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Subcultural Delusions and Hallucinations

Comments on the Present State Examination in a Multi-Cultural Context

L. SWARTZ, O. BEN-ARIE and A. F. TEGGIN

Summary: The challenges presented by the Present State Examination (PSE) in a multi-cultural context are explored. The general approach to the use of this instrument, difficulties with rating items relevant to cultural or subcultural conditions, and particularly the assessment of psychosis are considered, as well as the possibility of additions to and modifications of the PSE-CATEGO system. Though disagreement exists as to whether the research model which the PSE represents is adequate to deal exhaustively with cultural factors, the instrument is useful in cross-cultural research and also in stimulating debate and crystallising issues.

The Present State Examination (PSE) was devised by Wing *et al* (1974) for the standardised recording of psychiatric symptoms and signs. It consists of 140 items (mainly well-defined symptoms and signs), which when put through the CATEGO computer program yield a tentative diagnosis (if the clinician is satisified that all the information required for a diagnosis is contained within the PSE) according to the Eighth Edition of the International Classification of Diseases (Wing *et al,* 1974; Wing & Sturt, 1978). It has been used in many cultures (Okasha & Ashour, 1981; Orley & Wing, 1979) and some of the challenges presented by the Xhosa version have recently been documented (Gillis *et al,* 1982).

This article stems from continuing use of the PSE in a multi-cultural society with patients for whom the instrument was not standardised, and considers three major problem areas. The first concerns the general approach to the PSE in the above circumstances, including re-wording of questions, difficulties in translation, and the use of interpreters. The second involves technical issues of rating, and the third considers additions to, or modifications of the PSE and CATEGO program. This raises questions about the strengths and limitations of the PSE in a multi-cultural setting, and leads to a consideration of assumptions behind the design of the instrument.

The general approach

Gillis *et al* (1982) have documented factors with regard to the use of the PSE with Xhosa-speaking respondents. The most fundamental question concerns the degree to which different languages allow for similar expression of inner distress. The English term for 'depression', for example, does not have a Xhosa equivalent, and phrases with a similar but not identical connotation have to be used. What remains uncertain is whether these describe similar feelings of dysphoria. Another major difficulty is that many Xhosa speakers do not have access to objects which the PSE takes for granted. Weight loss, for example, has to be estimated by looseness of clothing, as some Xhosas do not have scales. Finally, certain behaviours which are acceptable in one group may look unusual to another. Thus, restriction of emotion in a Xhosa speaker during a PSE interview may easily be taken for blunting, rather than for the sign of respect which it is.

It would be an over-simplification to argue that because the Xhosa language does not have indigenous words to describe certain feeling states, these feelings do not in fact occur. For instance, it is possible to convey the sense of some English idiomatic expressions for emotions by using loaned words. There is no Xhosa equivalent for the term 'nerves' in the sense of 'suffering from nerves' (item 10), for example. The loaned term 'iinerves' is understood in this idiomatic sense by many Xhosa speakers, but the extent to which this type of loan can be used depends on the individual's familiarity with English and English-speakers.

Some difficulties may be resolved with increasing experience with the PSE in other groups. For example, in the original Xhosa translation of the PSE, the term *inimba* was used for 'emotions' (in item 54). It has since been learnt that though *inimba* denotes emotions, it does so specifically as a feeling-state that cannot be experienced by men; we have thus had to re-word an apparently adequate translation.

A particular problem occurs when a delusion contains an element of truth. A man may, for example, hold a delusional belief in his wife's

infidelity when she is, in fact, unfaithful; in such a case, a clinician must rely on skilled judgement of the pathological nature of the patient's beliefs and attitudes in order to rate morbid jealousy (item 84). This rating can be extremely difficult to make, even given optimal conditions, and may be impossible when the interview is conducted through an interpreter. In addition, Xhosa patients may give a positive answer to questions such as 'delusions of persecution' (item 74), and whether this is a culturally determined personal explanation of misfortune, or a morbid belief is likewise often difficult to determine through an interpreter. It is our practice to rate a symptom as present only when certain, but this may lead to under-diagnosis.

The usual definition of a delusion as 'not being acceptable within the culture' sometimes presents problems when it is not clear whether a *folie en famille* exists or whether illness is being explained in cultural terms. Some Xhosa patients have complained of being persecuted, and these complaints have been supported by family members. Raters have at times nevertheless suspected that such beliefs are morbid, but have been confused by the families' opinions and have been unsure how to score the item. These examples demonstrate problems in establishing boundaries between normality and pathology in a group culturally different from that of the rater.

The rating of culturally influenced items

There are two specific items in the PSE on which subcultural phenomena can be rated, *viz*-item 64 (1) — 'subcultural hallucinations' and item 83 — 'subculturally influenced delusions'.

In analysing subcultural phenomena, however, the PSE manual pays most attention to differentiating subcultural and hysterical possession states from delusions of control (item 71) (Wing *et al*, 1974). The guidelines for this are summarised in the Table.

The criteria for delusions of control are therefore quite clear; the delusions must occur in clear consciousness, are unacceptable within the culture, are often based on abnormal responses rated elsewhere, and the pathological control is felt as related to loss of identity. Subcultural possession is also reasonably straightforward; consciousness is dissociated or there may be stupor, and the state is both ego-enhancing and approved of within the culture. Determining hysterical possession is more problematic: there is a disturbance of consciousness, the state may or may not be acceptable to the subculture, but is explicable in terms of it, and the effect is not stated, though its 'motivation' should be obvious. The rating of hysterical possession in particular requires the use of clinical judgement, especially in the area of hallucinations.

The rating of 'subculturally influenced delusions' (item 83) is hampered in the same way by the question of when a phenomenon can correctly be assessed as pathological. The PSE instruction for a rating of '1' on this symptom requires that "one or more of the 'delusions' rated earlier could easily be no more than a belief shared by other members of the subject's subcultural group". This implies that the rater may be uncertain whether certain beliefs are culturally acceptable or pathological, for if he were sure of the former, he presumably would not have previously rated these phenomena as delusions.

TABLE I

Summary of PSE instructions for differentiating between delusions of control and possession states

	Delusions of control	*Subcultural possession*	*Hysterical possession*
Consciousness	Clear	Dissociated	Dissociated
Acceptable to subculture?	No	Yes	Not necessarily, but subcultural origins clear
Effect of symptom	'Experience of loss of identity'	'Ego enhancing'	Not stated, but 'motivation should be obvious'
Rating	Item 71 – delusions of control	1) Either item 100 (dissociative states) or 102 (clouding or stupor)	1) Either item 100 or 102
		2) Item 83: subculturally influenced delusions (rate (1) or (3))	2) Item 83 (rate (2))
		3) If hallucinations: 64 (1) – subcultural hallucinations	3) If hallucinations: 64 (1) or 64 (2) dissociative hallucinations

It is noteworthy that the terms 'delusion', 'culture', and 'subculture' are not explicitly defined in the PSE, which has a meticulous glossary for most other terms. Furthermore, the implicit definition of 'subculture' as "small groups with definitely idiosyncratic beliefs" is not applicable to large groups such as the Xhosa. Stratification within such groups exists, but may be difficult to recognise with sufficient discrimination to allow for an accurate rating on item 83. A similar point applies to the rating of a '3' on item 83: "more specific delusional states e.g. Koro, Witigo, etc." It is arguable whether these belong in this section, as not all culture-bound syndromes are necessarily psychoses (Leff, 1981), and in any event, they occur in groups too large to be called 'subcultures'.

The rating of '1' on item 83 appears to be designed to modify previously rated 'delusions' into culturally accepted beliefs. In practice, however, all such a rating does is to give a higher total symptom score, which in British patients may be an indication of the degree of psychopathology (Sturt, 1981). So, for example, if a belief of being poisoned is modified by the patient's explaining all illness in this way, the CATEGO tentative diagnosis will be the same as in someone with identical symptoms which are not culturally explained. Thus, even if he is not 'ill', he will paradoxically have a higher total symptom score. A second problem with item 83 is that if more than one delusion has been rated earlier, there is no way of recording which delusion a rating of '1' or '2' is intended to modify. In our experience, patients may hold truly delusional beliefs as well as beliefs which may appear to be delusional to a rater from another culture.

Culturally modifying factors always have the potential to make respondents seem more rather than less ill. For example, a score on 'clouding or stupor' (item 102) as a result of a subcultural possession state raises the score for the syndrome of 'non-specific psychosis' in the same way as a positive rating of clearly psychotic symptoms such as stereotypies, delusional mood, or incongruous affect. Even within the syndrome 'subcultural delusions or hallucinations', there is a lack of differentiation between the modifying quality of a score of '1' on item 83 and the probably abnormal behaviours rated as '2' or '3'. Thus, the gradation of severity generally used in the PSE's scoring system obscures the qualitative differences between these ratings in item 83.

Additions or structural changes to the PSE

One way of adapting the PSE for different settings is to enquire about specific cultural phenomena. In using an Arabic version of the PSE, Okasha & Ashour (1981) added four questions dealing with witchcraft, traditional healing efforts, sexual inadequacy, and praying. In the Xhosa version, for example, similar questions could easily be added, especially with regard to indigenous healers. This approach, however, limits cross-cultural comparisons, as positive answers do not necessarily indicate pathology, and certainly do not give a guide as to the nature of any psychopathological process.

It is possible to re-organise the CATEGO program so that the above additions (together with the 'subcultural delusions or hallucinations' syndrome) are presented separately, without affecting the total symptom score. Culture-specific items similar to those developed by Ebigbo (1982) in Nigeria could be added in a separate section of the PSE. This, together with a much more flexible approach to getting at the psychopathology underlying the existing items, could go a long way towards improving the instrument for cross-cultural use. Questions could be rephrased, and a different manner of asking questions could be adopted. Clinicians skilled in Western psychiatry and completely familiar with the culture of those being rated have an invaluable part to play. The advantages of using the PSE internationally have been made clear (WHO, 1973) and the above suggestions may go some way to extending its usefulness.

All the above considerations, however, are subject to the assumptions that mental illness consists, at least in part, of universal factors, and that these can always be tapped by a detailed checklist of items. Whilst these assumptions are not the focus of this article, the discussion would be incomplete without mentioning an alternative approach. It could be argued that the PSE will find only what is ostensibly common between groups and miss what is different (Kleinman, 1977). Proponents of this view would attribute the problem almost as much to the question-and-answer style of the instrument as to the content of the questions themselves. They would argue further that modifications to the detail of the PSE will not compensate for its ethnocentricity.

Within our unit, opinion ranges from those who view the PSE, with appropriate modifications of the type mentioned above, as potentially the most important cross-cultural instrument available at present, to those who argue that the very concept of a single cross-cultural instrument trivialises any attempt to come to grips with the relationship between culture and mental illness. These differences echo current debates in cross-cultural psychiatry as a whole (Kleinman, 1977; Leff, 1981;

Prince, 1983), and will continue, we hope, in productive fashion for many years to come. Being, in general, such a carefully-designed and clear instrument, the PSE is in an excellent position to stimulate debate and crystallize issues.

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L. Swartz, MSc (Clinical Psychology), *Scientific Officer*

*O. Ben-Arie, MB, ChB, FRCPsych, *Associate Professor*

A. F. Teggin, MB, ChB, MRCPsych, *Senior Lecturer*

MRC Clinical Psychiatry Research Unit, Department of Psychiatry, University of Cape Town, Groote Schuur Hospital, OBSERVATORY 7925, Rebublic of South Africa.

*Correspondence

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