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PSYCHIATRIC FIELD SURVEYS : PRACTICAL AND THEORETICAL PROBLEMS

by

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The value of epidemiological studies in psychiatry, particularly field surveys, becomes increasingly evident, not only because they produce opportunities to study the associations between population characteristics and disease, but also for the assessment of the community needs for psychiatric facilities.

Field survey in psychiatry is that aspect of the epidemiological study which can provide valuable knowledge about human personality, both in healthy and unhealthy condition. This knowledge can be obtained through data compiled as from fundamental demographic studies, community attitudes towards mental illness, and first-hand information.

The scope of these investigations is very wide, as in such studies the patient is being studied in relation to his surroundings and in a socio-cultural setting, which, in their turn, include numerous factors and variables. Therefore, the methods, as well as the site and size of the studies will vary according to the objectives.

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This valuable system of investigation requires much accuracy and precision both in the process of compilation of data and in their analysis, as well as in the interpretation of findings. As such, in practice, it meets with difficulties and raises some questions. The difficulties that are encountered in practice are obvious, and the ways of overcoming them are not manifold, nevertheless they are worth mentioning. What is more substantial is the underlying assumptions and the constituants of any epidemiological study, which deserves serious consideration. Some of the principles of these assumptions tend to vary from one culture to another, and more often than not, they can elude the attention of the investigators working in this field.

The practical difficulties

The shortage of psychiatrists in developing countries is the first to be mentioned. This is especially true regarding those psychiatrists who are familiar with the epidemiological methods and have training in this field.

The prevailing illiteracy in some countries should be considered another difficulty, mainly because it puts limitations to the administration of screening methods.

In a well-planned field survey and with the participation of an epidemiologist or a statistician, in most cases, the need of a psychiatrist will be limited to accomplish the psychiatric examination of doubtful cases, thus bringing the need of participant psychiatrist to minimum. In this case an appropriate screening instrument, applicable by a non-professional or a high-school graduate, is required, which at the same time must be designed in such a way as could be administered to illiterate or semi-literate persons.

Ideally, it would be desirable to open special courses in psychiatric epidemiology, both in theory and in practice, in those countries where postgraduate courses in psychiatry already exist. Otherwise it would be necessary to send candidates to be trained abroad.

The mobility of the population and the high rate of migration raise another practical difficulty. Although they may produce some limitations in the field survey, it could be solved satisfactorily if a sociological and demographic study precedes the psychiatric field survey. It has to be mentioned though, that with all its difficulty, psychiatric study of the mobile population, such as of migrants and nomads, has special interest; sometimes also, in such studies, the methods of investigation should be adjusted to their specific mode of life and condition.

Field surveys and the socio-cultural trends of the population under study

After outlining, in short terms, the more prominent practical difficulties encountered in field surveys, let us now turn to the social and cultural principles underlying field surveys, and discuss at the same time their implementation in this field.

In field surveys, the investigator who works among people and try to establish contact with them, may come across some unexpected problems. If the investigator has not foreseen these problems and is not prepared to cope with them properly, he may jeopardize the whole study.

It is not uncommon, in field surveys, to see that respondents regard the investigator as somebody who interferes with their routine affairs; enters into their lives; or imposes himself and his questions on them. They look to him as an alien who, nonetheless, asks questions about their feelings ideas and private life; and without been asked, inquires about their health. The whole proce s may appear to them irrelevant, and the investigator, as an obtrusive and unduly curious person.

In a morbidity study, carried out in a small village in Roodsar, Iran, a woman who was selected at random and had been visited previously in a general health survey, refused to receive us, protesting that since the first visit of the health officers, her neighbours would not mix with her any more. They said to her that she must have some kind of disease, otherwisewhy did the"health people" call on her and nobody else?

In contrast to this sole example there was another person who welcomed our presence and asked us to see his wife complaining that "her nerves were weak". Likewise, there were many others who would come forth with different complaints and would ask to be examined and receive medical advice, which of course we gave.

In Iranian society it is quite easy to keep contact with people, provided one shows respect to the local habits and behaves according to their standards of etiquette. As a rule particularly in villages, the first contact should be made with thehead of the family, introducing oneself, describing the purpose of one's visit, and asking permission to interview the family members, with whom, very often, it is possible to have private interviews. Meanwhile, it is not unexpected to see that the young wife or the daughter is unwilling to stay alone with strangers, in which case the interview should be done in the presence of others.

Although industrialization and the constant contact of villagers with the cities have changed many old traditions and customs, the general tendency is that women and girls keep a distance from those who are considered "not intimate", that is to say a stranger. For them it is not an honourable behaviour to unveil their private lives to others. They even may not reveal everything to intimates except to their mothers. Therefore, mothers and mothers-in-law usually are the best sources of information provided that they consider it appropriate to give the desired information.

In any case, it would be very difficult to tackle, in a single session, some questions such as questions regarding sex, marital life, husband-wife relationship, addiction, addiction, and history of some physical and mental illnesses in the respondent or in his family. The history of illnesses will almost always be denied when it is asked in the presence of the spouse or others.

The amount of monthly income usually is given less, and the kind of occupation is given in general terms.

Bash and Bash [1] in their psychiatric epidemiological study of the city of Shiraz, Iran, state that "We sedulously refrained from inquiring about addiction in order not to jeopardize our whole survey".

Giel and Van Luijk [2] had a similar experience in Ethiopia, stating that people were very reserved when it came to discussing such items as marital state and economic position; consequently they were obliged to limit the number and scope of their questions considerably.

As a rule the whole process of interviewing becomes easier when the home visits are made more than one person, and especially when there is a woman in the group.

The cultural groups and symptom clusters

There is evidence to believe that most probably different cultural groups have a natural proclivity towards certain preferred symptoms to express a particular psychiatric disorder. For example, Ellenberger [3] has reviewed the clinical manifestation of hysteria in different cultures to document the fact that the cultural context determines to a high degree the clinical manifestations of hysteria and concludes that each culture provides a model for the particular variety of hysterical symptoms observed.

Tseng and Hsu [4] comparing psychiatric patients of two different cultures, Chinese in Taiwan and Americans in Massachusetts, state that

Chinese psychiatric patients in Taipei tend to present a higher proportion of neurasthenic; hypochondriacal and psychosomatic symptoms than American patients in Boston, while depressive symptoms, common in Boston patients, are less frequent in Taipei.

Raymond Prince[5] reviewing the literature dealing with depressive disorders in Africa, between 1895 to 1965, has found that most of the authors report that African depressions differ from the European variety in that there is less verbalization of depressive effect, the self-accusation is rare, projection is common, hypochondriasis and somatic complaints abound and that suicide is uncommon.

More recently, Baasher et al[6] in Sudan, and Okasha et al[7] in Egypt, have shown that while the rate of psychiatric morbidity is similar to that of western countries, the mode and pattern of presentation of disease has some dissimilarities.

Pfeifer[8] opines that deviations from the classical text book picture of depression must be expected in extra-European depressives, and Murphy et al[9] point out that whether the psychotic process results in quiet self-absortive withdrawal, in agitation, or in self-interpretive deliberations, depends to a great extent on cultural factors.

It should be mentioned also that many authors from Eastern, Middle-Eastern and African countries have reported a very low frequency of obsessive symptoms in their patients.

The study carried out by Fabrega et al[10] in North America is interesting in that they have used Anglo, Negro and Mexican schizophrenics in matched samples to explore the significance of cultural background in determining the symptomatology of mental illness. By testing forty-four variables they deduced that of the three types of instruments used, namely psychiatrists' evaluation, nurses' evaluation, and a factor score from the

Holtzman Inkblot Test, the latter appears to be less affected by social variables than the other two. This suggests that social class or status may have a great relevance for the defenses and symptoms adopted by patients than for their personality organization. However, it has been frequently demonstrated that social and cultural factors have a bearing on personality development[11,12].

In a recent investigation, the International Pilot study of Schizophrenia[13] carried out by WHO in nine culturally different countries, among many interesting findings, it has been pointed out that similar groups of schizophrenic patients can be identified in every one of the nine countries, and that there are groups of schizophrenics which have centre specific characteristics.

These findings and the findings of many other authors in this respect indicate that in a particular cultural group, some psychiatric symptoms: (1) may stem from, or at least may become affected by the socio-cultural conditions specific to that culture, and (2) these symptoms may have relevance to the personality structure, characterizing the cultural group. Therefore, it is expected to see that some psychiatric symptoms may differ, in their rate of frequency, and possibly also in their character, from one culture to another.

It ensues then, that recognition of the symptoms prevalent in a particular cultural group should be considered most important for the detection of psychiatric cases in that culture.

The verbal expression of symptoms

Words and phrases used by patients to express their emotional and mental condition differs considerably from one culture to another.

The patients in Iran, very often use idioms and colloquial language to describe their condition, or they take examples from nature and climatic

changes, or they seek the help of proverbs, fables, poems and religious stories to demonstrate a particular symptom. Very often also, emotional conditions are described in reference to the malfunctioning of some body organs.

To give a few examples : "I escaped from a forge" (presumably like a spark), in Persian, stands for "loosing the temper"; or "being two-hearted" means to hesitate; or when sorebody says that he is possessed by the devil, he means that he is annoyed and is revengeful, but he is unwilling to take action. "To sink into thoughts" is a common expression equivalent to depressed mood.

When a patient says "my gall-bladder bursts", he means that he is terrified; "the liver does not function", means he is constipated; when somebody says he is weak, he may mean that he is suffering from impotency; but when he complains "my back is loose", he wants to say he is suffering from rapid ejaculation.

During conversation with a layman, especially in villages, such terms are used quite frequently. In a field survey particularly, when it is undertaken in remote parts of the country one has to be familiar with the medical interpretation of this terminology, and no doubt, try to avoid using psychiatric language; because, although the words may be understandable to the respondents, more often than not the answers would be misleading, as a considerable part of the psychiatric nomenclature, which is borrowed from spoken language has retrieved a different meaning and definition.

The problem of vernaculars used by different ethnic groups should not be overlooked. Sometimes it would be necessary to seek the help of an interpreter, which makes the whole process difficult indeed.

Definition of psychiatric "case"

One of the main objectives of a psychiatric morbidity study is to identify the cases in a population; but whom we call a case? This question

Besides its theoretical, social, ethical and legal aspects, has an operational importance; the immediate requisite following a survey, especially in developing countries, will be to advise on the necessary care and treatment the identified cases may need; which in its turn will tend to change the concepts, a given culture has about mental disorder, and tend to modify the criteria of judging a person mentally ill; a matter which does not always take place smoothly.

Generally speaking, there are two approaches to the question. First, using the criteria of well defined and unquestionable clinical patterns, or the pathology of the malfunctioning organs, and second, to adopt the statistical definition of normality, which permits to consider deviations from the normative norms as illness.

Needless to say that both criteria have their shortcomings. The first definition applies more to the organic cases, and the second, i.e. "the statistical definition of normal and deviance", as Savage et al [14] point out ""is easily explained and easily applied, but if employed independently of concepts about function and malfunction, it brings its own share of difficulties. Strictly applied, it would rule out the possibility of finding the majority of any cultural group to be neurotic", in other words not every conformity to the norms is an adequate evidence of normality, and similarly, not every deviation can be regarded as pathological. Nevertheless, it has the advantage of having the cultural selling in the background.

When the boundaries of psychiatric disorder are not clearly determined, no doubt, discrepencies will arise in cross-cultural findings. Therefore, in the evaluation of mental disorders in a community, the first step taken should be to define clearly the "cases" subject to identification.

It is obvious that the definitions will be changed according to the objectives of the study. However, in a general screening programme,

particularly in developing countries, it is advisable, as a starting point, not to make the range of the disorders so wide as to overwhelm the community tolerance towards persons labelled as mentally ill. This may create a resistive attitude in the society towards psychiatry; it may provoke social difficulties for the persons diagnosed as such, as well as, may create medical and possibly legal obligations for the psychiatrists, who may not have under their disposition the necessary facilities for dealing with all the problems.

Case identifying instruments

From what have been said until now, it can be deduced that one of the major problems in field surveys is the question of case-identifying instruments.

We will limit ourself to speak about the difficulties encountered in the administration of the case-identifying questionnaires, as besides their wide employment, most of the problems existing regarding this method applies to other methods as well.

The barrier of language could be considered as the first in the series. Those countries who have not developed a screening instrument of their own, they have to choose and translate one of the many existing questionnaires. Some investigations carried out in Western countries come to prove that the usefulness of the translated versions of examined questionnaires diminish notably, especially for the purposes of cross-cultural purposes [15,16,17].

In view to demonstrate the difficulties that may arise in translating queries, let us take the item "Do you usually feel unhappy or depressed ?" from C.M.I. When we translate and back-translate the word "unhappy" it will become "unfortunate, accursed or wretched", which seems an abusive language and will annoy the respondent, if it asked as a question, though a depressed patient may complain spontaneously of being accursed.

It is a constant observation that many of the items of a questionnaire though translated in a comprehensive language are not understandable to the respondent; either they answer at random or the interviewer is obliged to give complementary explanations and examples, and sometimes submerge into conversation with the patient to obtain a correct answer. At the end, it turns out that he has accomplished a psychiatric interview instead of administering a screening instrument. This is especially true in the case of illiterate patients. In addition, in those countries where illiteracy prevails the administration of self-completing check-lists are impracticable. In such countries the questionnaires should be read to the respondent, who in his turn, besides having the above mentioned disadvantage, meets with the practical difficulty of shortage of psychiatrists. There is no other way then, but to seek the help of non professionals, who can undertake this task, by receiving adequate training.

Having in mind these practical difficulties, and the points that were discussed in the previous pages, it ensues that in developing countries, the translated screening instruments or other questionnaires should be administered with much caution, and that for some surveys it would be more easy and more reliable to devise an independent screening method appropriate to the social and cultural conditions than to translate one.

REFERENCES

1. Bash, K.W. and Bash, J.L. (1974) A psychiatric epidemiological study of the city of Shiraz. Paper presented at WPA International Symposium of Epidemiological Studies in Psychiatry, Teheran.

2. Giel, R. and Van Luijk, J.N. (1969) Psychiatric morbidity in a small Ethiopian town. The British Journal of Psychiatry, Vol. 115, No.519

3. Ellenberger, H.F. (1968) Aspect ethno-psychiatrique de l'hysterie. Confrontations Psychiatriques, No.1, ESept.

4. Wen-Shing Tseng and Jing Hsu (1969) Chinese culture, personality formation and mental illness. Transcultural Psychiatric Research Review, Vol.4, Oct.

5. Prince, R. (1969) The changing picture of depressive syndromes in Africa. Is it fact or diagnostic fashion? Canadian Journal of African Studies, 1.

6. Baasher, T.A. et al. (1970) Depression in Sudan, S.M.J. Vol. 8, No.3.

7. Okasha, A., Kamel,M., Hassan, A.H., (1968), Preliminary psychiatric observations in Egypt. The British Journal of Psychiatry, Vol.114 No.513.

8. Pfeifer, M. Wolfgang (197)) Transcultural psychiatry - results and problems. Transcultural Psychiatric Research Review, Vol.7, Oct.

9. Murphy, H.B.M., Wittkower, E.D., and Chance, N.A. (1967) Crosscultural inquiry into the symptomatology of depression : A preliminary report. International Journal of Psychiatry, Vol.3.

10. Fabrega, H. Jr, Swartz, J.D., and Wallace, C.A. (1969) Ethnic differences in psychopathology. Clinical correlates under varying conditions. Transcultural Psychiatric Research Review, Vol.6, April.

11. Lambo, T.A. (1972) Characteristic features of the psychology of the African. A critical review of an earlier observation. Totus Homo, Vol.4, No L.

12. Davidian, H. (1973) The application of some basic psychological theories in the Iranian cultural context. International Social Science Journal, Vol.25, No.4.

13. The International Pilot Study of Schizophrenia, Vol.1 (1973), WHO Geneva.

14. Savage, Ch., Leighton, A.H., Leighton, D.C. (1965) The problem of cross-cultural identification of psychiatric disorders in approaches to cross-cultural psychiatry, ed. Murhy & Leighton Cornell Univ. Press.

15. Jaenger, G. (1968) Psychiatric outpatients in America and the Netherlands A transcultural comparison. Social Psychiatry, 3, No.4.

17. Glatt, K. (1969) An evaluation of the French, Spanish and German translations of the MMPI, Acta Psychologica, 29.

18. Kalimo, E., Bice, T.A., and Novosel, M. (1970) Cross-cultural analysis of selected emotional questions from the Cornell Medical Index - British Journal of Preventive and Social Medicine, 24.