas cerea: arm remains where it is put, for at least 15 seconds.
 Mitgehen: excessive co-operation in passive movement.
 Echolalia: imitates words and phrases with the same intonation and inflection of voice.)

AFFECT DURING INTERVIEW

120. OBSERVED ANXIETY (*tense worried look or posture, fearful apprehensive look, frightened tone of voice, tremor*).
121. OBSERVED DEPRESSION (*sad, mournful look, tears, gloomy tone of voice, deep sighing, voice chokes on distressing topic*).
122. HISTRIONIC (*feelings expressed in exaggerated, dramatic, histrionic manner*).
123. HYPOMANIC AFFECT (*unduly cheerful, smiling, euphoric, elated*).
124. HOSTILE IRRITABILITY (*unco-operative, irritable, angry, overtly hostile, discontented, haughty, antagonistic*).
125. SUSPICION

126. PERPLEXITY (*puzzlement*). (128)
127. LABILITY OF MOOD (*whether lability of one mood, or changing from one mood to another*).
128. BLUNTED AFFECT (*expressionless face and void, uniform blunting whatever the topic of conversation, indifference to distressing topics, whether delusional or normal*).
- 1= Blunting not uniform, e.g. at times responds affectively but at other time is markedly flat; or responds with some evidence of affect, but definitely less than expected.
- 2= Severe and uniform blunting.
129. INCONGRUITY OF AFFECT (*emotion is shown, but not congruent with topic*).

SPEECH DURING INTERVIEW

130. SLOW SPEECH (*long pauses before answering, long pauses between words*).
131. PRESSURE OF SPEECH (*more copious speech than normal, too rapid speech, very loud voice, too circumstantial speech*).
132. NON-SOCIAL SPEECH (*talks, mutters, whispers out loud, out of context of conversation with examiner*).
133. MUTENESS
- 1= Almost mute, fewer than twenty words in all.
- 2= Totally mute.
134. RESTRICTED QUANTITY OF SPEECH (*subject frequently fails to answer, questions have to be repeated, restricted to minimum necessary, no extra sentence, no additional comments*).
135. NEOLOGISMS AND IDIOSYNCRATIC USE OF WORDS OR PHRASES, e.g. 'One is called "Per-God" and the other is called "Per-the-devil"', '...miracle-willed through God's 'tarn-harn'...', 'Well, there is a frequenting of clairvoyance...': 'Per-God', 'Per-the-Devil' and 'tarn-harn' are neologisms; 'frequenting of clairvoyance' is an example of ordinary words being used idiosyncratically.

EXAMPLES:

DISORDER OF CONTENT OF SPEECH

Three types of disordered content are specified: in each case, the effect is to make it very difficult to grasp what the subject means. However, the symptoms are defined in terms of specific components so that it should, in most cases, be possible to say whether one, two or all three symptoms are present. If in doubt, rate hierarchically, i.e. rate incoherence in preference to flight of ideas and flight of ideas in preference to poverty of speech.

If the patient does not talk enough to give a rateable sample of speech, rate all three symptoms Y.

136. INCOHERENCE OF SPEECH: *The subject's meaning is obscured by distorted grammar, lack of logical connection between one part of a sentence and another or between sentences, sudden irrelevances or 'Knights move', grossly pedantic phrases, answering off the point, etc. For example:*
- 'We' ve seen the downfall of the radium crown by the Roman Catholics, whereas when you come to see the drinking side of the business, God saw that Noah, if he lost his reason, he got nobody there to look after them'.
- 'I did suggest to you, that intrinsic or congenital sentiment or refinement of disposition would be so miracle-willed through God's "tarn-harn" as to assume quite the opposite.'
- 'I believe we live in a world, in an age, where the elements are a force that elders of professionals hope, not to conquer, but to control.'
- 'What's your address?' 'Its supposed to be Salisbury near Birmingham.'

DO NOT RATE THIS SYMPTOM PRESENT UNLESS EXAMPLE IS WRITTEN DOWN

A rating of 2 means that very little normal speech is present.

N.B. A free flow of delusions is not necessarily incoherent. A subject may talk about delusion quite coherently.

137. **FLIGHT OF IDEAS:** *Words are associated together inappropriately by sound or rhyme (clang association). Although the original aim of the sentence may quickly be lost, a path can be traced through associations of the white-black-coffin or ring-wrong variety, or through associations with distracting stimuli, e.g.*

'How is your appetite?' 'I feel as if I have lost my appetite. I have had an orange. A real juicy orange.' (Sees patient walking past window.) 'She is going for E.C.T. Etcetera treatment or teddy bear's picnic. I call it'.

 (139)

DO NOT RATE THIS SYMPTOM PRESENT UNLESS EXAMPLE ARE WRITTEN DOWN

A rating of 2 means that very little normal speech is present.

138. **POVERTY OF CONTENT OF SPEECH:** *The subject talks freely but so vaguely that little information is given in spite of the number of words used: rambles on without coming to a point; may wander far from original theme. Exclude incoherence or flight of ideas. Rate only if severe and always give an example.*

139. **MISLEADING ANSWERS:** *Subject's answers are misleading because answers 'yes' or 'no' to everything, or frequent self-contradictions, or appears to be deliberately misleading. Do not include incoherence, flight of ideas or poverty of speech here.*

140. **RE-RATE ADEQUACY OF INTERVIEW**

0= Ratings made adequately represent the symptoms present.

1= Some problem but key symptoms have been rated.

2= Serious question as to adequacy of interview for rating key symptoms (other than sections 18-20).

3= Only sections 18-20 could be rated.

I.D. _ _

MAORI KNOWLEDGE QUESTIONNAIRE

For each question there are four choices, of which only one is right. Put a circle around the choice (a, b, c, d) that you think is the right answer. If you are not sure you can guess. The first question has been answered to show you how to do it.

Which of the following is **not** a fruit?

- (a) peach
- (b) apple
- (c) grass
- (d) lemon.

The answer is (c) grass.

Now turn over the page and answer the rest of the questions. Try not to worry whether you are getting them right or wrong, just do the best you can.

Kia Ora.

1. A person would *wear* a:
 - (a) kite
 - (b) moe
 - (c) piupiu
 - (d) tama.

2. The greeting "tena koe" refers to a greeting to:
 - (a) two people
 - (b) three people
 - (c) one person
 - (d) a group of elders.

3. A kuia is:
 - (a) an old woman
 - (b) a young woman
 - (c) an old man
 - (d) a young man.

4. The name of the Ariki Nui of Waikato is:
 - (a) Dame Te Ata-I-Rangi-Kaahu
 - (b) Paraone Reweti
 - (c) Matiu Rata
 - (d) Dame Kiri Te Kanawa.

5. After each speech on the marae:
 - (a) the men clap the speaker
 - (b) the women clap the speaker
 - (c) everyone sings a song
 - (d) the speaker is supported with a song.

6. What usually happens to the body after a tangi?
 - (a) buried
 - (b) cremated then ashes scattered over the sea
 - (c) taken to the house of the nearest relative
 - (d) cremated then ashes scattered over tribal land.

7. The legendary origin of the Maori people, before they discovered Aotearoa, is usually said to be:
 - (a) Kupe
 - (b) Kainga
 - (c) Hawaiki
 - (d) Samoa.

8. "Hongi" is an event which involves:
 - (a) an oven
 - (b) touching noses together
 - (c) a meeting of chiefs
 - (d) shaking hands.

9. Tututuku refers to:
- (a) a garment
 - (b) a plant
 - (c) woven panelling
 - (d) mats.
10. One of the canoes, said to have travelled to New Zealand was:
- (a) Waka Nene
 - (b) Te Kooti
 - (c) Rata
 - (d) Arawa.
11. Which one of the following words is different from the other three?
- (a) haere
 - (b) oma
 - (c) peke
 - (d) ataahua.
12. People acting as hosts for visitors on a marae are usually known as:
- (a) papa kainga
 - (b) tangi
 - (c) tangata whenua
 - (c) whanau.
13. What is a waka?
- (a) bird
 - (b) horse
 - (c) storm
 - (d) canoe.
14. Which one of these words is different from the other three?
- (a) puha
 - (b) pipi
 - (c) tuna
 - (d) kina.
15. The words "whai korero" refer to:
- (a) old ladies
 - (b) a song
 - (c) visitors
 - (d) speech-making.
16. Traditionally, when should the manuhiri arrive at a marae?
- (a) early morning
 - (b) during the day
 - (c) just after sunset
 - (d) at night.

17. When moving on to a marae, the arrangement of the manuhiri should generally be:
- (a) in a group, women in front, men behind
 - (b) in a group, men in front, women behind
 - (c) single file, women in front, men behind
 - (d) single file, men in front, women behind.
18. The word for bird is:
- (a) manu
 - (b) poi
 - (c) tangi
 - (d) kite.
19. When you leave a cemetery, what should you do first?
- (a) wash your clothes
 - (b) tell jokes
 - (c) sing a song
 - (d) wash your hands.
20. One of the sons of Rangi and Papa was:
- (a) Tane
 - (b) Maui
 - (c) Kupe
 - (d) Hongi Hika.
21. The opposite of enemy is:
- (a) manu
 - (b) hoa
 - (c) toru
 - (d) marae.
22. A koha is:
- (a) a fruit
 - (b) a vegetable
 - (c) a gift
 - (d) a weapon.
23. The manuhiri are generally called on to the marae with a:
- (a) korero
 - (b) waiata
 - (c) karanga
 - (d) whakapapa.
24. The North Island of New Zealand is said to have been fished up by Maui. The name for the North Island is:
- (a) Kapiti
 - (b) Te-Ika-a-Maui
 - (c) Waipounamu
 - (d) Manganui.

25. You should always take your shoes off before entering a:
- (a) whare nui
 - (b) marae atea
 - (c) whare kai
 - (d) whare paku.
26. Which one of the following words is different from the others?
- (a) Tainui
 - (b) Arawa
 - (c) Taranaki
 - (d) Mataatua.
27. To show sorrow and emotion is:
- (a) kata
 - (b) korero
 - (c) tangi
 - (d) wahine.
28. What does "whakahihi" mean?
- (a) to laugh
 - (b) to cry
 - (c) to talk
 - (d) to skate.
29. Tumutatauenga is the:
- (a) God of war
 - (b) God of agriculture
 - (c) God of the sea
 - (d) God of peace.
30. The customs or ceremonies of a marae are often referred to as:
- (a) kiwa
 - (b) kai
 - (c) kaha
 - (d) kawa.
31. A person involved in the discovery of New Zealand is said (by some tribes) to be:
- (a) Kupe
 - (b) Nga Puhī
 - (c) Te Rangi Hiroa
 - (d) Hone Heke.
32. Maui was destroyed by the laughter of the:
- (a) tom-tit
 - (b) kiwi
 - (c) laughing owl
 - (d) fantail.

33. In the stories of creation, Ranginui and Papatuanuku were separated by:
- (a) all of their sons
 - (b) Maui
 - (c) Tane Mahuta
 - (d) Tawhirimatea.
34. The meeting house is known as:
- (a) whare nui
 - (b) whare kai
 - (c) whare paku
 - (d) whare moe.
35. What does this proverb mean? "Kia u, kia mau ki to Maoritanga"
- (a) Hold on to your Maoritanga
 - (b) Eating is the heart of Maoritanga
 - (c) The Maoritanga and the birds are of one wing
 - (d) The Maoritanga of old is not new.
36. What is a haurangi?
- (a) a speaker for his people
 - (b) a man of great mana
 - (c) a drunk
 - (d) a farmer.
37. "Hura kohatu" refers to:
- (a) close relatives of a dead person
 - (b) burial of a body
 - (c) erecting a tombstone
 - (d) unveiling a tombstone.
38. In the meeting house, the hosts (tangata whenua) of most tribal groups usually sit:
- (a) wherever they please
 - (b) along the back wall
 - (c) to the left after going in the door
 - (d) to the right after going in the door.
39. A person's head is always seen as:
- (a) aue
 - (b) toi
 - (c) tapu
 - (d) moe.
40. In Maori mythology "Papa" refers to:
- (a) the sky father
 - (b) the God of darkness
 - (c) the earth mother
 - (d) the God of birds.

Provisional Maori Cultural Identity Questionnaire

I.D. ___

Provisional Maori Identity Questionnaire

1 Which ethnic group or groups do you identify with?

2 Do you identify with an iwi? Yes/No

If YES: What is your iwi?

3 Do you identify with a marae? Yes/No

If YES: What is your marae?

How often would you have visited this marae or any other marae in the last six months? (please circle)

0 1-5 6 and over

4 Can you speak Maori (please circle)

a) very fluently

b) fluently

c) Kohanga level

d) can understand some but not talk

e) not at all

5 Are you involved in the Maori community here? e.g. Kohanga Reo, Kura Kaupapa Maori, Maori sports clubs, Maori church or a Maori culture group Yes/No

If YES: What sorts of involvement do you have?

6 Have you been involved in the Maori community in the past? Yes/No

7 Indicate any of the following people who have handed on aspects of your Maori heritage to you (please circle)

- a) parents
- b) grandparents
- c) other relatives
- d) other (specify)

Please explain briefly what aspects of your Maori heritage have been passed down to you and by whom

Kia Ora

SYMPTOM CLUSTERS DERIVED FROM PSE ITEMS

Appendix F

HALLUCINATIONS *

- 62 Voices in third person
- 63 Voices speaking to subject
- 64 Dissociative hallucinations
- 66 Visual hallucinations
- 68 Olfactory hallucinations
- 69 Delusion of smell
- 70 Other hallucinations

DELUSIONS *

- 71 Control
- 72 Reference
- 73 Delusional misinterpretation
- 74 Persecution
- 75 Assistance
- 76 Grandiose abilities
- 77 Grandiose identity
- 78 Religious
- 79 Paranormal
- 80 Physical forces
- 81 Alien forces
- 82 Primary delusions
- 83 Subcultural delusions
- 84 Morbid jealousy
- 86 Sexual
- 87 Fantastic
- 88 Guilt
- 89 Appearance
- 90 Depersonalisation
- 91 Hypochondriacal

- 92 Catastrophe
- 93 Systematization of delusions
- 94 Evasiveness
- 95 Preoccupation
- 96 Acting out delusions

GRANDIOSE AND RELIGIOUS DELUSIONS **

- 76 Delusions of grandiose ability
- 77 Delusions of grandiose identity
- 78 Religious delusions

SUBCULTURAL DELUSIONS AND HALLUCINATIONS **

- 64 Subcultural hallucinations
- 83 Subcultural delusions

DELUSIONS OF REFERENCE **

- 72 Delusions of reference
- 73 Delusions of misinterpretation

SEXUAL AND FANTASTIC DELUSIONS **

- 59 Thoughts read
- 70 Delusional elaborations of hallucinations
- 75 Delusions of assistance
- 79 Delusional explanation (hypnotism etc.)
- 80 Delusional explanation (rays etc.)
- 84 Morbid jealousy
- 85 Delusions of pregnancy
- 86 Sexual delusions
- 87 Fantastic delusions
- 88 Delusions concerning appearance
- 90 Delusions concerning lack of organs

DEPRESSIVE DELUSIONS AND HALLUCINATIONS **

- 61 Verbal hallucinations based on depression or elation
- 88 Delusions of guilt
- 91 Hypochondriacal delusions
- 92 Delusions of catastrophe

THOUGHT DISORDER **

- 55 Thought insertion
- 56 Thought broadcast
- 57 Thought echo
- 58 Thought withdrawal
- 59 Thoughts being read
- 49 Delusional mood

DELUSIONS OF PERSECUTION, CONTROL AND ALIEN FORCES ***

- 71 Delusions of control
- 74 Delusions of persecution
- 81 Delusional (alien forces)

* obtained from syndromes in PSE manual (Wing et al., 1974)

** obtained from psychopathological profiles (Jablensky et al., 1992)

*** formed for present study. The symptoms within this cluster were hypothesised by the researcher as being items relevant to Maori cultural beliefs.