The 'present state' examination and the structured clinical interview in Zulu

B. G. BUNTTING, W. H. WESSELS

Summary

The language, cultural and reality factors found to be important in the Zulu translation of the 'present state' examination (PSE) and the structured clinical interview for the *Diagnostic and Statistical Manual of Mental Disorders* (SCID) are discussed and compared with a previous translation of the PSE in Xhosa. The psychopathological items of the PSE and SCID apply to Zulu-speaking patients and the instruments are valid in this setting.

S Afr Med J 1991; **79**: 96-98.

The two major sources of differences or variance between clinicians' diagnoses in psychiatry have been traced to the information collecting process and the criteria used for scoring this information by Spitzer *et al.*[1] The 'present state' examination (PSE) from Wing *et al.*[2] and the structured clinical interview for the 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders* (SCID) from Spitzer and Williams[3] gather information in a standardised way, with specified rules for scoring, thus reducing the two sources of variance.

Cross-cultural diagnosis of psychopathological processes is more difficult and challenging than biopathological diseases because of the prominent role of cultural and language factors, as stated by Westermeyer.[4]

Zulu is spoken by the largest number of blacks in South Africa. The PSE and SCID were therefore translated into Zulu and validated in a random sample of 30 Zulu-speaking psychiatric patients by Buntting.[5] In this study PSE diagnoses were correlated with a psychiatrist's diagnoses and the diagnoses made using the Zulu version of the SCID. The PSE and SCID proved to be valid instruments for use in Zulu-speaking patients. The cultural, language and reality factors found to be important in this study are discussed and compared with a previous Xhosa study by Gillis *et al.*,[6] since the Zulu and the Xhosa groups are closely related in language and culture.

Language difficulties

The difficulty in translation of the different sections of the PSE and SCID varied, the emotional states being more difficult than the psychotic section. These findings are in keeping with those of other workers, such as Orley and Wing[7] and Sabin.[8] The first problem encountered in translation was understanding the question. An indication of understanding was given by the degree of relevance of an answer and whether the patient was able to repeat the meaning of the question in his or her own words. The second part of the problem of translation was in the reply. Problems with the reply were either because an experience was foreign to the patient's culture or else there was no easy way of expressing the particular experience in Zulu. The word 'item' is used to refer to the specific items of the Zulu PSE only, thus allowing comparison with the Xhosa PSE.

There is no single universally accepted word for anxiety and for 'worry' (item 4) in Zulu. These terms have a more cognitive meaning in English, i.e. one worries in the mind, whereas in Zulu, as in Xhosa, they are related more to the heart. The Zulu words for anxiety and worry include *inhliziyo ibuhlungu* — the heart is sore, *ukukhathazeka* — worried or anxious, *ukusaba* — being afraid, *ukuba novalo* — being anxious or afraid, *ukuphatheka kabi* meaning to feel bad. *Ukukhathazeka* was the term most patients understood to mean anxiety. However, patients also use the other terms in the interview situation and therefore one has to be aware of their meaning and the context in which they are used.

'Depression' also does not have a single Zulu equivalent and Zulu terms for depression include *umoya uphansi* — the spirit is down, *umzimba uphansi* — the body is down, *inhliziyo ibuhlungu* — the heart is sore, *ukukhathazeka* — worried or anxious, *ukupatheka kabi* — not feeling well. The term most patients used for depression was *umoya uphansi* followed by *inhliziyo ibuhlungu*.

Despite the overlapping terminology it was possible to separate anxiety from depression by combining the terms. For example for 'depressed mood' (item 5) three different terms, *uphansi umoya, unomunyu* and *ukhathazekile,* were used, all enquiring about depression. Also the response to questions relating to crying and loss of interest assisted further in separating anxiety from depression. Comparing the feeling of depression with grief usually overcame any doubt about the feeling being depression.

Item 46, relating to obsessional ideas and ruminations, was not easily understood by Zulu-speaking patients, as had been the case with Xhosa-speaking patients because questioning the meaning of the universe is foreign to their traditional viewpoint that sees the universe as meaningful. Item 47, concerning derealisation, and Item 49, concerning delusional mood, were poorly understood by both groups. These are difficult concepts to understand in English and therefore translation difficulties are understandable.

Concrete and literal interpretation of questions was often encountered. Item 58 'Can anyone read your thoughts?' was misinterpreted as, for example, having a coincidental similar idea. Another example was an affirmative response to the question about hearing of voices, when what really was meant was hearing the doctor's voice or other patients' voices. Assessing the severity of symptoms for adequate scoring was sometimes a problem. When questioned about the different emotional states some patients responded in the affirmative although they actually meant normal degrees of the various emotions. When questioned about the severity they answered 'bad' or 'very bad' leaving the examiner uncertain about the meaning of these terms. A useful way of sorting this problem out was to ask whether the emotional state was experienced to the same degree as ordinary people. The patients were then able to say whether the emotional state was abnormal in severity or not.

Department of Psychiatry, University of Natal and Durban and Midlands Hospital, Pietermaritzburg
B. G. BUNTTING, M.B. CH.B., M.MED. (PSYCH.)
W. H. WESSELS, M.B. CH.B., D.P.M., D.M.

Accepted 20 June 1990.

Based on a paper presented at the 6th South African National Psychiatric Congress, Sandton, Tvl, 6 — 8 March 1989.

Reality factors

The actual life experiences and objects in the environment of some of the Zulu patients affected the structural interviews in the same way as occurred in Xhosa patients. Consequently, familiar activities such as playing *mulabalaba* (a board game), watching soccer or listening to the radio had to be substituted for reading the newspaper or watching television. Items such as scales to assess weight loss had to be substituted by enquiring about the fitting of clothes. Some patients did not have clocks to assess delay in sleep (item 35) or early morning waking (item 37) and restless sleep or sleep after or waking before other members of the household had to be enquired about. Also, none of the patients used sleeping tablets.

Cultural factors

The problem of patients not reporting symptoms, such as anxiety and depression, because of the cultural belief that they did not have medical implications, as reported by Muhangi and Ndetei,[9] was not encountered in this research. This is probably because the above authors used an unstructured interview whereas this research used structured instruments that asked specific questions about these emotional states. Therefore information about anxiety and depression was obtained irrespective of the patient's belief about its medical significance.

The traditional view of causation of mental illnesses includes morality, natural and mystical processes that involve social situations, and ancestors' wrath at the absence of performance of certain sacrifices, according to Ngubane.[10] This, combined with the fact that illnesses and misfortunes are blamed on somebody else in traditional culture according to Mbiti,[11] affects the sections on delusions and hallucinations in the structured interviews.

Item 74, concerning delusions of persecution, has to be differentiated from the cultural explanation of illness. Many patients felt that they were being poisoned or harmed by others owing to a cultural explanation of illness. If the patient felt threatened by people who were unlikely to do him harm, such as very close family, other patients, doctors and nursing staff, then this pointed toward a delusion. Similarly, a delusion was probable if the patient felt threatened by a large number of people. The above situation also applies to item 72, which deals with delusions of reference. These findings are similar to the findings of the Xhosa PSE.

Item 79 asks 'Is there anything such as telepathy, hypnosis or occult going on?' and was understood by Zulu-speaking patients, similarly to Xhosa patients, as meaning a cultural explanation of illness. These findings are also applicable to item 80, which deals with delusional explanations in terms of physical forces and item 81 which deals with delusions of alien forces penetrating or controlling the mind or body.

A negative score was given when there was any doubt about an item. The same method was used in scoring the results in the Xhosa study.

Subculturally influenced delusions, item 83, is probably not applicable to Zulu-speaking patients for the same reason as in Xhosa-speaking patients, since both groups are too large to be defined as 'small groups' with definitely idiosyncratic 'beliefs', as defined in the glossary of the PSE. Therefore the visual and auditory hallucinations sections of the structured interviews had to be separated from normal cultural experiences. Another problem concerning visual hallucinations is that the term *ukubona* or 'to see' also means 'to have foresight'. Therefore patients have to be asked whether things are seen with their eyes when enquiring about visual hallucinations.

Item 24 asks 'How do you see the future?' and which presented problems for some Xhosa patients was, however, very well understood by most Zulu-speaking patients. Manic patients spoke of a future glittering like gold, depressed patients spoke of a dark future, while patients with no mood disturbance gave an appropriate answer. Similarly, item 29 which asks 'What is your opinion of yourself compared with other people?' was well understood and responded to by the Zulu patients as opposed to the findings in Xhosa-speaking patients. These differences are probably related to differences in translation in the two African languages rather than to cultural differences, as explained by Gillis *et al.*[6]

Experiences in the observation section of the structured interviews with Zulu-speaking patients were again similar to those of Xhosa-speaking patients. *Ukuhlonipha* or respect, which involves the lack of display of affect in the presence of strangers together with poor eye contact especially in the married women, could easily be mistaken for depression (item 121) and blunted affect (item 128). Drug abuse (item 98) also resulted in some uncertainty about whether it was 'abnormal use' or not.

In the overview section of the SCID, a simple item on marital status was a problem because many patients were in the process of marriage involving payment for the bride or *lobola*. Many patients answered that they were not married even though they had lived as man and wife for many years and had children because the cultural wedding processes had not been completed.

The description of the presenting problem was often inadequate, many patients answering 'mental illness'. A few more probing questions such as 'What was happening to you when you were mentally ill? What did you do?' were added.

The estimation of time or duration of symptoms especially if related to a long period, was a problem for many patients. They often answered 'A long time ago', leaving the interviewer uncertain of exact duration. To overcome this problem the patients were asked to link the age or height of their children to the duration of the illness. This method gave a reasonable estimation of the duration of symptoms.

The section on possible precipitants of the present illness was also not well understood by many patients. Examples of specific precipitants had to be asked for more meaningful answers. Also, cultural stress factors, such as rituals that were not performed after a year had passed since the death of a loved one, were not spontaneously mentioned by patients. Additional questions had to be asked concerning cultural stress factors or traditional treatments received.

Deterioration in occupational functioning was also difficult to assess in patients who often work irregularly doing unskilled temporary jobs also called 'tog' or 'piece work' in a relatively depressed economic climate. This problem was solved in most cases by asking whether the patient worked as well as he or she did before the mental illness. Also, periods of increased unemployment after mental illness were looked for and the patient was asked whether these were related to illness or lack of jobs.

Conclusion

Psychopathology as elicited by the PSE and SCID exists in Zulu patients and does not differ from that found among English- or Xhosa-speaking patients once cultural factors have been considered. Bearing in mind that the Zulu PSE and Zulu SCID decrease interpreter-related distortion, information variance and criterion variance, while taking into account cultural factors, suggest that they will be very useful instruments for the assessment of Zulu-speaking patients.

REFERENCES

1. Spitzer RL, Endicott J, Robins E. Clinical criteria for psychiatric diagnosis and DSM III. *Am J Psychiatry* 1975; **132:** 1187-1192.
2. Wing JK, Cooper JF, Sartorius N. *The Measurement and Classification of Psychiatric Symptoms.* London: Cambridge University Press, 1974: 189-228
3. Spitzer RL, Williams JB. *Instruction Manual for the Structured Clinical Intverview for DSM-III (SCID).* 2/1/85 revision. New York: Biometrics Research Department, New York State Psychiatric Institute, 1985.
4. Westermeyer J. Psychiatric diagnosis across cultural boundaries. *Am J Psychiatry* 1985; **142:** 798-805.
5. Buntting BG. Comparison of the present state examination and the structured clinical interview after translation into Zulu. Thesis for degree M.Med. (Psych.), University of Natal, Durban, 1988.
6. Gillis LS, Elk R, Ben-Arie O, Teggin A. The present state examination: experiences with Xhosa-speaking psychiatric patients. *Br J Psychiatry* 1982; **141:** 143-147.
7. Orley J, Wing J. Psychiatric disorders in two African villages. *Arch Gen Psychiatry* 1979; **36:** 513-520.
8. Sabin JE. Translating despair. *Am J Psychiatry* 1975; **132:** 197-199.
9. Muhangi J, Ndetei DM. The prevalence and clinical presentation of psychiatric illness in a rural setting in Kenya. *Br J Psychiatry* 1979; **135:** 269-272.
10. Ngubane H. *Body and Mind in Zulu Medicine.* London: Academic Press, 1977: 22-150.
11. Mbiti JS. *African Religions and Philosophy.* London: Heinemann, 1975: 194-215.