Brit. J. Psychiat. (1982), **141**, 143–147

The Present State Examination: Experiences with Xhosa-speaking Psychiatric Patients

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Summary: Language, conceptual, and cultural factors are discussed in relation to a Xhosa translation of the Present State Examination which was administered to a series of 120 consecutive new admissions to a psychiatric hospital.

The experiential events of psychiatric disturbance as defined by the PSE exist in Xhosa-speaking patients and it is a valid instrument.

The Present State Examination is an interview designed to elicit and record the phenomena of psychiatric symptoms in a standard and comparable manner (Wing *et al*, 1967, 1974). It is based on a structured schedule of 140 rateable items and a glossary of definitions, and is much used in contemporary psychiatric research. Extensive studies of reliability have been carried out (Kendell *et al*, 1968; Luria and McHugh, 1974; WHO, 1973, 1975, 1979; Wing *et al*, 1967, 1977; Sartorius *et al*, 1970). It has been translated into several African languages including Yoruba (Leighton *et al*, 1963), Luganda (Orley and Wing, 1979), Swahili and Kikuyu (Gatere, 1980), and Arabic (Okasha and Ashour, 1981). This is the first known translation into Xhosa which is spoken by over 4 million people in Transkei, Ciskei and the eastern and southern Cape Province of South Africa.

Difficulties of translation are considerable, particularly where languages have different lexical and cultural roots. There is not a great deal in the literature to assist with these problems but most authors agree that translations are more adequate for eliciting the hard diagnostic data of psychosis than for fine discrimination of emotional states (Le Roux, 1973; Sabin, 1975; Orley and Wing, 1979). Misinterpretations of both questions and answers are common. Cheetham and Griffiths (1981), for instance, report a marked variance of symptoms and diagnoses in Xhosa patients admitted as schizophrenics, and even the nature and type of certain mental disorders appear to differ (WHO, 1973; Sartorius *et al*, 1970). This has led to continuing speculation about the existence and incidence of certain forms of mental disorder in Africans, some asserting that psychopathology is essentially the same as in Europe (Baasher, 1963; Lambo, 1960; German, 1972). Not all agree on this (Sow, 1980).

For these reasons the SA Medical Research Council Clinical Psychiatry Research Unit has developed a standard evaluation procedure of which a translation of the PSE forms part. It has also been translated into Afrikaans, an easier task, as the language shares roots with English. The Xhosa translation was done by a trained and experienced Xhosa psychiatric nurse and a Xhosa teacher, and then independently re-translated into English by a Xhosa psychiatric social worker, and checked by a psychiatrist against the original English. Simple and colloquial language was used but many difficulties were encountered, for the PSE employs figures of speech and abstractions for which there are no equivalents in Xhosa. The translation was, however, as close to the meaning of the original as could be managed. This was then tested on a series of Xhosa patients in Valkenberg Psychiatric Hospital, Cape Town.

A series of 120 PSE interviews were then carried out on a consecutive series of admissions by a team of eight psychiatrists, psychiatric nurses and psychiatric social workers all of whom had been trained in its use by a member of the British MRC Social Psychiatry Unit. Checks were made of inter-rater reliability which were of satisfactory comparability. Since none of the interviewers was fluent in Xhosa, an interpreter was used whenever the patient could not answer fluently in English or Afrikaans. The requirements of Marcos (1979) were complied with, that is, using a trained indigenous interpreter (a nurse) with an acceptable level of competence in Xhosa and English, experience in psychiatry, and a good knowledge of the PSE and its requirements. To avoid misleading reporting by the

interpreter, pre-interview discussions of the goals of evaluation and post-interview meetings for clarification of the material were regularly done.

Communication difficulties were experienced in the following areas:

(1) arising out of linguistic and conceptual differences;
(2) reality circumstances;
(3) culturally determined factors.

In practice it was often difficult to distinguish between these, for cultural values were usually related to both language and life style.

Language and conceptual difficulties

Most Xhosa patients come from a rural background and have little formal schooling. Many do not speak English or have only a smattering of basic words so that complex terms and nuances of English metaphor and meaning are not understood. The PSE was easier to administer to the more educated group who could speak English or Afrikaans, but even these were more comfortable in their primary language, or seemed to lose their fluency in English when emotionally aroused or confused. This would appear to be due to the regression of thoughts and belief that takes place under such circumstances (Manganyi, 1974). The biggest problem lies in getting an understanding of the intent of the question which often has to be put in the spirit of the enquiry rather than the prescribed letter of the PSE—to get at the "concept behind each item" (Orley and Wing, 1979).

There was a particular difficulty in making some of the linguistic distinctions which are second nature to Westerners for we live in a language-limited world and think what our language allows (the Sapir-Whorf hypothesis). The Xhosa language is capable of very subtle discrimination but this may not lie in the same areas as in English. For example, there are many words for 'grass' or methods of carrying, but few for expressions of anxiety. Similarly a question put in a Western mode may not be understood, or the means of answering it in the same form may not be available. A good example is depression. The original meaning of this is 'down' but it has become the name in English for an experiential state. There is no Xhosa translation, only the term 'dakumbile', also meaning 'down', but not in terms of affect. 'A feeling of sadness' ('utyhafile') may describe the state better and this is the meaning in Luganda (Orley and Wing, 1979), but others consider that the experience is better described in terms of a loss of vital force expressed as 'my body (self) feels broken' in Xhosa, and in Yoruba as 'my heart goes weak' (Leighton *et al*, 1963). In practice, therefore, the Xhosa when asked if he is depressed may answer negatively, although other symptoms testify to the condition; or he may express the feeling in terms which come easier to him such as 'my thoughts choke me'.

The following were found to be particularly difficult areas of enquiry. Tribal people cannot comprehend the term 'worry' (Item 4). This is defined in the PSE as 'unpleasant thoughts which constantly go round and round in the mind'—a cerebral connotation; but in Xhosa one worries with one's heart which relates to a feeling in the precordium connoted by the term 'ukatazeka'. In any case, the term 'mind' used in the probe question is misleading since this refers to higher mental functions such as wisdom. There is likewise no close translation of 'concentration' (Item 20) and it is impossible to get the idiomatic phraseology of the probe questions understood (e.g. "Do your thoughts drift?" and "state of mind".)

Misinterpretations due to a different frame of reference often arise. The question "Have you wanted to stay away from other people?" (Item 28) will often get an irrelevant answer, for example ,"I should keep away from drunken pals as they are bad for me". Patients often admit to feeling particularly cheerful without any reason (Item 41) but on closer questioning it transpires that there is a cause such as listening to music. We have learnt here, as in other such instances, not to take answers at face value.

A particularly difficult question relates to obsessional ideas and ruminations (Item 46). The question, "Do you constantly have to question the meaning of the universe?" is virtually incomprehensible for the African universe is completely meaningful within the context of their beliefs. Patients also express difficulty in understanding the concept of derealization (Item 47) and detailed explanations and concrete examples are often necessary. The notion of delusional mood, where the subject feels that his familiar environment has changed in a way which puzzles him (Item 49), is difficult enough for English-speaking persons to comprehend, but is often beyond the tribal Xhosa. A constant problem is the tendency to think in concrete terms. For instance, in regard to thought insertion ("Are thoughts put into your head which you know are not your own?" Item 55), patients often answer affirmatively when what they really mean is that an idea has been suggested to them. If however the instruction that it must be an *alien* thought is made clear the difficulty may be resolved. Enquiry about pseudo-hallucinations can be most difficult, particularly in making the distinctions between voices which are heard in the mind and those which are heard in the ears. Our experience is that a positive response often signifies true hallucinations but the distinction is not easy to make, as can be judged from the following poem:

"The voice of the Fire can be heard
Hearken to the Voice of the Water.
In the Wind
Listen to the sobbing of the Bush;
It is the breath of the Ancestors".
B. Diop quoted by Sow, 1980

Reality factors

Questions about actual life experiences or specific objects such as reading a newspaper or watching television (Items 20 and 73) often miss their mark, for the respondent may not have had the opportunities referred to or be familiar with the article. In such cases we have found it necessary to substitute familiar experiences such as reading the Bible or listening to the radio. Another example is in relation to weight loss (Item 54). The PSE asks for specific details but weight consciousness is not an important concern in Xhosa culture unless there is extreme loss or gross obesity. As one patient put it "We Africans don't weigh ourselves". Also many people do not have access to scales. We have found however that if there has been looseness of clothes or prominence of cheekbones it is significant of a severe degree of weight loss. Similar considerations apply to delay in falling asleep and early morning waking as many do not have a watch (Items 35 and 37), but this may also have to do with a different perception of time, as will be discussed later. The difficulty can sometimes be overcome by asking questions about tossing and turning, waking before others in their household or before the cock crows.

Cultural factors

Many of the difficulties in administering the PSE arise out of a different world view. The African reality consists of a variety of interdependent interacting life forces of differing magnitude and potency. "Depending on an individual's social and other circumstances his life force could be vitalized or devitalized, increased or decreased. He could as it were, be healthy or ill. The aetiology of his decreased vital force is to be searched for and understood in relation to his existential relations with other vital forces in his psychosocial environment" (Manganyi, 1974). The cause of mental illness may thus be seen as social in nature: bad relations with neighbours, neglect to fulfil certain ritual functions. The cure may be to make retribution to the community or to sacrifice a goat. Thus a positive reply to the question, "Do you ever feel under the control of a force or power other than yourself?", (Item 71) does not necessarily indicate ideas of influence or control. They mean that they would never have behaved in such a fashion without the intervention of an outside power. "This mystical power is not fiction: whatever it is, it is a reality, and one with which African people have to reckon. Everyone is directly or indirectly affected, for better or for worse by beliefs and activities connected with this power, particularly in its manifestation as magic, sorcery and witchcraft" (Mbiti, 1975). The question, "Is there anything like telepathy, hypnosis or the occult going on?" (Item 79) may also be interpreted in this light, and although fuller enquiry may reveal a cultural belief, the dividing line between what is thus determined and what is delusional is very thin at times.

Cultural beliefs make for very different interpretations. For example, the question, "Can anyone read your thoughts?" (Item 59) often gets an affirmative response because it is accepted that a diviner ('isanuse') can know what a person's problems are. Another difficult rating is of paranoid ideas as sought by the question, "Is anyone deliberately trying to harm you?" (Item 74) for there is a widespread belief that ill-fortune may befall an individual if he has displeased his ancestors or omitted some ritual. It is not persecutory so much as retributive. Furthermore, the 'isanuse' whom the patient may well have consulted prior to seeing the psychiatrist will have told him that his symptoms are caused by someone directly or through the use of mystical power. In any case, there must always be an agent of harm that has been sent. "Even if it is explained to a patient that he has malaria because a mosquito carrying malaria parasite has stung him he will still want to know why that mosquito stung *him* and not another person. The only answer which people find satisfactory to that question is that someone has 'caused' (or 'sent') the mosquito to sting a particular individual, by means of magical manipulations" (Mbiti, 1975). Item 83 which assesses subculturally influenced delusions may well throw light on such responses, but if the interviewer is not familiar with the Xhosa culture they can quite easily be a source of error.

One has to bear in mind that ancestors live in the same psychic world as the individual and their influence can be tangible. It is commonly believed, for instance, that they call him by name and the voice may be extremely difficult to distinguish from an auditory hallucination. Similarly, the question, "Do you ever feel someone touching you but when you look there is nobody there?" (Item 70) can be rated as a delusional elaboration when it is no more than a communication by the living dead. Voices heard and visions seen in sleep are frequent amongst normal people.

Confusion sometimes arises because of different societal ways. For example, one often gets a false positive response to an enquiry about ideas of reference or to the question, "Can anyone read your

thoughts?" (Item 59) because people tend to live in closely enmeshed kin relationship and even neighbours can be aware of intimate behaviour and may in fact laugh at the person or talk about him. "This corporate type of life makes every member of the community dangerously naked in the sight of other members . . . Everybody knows everybody else: a person cannot be individualistic but only corporate. Every form of pain, misfortune, sorrow or suffering; every illness and sickness . . . are blamed on somebody in the corporate society" (Mbiti, 1975).

Much difficulty arises out of a different conception of time which tends to be judged in terms of events rather than on a linear basis. The question, "How do you see the future?" (Item 24) may therefore have little meaning, for the events which actualize it have not yet occurred. The same applies to the question, "Does time go too fast or too slowly?" (Item 53). Many patients interpret this in a concrete fashion, for example, "Time passes quickly when I am having a good time". A further manifestation is seen in relation to the question, "Do you have the feeling that something terrible is going to happen?" (Item 92). This is difficult to answer, for, "in traditional African thought, there is no concept of history moving 'forward' towards a future climax, or towards an end of the world. The notion of . . . a final destruction of the world, has no place in the traditional concept of history" (Mbiti, 1975). A practical difficulty lies in the instruction that the experiences being rated should have taken place within the last few weeks because events which may have happened a long time ago but whose effects are still active are often counted by the patient to be in the present. Comparisons also cause problems. The question, "What is your opinion of yourself compared to other people?" (Item 29) often causes bewilderment, because there is a strict and complex hierarchy of age, life development and status among the Xhosa and general comparisons are just not possible. One can only compare oneself to peers, and even this is problematical because if one says one is better, one lays oneself open to envy and possible malevolent action.

Even in the sphere of dress and observed behaviour there are difficulties. Beads of many colours on the head and arms may indicate a tendency to manic over-decoration or signify that the woman is about to be married, and strands of coloured wool worn around the arms could indicate a visit to a particular faith healer. Slowness and underactivity can be extremely difficult to rate as many patients sit abnormally quietly out of deference to the doctor. Similarly, they may appear to be depressed (Item 121) or blunted (Item 128) because it is considered impolite to display affect in the presence of strangers. These difficulties can be overcome by observing the patient outside the interview situation. Parenthetically, we have found that many patients who appear to be seriously depressed are in fact, merely homesick, and the condition is immediately relieved on discharge from hospital.

A few comments on the actual PSE interview are pertinent. Its interrogative style is foreign to the expectations and practice of the tribal Xhosa who normally converse in a much more discursive way, and are moreover used to the diagnostic practices of tribal diviners who say what is wrong with the patient rather than ask a lot of questions regarded by the Xhosa as 'silly'. There is also the guardedness of peasant people who do not trust 'clever ones'; and men or women will not speak of certain matters to an interpreter or nurse of the opposite sex. Then there is the previously mentioned shyness and reserve that is normal in front of a white doctor; sometimes too, affirmation may be a polite cover for non-understanding or they may offer answers which they feel will be acceptable. For example, they may describe an emotion or an unpleasant experience in terms which they feel will be understood: "my head is sore" for feelings of tension.

Very frequently the PSE has to be done in several sessions as patients tire easily and then become evasive or negativistic. In general, we found that with persistence and enough time an experience or manifestation, if present, will be found.

Conclusions

It is the unanimous opinion of our interviewers that although the administration of the PSE in Xhosa is a difficult and sometimes uncertain task, an adequate translation, an informed and trained interpreter and an understanding of certain cultural differences are sufficient to produce definite answers to the prescribed questions. One may, however, have to go beyond the prescribed method of administration and use analogies, metaphors, comparisons and gestures. The greater problem is to decide on severity and degree, and to make some of the fine distinctions of the English version. Less difficulty is experienced with psychotic conditions than with adjustment and neurotic reactions and personality problems, but the PSE is in any case less definitive in these areas. The differentiation of certain affective states can be particularly difficult, as it is a matter of learning to differentiate between related feelings, for example, those of anxiety and anger. The Xhosa are in fact, very much in touch with their feelings—perhaps more so than many who mentate in the Western mode—because they do not obscure or defend against them by intellectual processes. However their sensitivity to

certain experiential states and their translation into specific words may not have been developed to the same extent.

Our experience with the PSE has also brought us to the important conviction that the experiential events of psychiatric disturbance and the elements of psychiatric illness defined by it exist in the Xhosa, and do not differ from those found amongst English-speaking peoples. There are undoubtedly differences in the manner by which they are expressed or described, and in the syndromes and compound diagnostic entities, but these are ascribable to cultural factors.

Acknowledgements

We wish to thank the South African Medical Research Council and the Medical Superintendent, Valkenberg Hospital, Cape Town for their support. Also the Department of African Languages of the University of Cape Town, Dr Vera Bührmann, Mrs J. Ntoyi and Mrs I. Mbanga.

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(*Received 22 February 1982*)