PSYCHIATRIC PROBLEMS IN THE PRIMARY HEALTH CARE CONTEXT: A STUDY IN THE BORDER-KEI AREA.

THESIS

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ABSTRACT

A clinic survey was undertaken to investigate the nature of psychiatric problems experienced by the primary health care (PHC) patient population in the Bisho-King William's Town area of the Eastern Cape Region. The study took as its point of departure research findings which attest to the high rate of psychiatric distress amongst this population group in different parts of the world and observations regarding the form of presentation in terms of physical complaints. Hypotheses posited relationships between psychiatric problems experienced by patients attending PHC clinics in the study area and four types of variables, namely; somatic complaints, socio-demographic characteristics, patterns of health service utilisation and patient satisfaction with health services.

Using a quasi-experimental descriptive approach, a two-stage screening procedure sorted the patient sample into three groups on the basis of the degree of psychiatric symptomatology experienced. The triangulation of the results of between-groups analyses with case materials recorded during psychiatric interviewing provided for an ethnographic account of the cultural experience of distress in the study area. The screening process used standard instruments, the Self-Reporting Questionnaire (SRQ) in the first stage and the Present State Examination (PSE) in the second stage. A pilot study was conducted prior to the fieldwork for the main study. Using the SRQ, thirteen psychiatric patients and 31 general PHC patients were sampled for the pilot study and 148 PHC patients were sampled for the main study. Using the PSE, 11 and 57 PSE interviews were conducted in the pilot and main studies respectively.

Between-groups analyses used chi-square and F-statistics to investigate possible associations with identified patient correlates ($P<0.05$). These were socio-demographic, utilisation and satisfaction variables, measured by a separate face-valid self-response instrument compiled for the purposes of this study. Psychiatric symptomatology was found to be statistically significantly related to age, marital status and educational level. Further, patients experiencing more psychiatric symptomatology reported significantly more illnesses requiring treatment, longer consultation periods and a greater number of sick bed days. No statistically significant relationships were found between psychiatric symptomatology and number of children, number of failures at school, amount of treatment utilised, number of consultations, or patient satisfaction with services. Descriptive analyses of symptom and syndrome profiles found certain somatic complaints to be particularly prevalent amongst the patient sample. These include headaches and various tension pains, decreased energy levels and digestive problems.

Qualitative analysis of interview data found that many somatic and psychiatric problems experienced constitute culturally defined and meaningful experiences, especially 'umbilini' (or nerves), 'ufufunyana' (a possession state), and accusations of witchcraft. Interpretation of complaints from the local traditional healing perspective, revealed a more complex mode of communication between patients and the health delivery system than may be accounted for in terms of a simple biomedical model. The interpretive analysis in the study showed that some forms of presentation incorporating somatic symptoms, such as 'nerves' may be viewed as help seeking behaviour of the socially unempowered.

Implications of the results are discussed in relation to the need for improved identification and management of psychiatric distress at PHC level facilitated by a better developed referral network and closer interaction between biomedical and anthropological perspectives.

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PREFACE

While only a small proportion of any community receive treatment for psychopathology, it is becoming increasingly apparent that a much larger proportion of the general population suffer from some debilitating or troublesome psychiatric symptoms at some stage in their lives. These symptoms may not be severe enough for diagnosis as a mental disorder, but may cause some degree of discomfort to the individual and manifest in complaints for which help may be sought at general or primary health care services. It has been shown that a fairly high degree of the distress observed among primary health care patient populations is of psychiatric or psycho-social etiology and that various characteristics of this population make for a high risk sub-group of the general population. This was the observation which prompted the question; 'What is the nature of psychiatric distress occurring in the primary health care settings of a defined geographical area?' The present study is built around this question and analyses it in terms of various patient characteristics including presenting symptomatology, socio-demographic characteristics, patterns of utilisation and satisfaction with services.

The relevance of this problem extends beyond the basic academic research orientation and has definite implications for health service planning. It was therefore considered important to conduct the study in an area for which there exists no related research information and in which there exists an identified need for health service restructuring. Due to the distance of the Bisho-King William's Town area from any university, relatively few studies have been conducted in the communities of this area, especially in the clinics. This is also an area that has experienced some important political changes, but in which the majority of the population remain economically disadvantaged and under-serviced. Although much restructuring is required, resources are strained, which means that ways must be found to ensure more efficient use of health service resources in line with primary health care principles demanding acceptability, accessibility, effectiveness and participation of local communities in the design of services.

Measuring psychiatric symptomatology at primary health care level is subject to local cultural variations in responses to psychiatric screening instruments developed in other parts of the world, which compounds the complexity of the research problem and requires an approach which goes beyond mere quantification of observations. The present study sought to do justice to the cultural and social richness of the area by exploring local modes of expressing distress and alternative channels through which this distress could be dealt with. These modes were found

to provide a sophisticated alternative to the Western mode of psychological symptom presentation and highlight the importance of a working knowledge of the local ethnography for primary care workers and researchers.

However, while there exists the need to manage psychiatric problems at community level, negative stigmas relating to psychopathology may obscure patient perceptions of psychiatric services and treatment. It may be that the separate administration and location of community psychiatry alienates this service from normal community processes. Integrating psychiatry with local primary care services, which already have wide acceptance in the communities, may demystify this area of health care and enhance already existing interventions.

CHAPTER OUTLINE

Chapter 1 briefly outlines the developments leading to the World Health Organisation articulation of the primary health care approach and places mental health care within this frame and, more specifically, within the South African context. A review of the literature relevant to the epidemiological study of mental disorders, particularly as they occur in the primary health care setting, considers the modes of presentation as well as patient and health service correlates. The review then focuses on the problem of mental-illness in primary health care settings in Africa and South Africa and presents some research findings relevant to planning for primary mental health care.

Chapter 2 describes the population of the study area in terms of general socio-demographic characteristics and looks at the functioning of primary health care services in particular, outlining the need for integrated primary mental health service provision.

Chapter 3 provides an outline of the methodology according to which the study was conducted, including the research goals, research design, sampling techniques, research tools, procedures, data analysis and fieldworker training. This section also includes an account of the pilot study and a summary of its implications for the main study.

Chapter 4 documents the results of the study by describing the patient sample in terms of general socio-demographic characteristics, describing the outcome of the two-stage screening process, and outlining the relationship between psychiatric symptomatology and identified variables.

Descriptive summaries of the data are provided in graphic and tabulated form.

Chapter 5 firstly identifies some methodological strengths and weaknesses of the study before discussing the quantitative findings in terms of the literature and in terms of the qualitative observations made during the PSE interviews. Analysis of case notes in terms of the ethnographic literature provides for a description of psychiatric symptomatology from a local cultural perspective. This discussion takes issue with the style of ethnography which looks to the 'tribal' roots of contemporary social phenomena, emphasising rather the magnitude of contemporary stressors in shaping cultural response to distress.

Chapter 6 deals with the relative strengths and weaknesses of the psychiatric screening instruments for use in local epidemiological research. This section identifies characteristics of both the instruments and the process of administration that are likely to produce culturally biased responses when applied to the local primary health care patient population, and discusses how these were dealt with in the present study. It is hoped that this discussion will inform and enrich future research involving standardised psychiatric screening as well as alert the reader to possible weaknesses within the present study.

Chapter 7 draws together the most salient outcomes of the study and summarises them in a set of conclusions.

CHAPTER 1 - REVIEW OF THE LITERATURE

1.1 HEALTH SYSTEMS REORIENTATION

1.1.1 ORIGINS OF THE PRIMARY HEALTH CARE APPROACH

Worldwide efforts at reorienting national health systems towards a primary health care approach are the outcome of three distinctive international agreements facilitated by the World Health Organisation (WHO). These crucial events are outlined by a WHO publication produced as a policy-making guide to the reorientation of national health systems (NHS) and include:

i. The adoption of the common goal of 'health for all by the year 2000' for the WHO and its Member States at the Thirtieth World Health Assembly in 1977 (Kleczkowski, Elling & Smith, 1984).

ii. The formulation of a strategy conceived of as Primary Health Care (PHC) to achieve the goal of 'health for all', as it became known, in 1978 (Kleczkowski, Roemer & van der Werff, 1984).

iii. The adoption of the 'Global Strategy of health for all by the year 2000' by the thirty-forth World Health Assembly in 1981. The global strategy advocated the reorientation of NHS's to develop an organisational infrastructure based on PHC and motivated by a regard for equity, social responsibility and human rights (Kleczkowski et al., 1984).

Although the birth of the PHC approach is commonly attributed to the 1978 WHO-UNICEF declaration of Alma Ata, this only signals a convergence of ideas that had changed the thinking about health care over the decades preceding the event. These ideas have been loosely grouped by various authors (Segall, 1983; Walt & Vaughan, 1981; Kleczkowski et al., 1984) into five general factors which together gave rise to a new broader meaning of health and ill-health.

i. Changes in thinking about development saw the 'modernisation theories' give way to the basic needs approach which grew out of a Marxist perspective on the causes of underdevelopment. Modernisation theorists saw health and other social services as consumption sectors that should be rationalised in favour of strategies aimed specifically

at increasing the national income. However, empirical evidence of persisting inequalities between social groups, characterised by differential unemployment and poverty, suggested that access to resources that secure basic needs to sustain life is a more sensitive measure of the development of the country.

ii. During the 1960's population growth was commonly considered to be central to the slow rate of development of poor countries and thus arose a perceived need for birth control services and national and international investments in family planning.

iii. General disillusionment with the medical model of health care arose out of the recognition of its inappropriateness to the health problems of developing countries where rising costs of treatment, over concern with the 'pathogen' and 'hospicentric' services rendered health services inaccessible to the majority of the population. The medical model has been attacked for its elitist orientation and lack of accessibility to the poorer social classes. This gave rise to the idea of 'Basic Health Services' as a strategy of extending health services to make them available and acceptable to local communities, and paved the way for the PHC approach.

iv. The reported failure of the Basic Health Service strategy to have a significant effect has been attributed to the fact that it was to be implemented within the framework of health services based on the medical model and was conceived of as a strategy for supplementing these services. As an instance of the medical approach to health care delivery, the Basic Health Service approach has been described as 'technocratic' and 'paternalistic', where health is seen something delivered to populations by health care professionals.

v. The reported successes of certain practical experiences with community involvement in health service programmes led to the recognition of the potential for a health movement through the organisation of people by social and political structures. This further strengthened the conceptual relationship between health and general socio-economic development of communities.

The orientation towards health which emerges is much broader than that advocated by the pathogenic orientation associated with the medical model, and is embodied in the WHO

definition of health as;

> "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (cited in Ross, 1984, p. 1).

The definition of PHC to emerge from the 1978 meeting and growing out of this definition of health is;

> "essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self- determination" (Walt & Vaughan, 1981, p.1).

This definition is broader than the Basic Health Service approach and is underlined by five principles which serve to distinguish it from its predecessor. These are; equitable distribution, community involvement, emphasis on prevention, appropriate technology and a multisectoral approach (Walt & Vaughan, 1981).

1.1.2 PRIMARY HEALTH CARE - A SOCIO-POLITICAL MOVEMENT

The PHC movement holds political and social implications. It entails the devolution of responsibility for much health service planning, management and provision from central to regional, district and local levels (Turshen, 1993). It requires organised involvement of communities on these matters (Segall, 1983). It attempts to meet local needs by channelling resources to where they are most needed and by utilising existing local resources optimally (Bryant, Creese, Ginawi, et al., 1990). As a strategy for redistributing health care resources to the economically and politically powerless, the success of PHC interventions require commitment to political empowerment at community level (Walt, 1990; Binedell, 1993).

In terms of the PHC approach, health is considered part of overall socio-economic development and requires the support of the political system and the participation of the communities in designing and implementing cost-effective activities which will benefit the people in greatest need. Rifkin (1986), recognising the political implications, proposed a model for participation by community members in health programmes, according to which community members become involved at various levels, starting at the level of benefits of the programme, and proceeding through activities, implementation, monitoring, evaluation and planning.

Establishing and sustaining broad-based community participation is largely the responsibility and function of health service administration and management (see 1.8.2) as well as local government.

1.1.3 PRIMARY HEALTH CARE AND PSYCHIATRY

The delivery of mental health care within the PHC context should ideally form part of a broad-based development framework, since the more urgent and pressing material needs of communities have to be dealt with in creating space for mental health programmes (Peterson, 1992). Consistent with the PHC approach, principles applying to the provision of primary mental health care would include decentralization of administration and treatment, community participation (including changing negative attitudes towards the mentally ill), deprofessionalisation of mental health services (requiring appropriate training and orientation of primary care workers), and intersectoral collaboration (addressing the factors influencing mental health in other sectors) (Binedell, 1993).

Due to research in the field of psychiatric epidemiology, mental health has received increased attention as an area for PHC intervention. In this context psychiatric health care ideally goes further than merely treating mental disease. It incorporates promotive and preventive strategies and implements them using appropriate technology. Bringing mental health care principles into PHC settings would ideally also enhance the effectiveness of the other PHC interventions through, for instance, the appropriate and effective use of communication and behavior modification techniques (WHO, 1990).

This approach to mental health care follows from the WHO definition of health, in terms of which health does not necessarily follow from a state of physical well-being. Most psychiatric disorders appear to be multifactorial in aetiology (Paykel, 1990), yet the powerful influence of the medical model still sees mental ill-health treated by specialised facilities while the mental health aspect of human life is ignored. Likewise, physical health care interventions are less effective if the social and psychological components are ignored or treated separately (cf. Diekstra & Jansen, 1990 and Ingham & Bennett, 1990).

1.2 THE SOUTH AFRICAN NATIONAL HEALTH SYSTEM

1.2.1 SHORTCOMINGS OF THE PAST

Reviews and analyses of the South African NHS routinely focus on the shortcomings of health care delivery. Most of the reported shortcomings are consequent upon Apartheid policies which have resulted in inequitable distribution of resources between racial groups. A brief overview would serve as a spring-board for a consideration of options for the integration of mental health care into PHC within the context of NHS transformation.

i. Fragmentation of health services between 14 different health authorities and the administrative separation of the primary, secondary and tertiary tiers in the past has resulted in inefficiencies and duplications through lack of co-ordination (Sewpaul, 1990; S.A. Institute of Race Relations, 92/93; What kind of health care?, 1994).

ii. Over-centralised and bureaucratic control of health services has neglected community involvement in planning and management, resulting in a top-down management style and its concomitants; inflexibility and lack of responsiveness to local needs. This was evident in late government attempts at restructuring the NHS, which were resisted by progressive health care organisations and criticised as unilateral (Not what the doctor ordered, 1993; Apartheid health will linger, 1994).

iii. Urban bias in resource distribution and the location of hospitals in urban centres has resulted in inadequate service provision in the rural areas, which translates reliably into racial inequalities (Freeman, 1990).

Central to all of these criticisms is the reported lack of real commitment on the part of government to restructuring the NHS in terms of the PHC approach.

South Africa's suspension from the WHO in 1974 and its consequent academic isolation from global developments in the field of public health may be seen as partly responsible for a belated policy commitment to the principles of PHC. This came in 1980 in the form of the National Health Services Facilities Plan of 1980 (cf. Ross, 1984), the National Health Plan of 1986 (S.A. Institute of Race Relations, 1986) and, more recently, the Plan for the Rendering of Health

Services of 1990. The latter plan was envisaged to create a NHS that would be rendering an affordable and comprehensive service within five years (S.A. Institute of Race Relations, 89/90) through reducing the costly and inappropriate utilisation of secondary and tertiary services (NHPD, 1992). The National Policy for Health Act of 1990 commits the State to a unitary health system emphasising local health care (Dick & Pekeur, 1995). Those attesting to the failure of these commitments do so in relation to certain health status indicator statistics (cf. Steyn, 1991; Hirschowitz, Orkin, Morake, et al., 1994), and national health budget allocations (S.A. Institute of Race Relations, 1992/93).

The non-governmental sector in South Africa began implementing PHC principles through community projects in the 1970's and provided the impetus for the development of this approach. It was thus that the National Progressive Primary Health Care Network (NPPHCN) was established in 1987 as an alliance of progressive organisations opposed to unilateral government restructuring of health services and committed to the principles of PHC and to developing a national PHC strategy for an appropriate health care system (Binedell, 1993).

Community mental health care is administered separately to PHC and still functions largely as a referral service. Non-governmental (NGO) and parastatal organisations such as FAMSA, South African Mental Health Society, SANCA, NACOSA, Child Welfare and Lifeline offer a variety of services that may be classified as primary mental health care, in the sense that they are 'walk-in' services. However, the emphasis is on crisis intervention and few have resources for preventive services. These services are also not widely known and are therefore inaccessible to a large proportion of the population. Some identified need areas for primary mental health care in South Africa include treatment and counselling on alcoholism and drug abuse, child psychiatry, half-way services (for the reintegration of institutionalised patients into the community), AIDS education and counselling and care for the chronically mentally-ill in the community (Allwood, 1979; O'Dea, 1986; Binedell, 1993).

1.2.2 ORIENTATION FOR THE FUTURE

The Reconstruction and Development Programme (RDP), along with its focus on health service transformation in the new South Africa, also commits itself to the promotion of mental and psychological health of South Africans through increased quality, quantity and accessibility of mental health support and counselling services and through increased communication between

traditional healers and medical and social workers. It identifies substance abuse, violence, including family violence, and disability as priority areas deserving of particular attention (ANC, 1994).

The extension of mental health care into PHC holds certain implications for NHS transformation. A WHO document outlining the introduction of a mental health component into PHC (1990) proposes that a NHS operate under a single national department of health, with central co-ordination and planning and decentralised decision-making in geographical areas allowing for adaptation to local conditions.

Consistent with this approach Freeman (1992) advocates for a unified Department of Health and Welfare with a Division of Mental Health within it. He further recommends subdivisions within the mental health division that would deal with medical, social, psychological and rehabilitative care. Regional and local structures would be modelled on the national structure and assume responsibility for decentralised planning and practical implementation of services. As part of the service approach he advocates that mental health care is integrated into PHC provision and operates according to the PHC philosophy articulated in the Alma Ata Declaration (1978). One of his proposals for resource utilisation is that efforts are made to encourage more participation by mental health practitioners in the public sector, and specifically in the rural areas. Another proposal offered by Levin (1994) is the training of mental health practitioners who speak the local languages and understand the local cultures.

The mental health component of PHC is dealt with in the literature as comprising two distinct areas. Firstly, psycho-social and behavioral science skills are of vital importance in enhancing the effectiveness of general health care interventions through the use of improved interpersonal techniques. Secondly, the control of psychopathology in general health care settings requires improved techniques of detection and management of psychiatric diseases.

The results of studies conducted in the field of psychiatric epidemiology indicate the need for psychiatric interventions at PHC level.

1.3 PSYCHIATRIC EPIDEMIOLOGY AND PRIMARY HEALTH CARE

"Epidemiology" is a term used in the medical context as referring to the study of populations rather than individuals (Shephard, 1978) and has been defined as:

> "the study of the distribution and determinants of health related conditions and events in populations and the application of this study to the control of health problems" (Last, 1988, quoted in Miller & Swartz, 1992).

Epidemiological literature supports an understanding of disease as having multiple causation and the incorporation of psychosocial factors into explanations of health, disease and illness (cf. Helman, 1989, pp. 267-284). For this reason it is important that service planning is founded on epidemiological research (Miller & Swartz, 1992), thus contributing to the strategy and design of appropriate interventions (Kleczkowski et al., 1984).

In fact, Shephard (1978) used this line of reasoning to assert that, "in no branch of medicine is [epidemiology] needed more than in psychiatry" (p. 297). Through an elucidation of Goldberger's work on Pellagra, Shephard illustrates the value of applied epidemiological research to the workings of health services, in particular, the administrative aspects of psychiatry, and clinical psychiatry.

Thus, in the strengthening of the psychiatric component of PHC, psychiatric epidemiology can contribute to an understanding of the nature of mental disorders presenting at the PHC level. As a component of health systems research such information would be used to guide the planning and evaluation of mental health services, thereby facilitating innovative and appropriate change (Dick & Pekeur, 1995).

Dohrenwend and Dohrenwend (1982) describe the first two generations of epidemiological studies to have been conducted since the turn of the century and, on the basis of an analysis of their 'legacy', detail possibilities for a third generation. They are able to discern two central themes running through research belonging to the first two generations: (i) methodological problems relating to conceptualising and measuring mental disorders independently of treatment status and (ii) consistency in findings relating to the prevalence of various types of mental disorder, the proportion treated and untreated by health care interventions and the distribution of disorders according to certain population parameters, including gender, rural vs urban location

and social class. In providing direction for a third and future generation of epidemiological research, Dohrenwend and Dohrenwend (1982) advocate increased focus on the methodological problem of case identification and classification. This would require reliability and validity data on basic symptom measurement and diagnosis of syndromes or symptom profiles.

Literature detailing psychiatric epidemiological research in the PHC setting reflects the difficulty of separating the concepts of case definition and case detection (Tansella, De Girolamo & Sartorius, 1992). Case definition has largely been a function of the system of case identification employed in a particular study (Dean, Surtees & Sashidharan, 1983). However, criteria for identification are taken from clinical settings which, for various reasons, calls into question their validity for community and PHC surveys (Williams, Tarnopolsky & Hand, 1980).

1.3.1 CASE DEFINITION IN THE PHC SETTING

A reading of the literature reveals that there is still no consensus as to what constitutes a case of psychopathology, yet much progress has been made in this direction since 1965 when Dohrenwend & Dohrenwend referred to the difficulty of interpreting the results of studies of clinical populations in which "...the fact of being in treatment constitutes the sole definition of a disorder" (p. 52).

The search for diagnostic criteria for use in psychiatric research represents a recognition of the need to compare data gathered in different centres and to promote communication between investigators. Such were the goals of Feighner, Robins, Guze et al. (1972) in systematising the diagnostic criteria for 14 psychiatric illnesses from data gathered in studies of both outpatients and inpatients, family studies and follow-up.

Researchers in the field of psychiatric epidemiology have called into question the applicability of criteria derived from the clinical setting for describing psychopathology in PHC or community settings (Dohrenwend & Dohrenwend, 1974; Dohrenwend, Shrout, Egri et al., 1980). In the community setting epidemiological research must deal with large numbers of respondents who present with fewer, minor and non-specific symptoms, as opposed to the clinical setting. Goldberg (1979) notes that disorders encountered in primary care settings are less well differentiated than those seen in clinical settings.

Psychiatric illness in the clinical setting is effectively defined by the referral pathway by which patients arrive at this setting. Goldberg & Huxley (1980; 1992) trace this pathway and the filters which determine the passage from one level to the next. In so doing they are able to argue that only certain patients with psychiatric problems reach the clinical setting and these patients constitute an atypical portion of the morbidity pool. Data derived from this setting is, therefore, not applicable to community research.

Most psychopathology encountered in PHC and community settings is non-psychotic and presenting symptomatology may fail to fulfill the requirements for assignment to a particular category of disorder (Dohrenwend et al., 1980; Mitchell, 1985). Yet there is little doubt about impaired functioning within a specific social or cultural context. What emerges from epidemiological research in the PHC setting is the need for data derived from general community and PHC settings in establishing the criteria for case identification in these settings (Williams et al., 1980; Williams, Tarnopolsky & Clare, 1980).

In developing systems of classification which are appropriate for use in the community and PHC settings, and which cater for individuals who do not fit into any particular diagnostic category, certain guidelines have emerged from research findings. One is that psychiatric morbidity must be viewed as a continuum since there is no clear answer as to where normality ends and clinically significant disturbance begins (Miller & Swartz, 1980; Goldberg & Huxley, 1972). Another is that a dimensional model of community diagnosis be adopted where, due to the difficulty of diagnostic classification of psychiatric morbidity at PHC level, the goal of the epidemiologist would be to rate individuals on one or more axes (Goldberg & Huxley, 1992).

Goldberg and Huxley (1980; 1992) follow this line of argument in proposing a triaxial model where individuals are rated in terms of symptomatology, personality and social functioning. In fact, much research has focussed on the relationship of social and personality factors to mental health (Jegede, 1980). This model provides clearer direction for solving the problem of definition where, for instance, symptomatology in excess of a threshold cut-off point would be an indicator of 'caseness' (Goldberg & Huxley, 1992) and the goal of the practitioner would be to classify only to the extent that classification contributes to better care. This is consistent with the DSM approach (APA, 1994) where no assumption is made that each disorder is a discrete entity, discontinuous with other mental disorders. Each category of disorder is justified only by its clinical usefulness.

This reasoning has influenced the nature of psychiatric measurement in community and PHC settings both in terms of research design and the instruments used. Due to recent research developments it is now possible to apply standard techniques of defining, measuring and recording symptoms with some reliability (Luria & Mc Hugh, 1974; Wing, Mann, Leff et al., 1978).

In fact, Sartorius et al. (1993) produced evidence from a large longitudinal multicentre collaborative study to demonstrate the applicability of standardised sampling and data collection and assessment instruments in widely varying cultural settings.

1.3.2 CASE IDENTIFICATION IN THE PHC SETTING

In 1960 a WHO committee defined a psychiatric case as:

> "a manifest disturbance of mental disorder specific enough in clinical character to be consistently recognisable as conforming to a clearly defined standard pattern and severe enough to cause loss of working or social capacity, or both, to a degree which can be specified in terms of absence from work or of the taking of legal or other social action" (quoted in Bennett, 1988, p.159).

This definition highlights the involvement of both clinical and socio-cultural considerations for conceptual case definition, which problematises the task of operationalising the concept at community and PHC level in different social settings and across cultures.

A further problem associated with case finding has been the difficulty in standardising measures of symptoms, the expression of which may depend on a number of factors (Dohrenwend & Dohrenwend, 1974; Williams, et al., 1980). Issues of reliability and validity are central to developing a standardised system of case identification (Warheit & Bell, 1983).

Early research addressing the problem of validity in field studies of psychiatric disorder uncovered construct validity as the appropriate validity measure in this setting. After systematically considering various types of validity measures, Dohrenwend and Dohrenwend (1965) proposed that a nomological framework be constructed which can be used to validate the construct of psychiatric illness. This appears to have led researchers to consider the relationship between psychosocial, socio-cultural and demographic factors and symptomatology through the inclusion of social adjustment and social functioning scales in the design of research studies

(Clare & Cairns, 1991) (cf. Holmes & Rahe, 1967 and Masuda & Holmes, 1967). Even where separate psychosocial scales have not been included, many studies build some form of demographic analysis into the research design.

1.3.2.1 Design considerations

The most frequently used method of case identification in the PHC setting has been one or a combination of survey techniques, mostly questionnaire and interview, sometimes complemented by practitioner judgements.

The most frequently employed design for case identification has been the two-phase design (Duncan-Jones & Henderson, 1978), where the first phase consists of a psychiatric screening test, usually a self-report questionnaire, and a more in-depth psychiatric interview takes place in the second stage.

The most important consideration in choosing a first stage screening test for such survey work is not to miss cases (false negatives). Undetected cases may be lost to the survey in the first-stage screening, whereas those incorrectly identified as cases (false positives) can easily be reclassified at a subsequent stage (Goldberg & Blackwell, 1970).

This consideration is dealt with in the literature in terms of 'sensitivity' and 'specificity' of psychiatric case detection. The sensitivity of a measure refers to the proportion of true positives that it identifies. The specificity is the proportion of true negatives. While the best screening instrument would have both high sensitivity and high specificity, improving one of these measures by adjusting the threshold will compromise the other to some extent (Abramson, 1988).

Where the cost of false negatives outweighs that of false positives in the screening stage of a psychiatric prevalence survey, sensitivity takes precedence. Specificity will become a more important consideration in the second stage. Therefore, the first stage screening instrument should ideally have a high sensitivity, while the second stage instrument should have a high specificity (Tarnopolsky, Hand, McLean et al., 1979).

Research on instruments of detection has been guided by the goal of finding the optimal balance between the two considerations.

1.3.2.2 Instruments of case detection

Apart from other forms of case detection such as practitioner judgement and community and self-referral, case detection instruments used by psychiatric epidemiologists generally fall into one of two broad categories; self-response rating scales and psychiatric interviews. In a two-phase prevalence survey the self-rating scale would be used in the first phase as a psychiatric screening test and the interview would be used in the second phase.

a. Self-response instruments

These instruments are validated and structured. They are designed in such a way that a score is calculated from a rating scale with fixed response options which the respondent uses to build a picture of present functioning, thereby indicating the likelihood of psychiatric caseness (Silverstone & Turner, 1978).

The two self-response instruments most frequently used at community and PHC levels are the General Health Questionnaire (GHQ) developed by Goldberg (1970) and the its successor, the Self-Reporting Questionnaire (SRQ) developed by a research team for use by the WHO in developing countries (Harding, De Arango & Baltazar, 1980).

In laying the foundation for the GHQ Goldberg (1972) reviewed the self-response instruments used in earlier studies. These included Macmillan's Health Opinion Survey (1959), Langer's 22-Item screening Test (1962), the Symptom Rating Test of Kellner & Sheffield (1967), the Personal Questionnaire of Ingham (1965) and the Symptom Sign Inventory of Fould (1965) (in Goldberg, 1972).

The GHQ was specifically designed as a screening instrument for identifying psychiatric illness in general practice patients in a two-phase survey and is primarily concerned with functioning and disturbance at the time of testing (1970; 1972). Goldberg began work on the GHQ in 1969 and in 1970 Goldberg and Blackwell, recognising the need for an instrument that eliminated observer variation, thereby allowing for comparisons of psychiatric morbidity prevalence rates, conducted a validity study of the GHQ. The results of the study uncovered a correlation coefficient of +0.80 between overall clinical assessment and GHQ scores and therefore it was accepted as capable of comparative assessment across general and PHC practices.

Comparisons with other psychiatric screening tests have produced convincing results (Goldberg, Rickels, Downing et al., 1976) and much research has been devoted to developing different versions of the GHQ and validating it for different populations (Goldberg & Hillier, 1979; Benjamin, Decalmer & Haran, 1982).

There is, however, research evidence to indicate that the GHQ has limited sensitivity in detecting patients who have become accustomed to their long-standing symptoms, and it may therefore miss chronic illness (Benjamin et al., 1982). The validity of GHQ has also been shown to vary across settings and population groups (Tarnopolsky et al., 1979; Benjamin et al., 1982; Hobbs, Ballinger & Smith, 1983).

The SRQ, a 25 item screening test, is the outcome of a WHO effort to develop and evaluate low-cost methods of mental health care as part of PHC services in developing countries. The items were selected by a consensual process by comparing items from four other instruments used in different cultural settings. One of the four instruments was the GHQ (Harding et al, 1980). The levels of sensitivity and specificity and high correlations with clinical judgement have led to extensive use of the SRQ in PHC settings (Mari & Williams, 1986; Sen, Wilkinson & Mari 1987).

A comparison of the validity of the GHQ-12 and SRQ-20 questionnaires (shortened versions of the original GHQ and SRQ instruments) revealed that, while both instruments were found to be acceptably valid when assessed against the Clinical Interview Schedule (CIS) in three primary care settings in Brazil, the GHQ showed the highest sensitivity and the SRQ showed the highest specificity. The SRQ performed slightly better than the GHQ as an indicator of severity (Mari & Williams, 1985).

The main advances of the SRQ over the GHQ for PHC settings in developing countries relate to the simpler response options, improved comprehensibility of items, ease of translation (Sen et al, 1987) and speed of administration (Mari & Williams, 1986; Rumble, 1994).

The Mental Health Division of the WHO compiled and tabulated a summary review of 33 different research studies using the SRQ in both developed and developing countries around the world (1994). This review showed that, in most of the cases where the SRQ was used as the first stage instrument in a two-stage design, the instrument used in the second stage was either the Present State Examination (PSE) (Wing, Cooper & Sartorius, 1974) or the Standardised

Psychiatric Interview (SPI), also known as the CIS (Goldberg et al., 1970).

b. Psychiatric interviews

Endicott, Spitzer, Fleiss et al. (1976) discern two alternative strategies for describing psychiatric disturbance. Multidimensional psychiatric rating scales describe particular features of a disturbance in terms of symptoms or syndromes, and an attempt is made at classification or diagnosis. The other strategy is to directly assess the overall severity of the disturbance, combining many elements of severity into a single dimension.

An example of the second strategy for measuring disturbance is that of the Global Assessment Scale, which represents a rating scale for evaluating the overall functioning of a subject during a specified time period, or individual change over time, on a continuum of psychiatric sickness to health (Holcomb & Randall, 1988). This measurement strategy has the advantage of combining multiple elements of psychopathology into a single severity index, with applicability to a wide variety of clinical and research problems (Endicott et al., 1976).

Standardised psychiatric interviews are designed to provide a quantitative estimate of findings obtained during a clinical interview according to a clinical rating scale. There are two types of clinical rating scales; those that describe a wide range of symptoms and those that measure changes in some specific disorder. Examples of the latter type are the Hamilton Anxiety Scale and the Hamilton Depression Scale (Silverstone & Turner, 1978).

The most widely used of the first type of scale is the Present State Examination (PSE), which represents a multidimensional approach to measuring disturbance. The various contexts in which it has been used make it a versatile instrument in psychiatric epidemiological research. It has demonstrated ability to standardise case-finding and case-description in both referred and non-referred populations (Wing et al., 1978), as well as describe and classify the symptoms exhibited by both inpatients and outpatients (Wing, Nixon, Mann et al., 1977). This is probably due to the detail of the sections dealing with the commoner and less severe complaints and symptoms found in a significant proportion of the population of 'normal subjects' (Cooper, Copeland, Brown et al., 1977).

The PSE has demonstrated a high degree of reliability and provides a detailed case profile (Luria, 1974). Reproducibility of results holds true at the level of symptom, syndrome, total

score and index of definition of psychiatric disorder, as well as between trained non-medical interviewers and psychiatrists on most non-psychotic sections (Wing et al., 1977). Cooper et al. (1977) describe the stages of training required for achieving comparable standards of inter-rater reliability between non-psychiatric interviewers and psychiatrists. Its value as an instrument in epidemiological research derives from its capacity to provide a standardisation of an ordinary clinical approach, thereby facilitating comparison across studies (Wing, 1983).

An advantage of the multidimensional approach to measuring disturbance is that it provides detailed information that may be lost in the one dimensional approach (Endicott et al., 1976).

The second stage screening instrument used in the WHO international study of psychological problems in primary care (Sartorius, Ustun, eSilva et al., 1993) is the Composite International Diagnostic Interview - Primary Health Care Version (CIDI-PHC). This is a lengthy instrument consisting of (i) documentation of the main reason for contact and the Pathways Interview, (ii) parts of the Composite International Diagnostic Interview (somatisation, anxiety, depression, hypochondriasis and neurasthenia), (iii) questions relating to chronic diseases, medications used, co-existing physical illness and psychological distress, and (iv) Alcohol Use Disorders Identification Test (AUDIT).

1.4 PREVALENCE OF PSYCHIATRIC MORBIDITY IN THE PHC SETTING

A discussion of prevalence rates requires an understanding of the distinction between the concepts of incidence and prevalence. Where the former refers to the frequency of an event in a group or population during a given period, the latter refers to the proportion of individuals with a given condition at a given point in time (point prevalence) (Abramson, 1988).

Ingham and Miller (1976) regard as over simplistic statements about prevalence information taking the form "x% of the general population are mentally ill." This is predicated on the idea of a cut-off point, or some other arbitrary criterion, in identifying psychopathology. Instead, they propose an index of prevalence that compares the cumulative frequency distributions of defined psychiatric dimensions for different groups. Although this system has the advantage of making intra-group comparisons more meaningful, it does not seem to have gathered a following in the research literature.

While prevalence rates vary, research literature concurs that attenders at PHC services are generally more psychiatrically disturbed than a random sample of the practice population, even when those attending specifically for psychological symptoms are discounted (Goldberg, Clifford & Thompson, 1976). There is, however, less variation between recent estimates for rates of illness in random samples of populations than there were in the studies reported up to the early 1970's.

A comparison of research results between developed and developing countries of the world are surprisingly consistent. Among the studies conducted in developed countries, Goldberg et al. (1976) reported that approximately 11% of a systematic random sample of attenders at general practice were probably disturbed, Barret, Barret, Oxman et al. (1988) report a 26.5% prevalence rate, while Hoeper, Nycz & Cleary (1979) report a 27% rate of primary care patients meeting research diagnostic criteria for mental illness. An early psychiatric survey carried out in 1951 by a general practitioner in a small Norwegian community arrived at an estimated prevalence rate of no less than 25% (cited in Goldberg, 1972).

In a survey of the frequency of mental disorders in developing countries Harding et al. (1980) discovered an overall frequency of 14%. Early estimates of prevalence rates in Africa were based on hospital statistics and have been found to have grossly underestimated the problem of psychiatric morbidity in Africa. The more recent picture is very similar to reported prevalence rates for the Westernised world, ranging from 14% (Harding, Climment & Giel, 1980), 19% (Giel & van Luijk, 1969), 20% (Ndetei & Muhangi, 1979), 25% (Orley & Wing, 1979), 29% (Dhadphale, Ellison & Griffin, 1983) to 32% (Dhadphale & Ellison, 1983).

South African research reveals prevalence rates of psychiatric morbidity at 8.3 % (Freeman, 1991a), 11.8% (Gillis, Lewis & Slabbert, 1968), 14.38% (Thom, Zwi & Reinach, 1992) and 27.1% (Rumble, 1994).

In terms of the referral pathway conceptualised and articulated by Goldberg & Huxley (1980, 1992), the community is the first level in the referral system and the PHC setting the second level. Research into the prevalence of psychiatric morbidity must recognise that there are individuals with psychiatric problems who do not attend clinics at all. There is, however, research evidence based on comparisons of clinic-based and community-based prevalence rates, to suggest that the number of psychiatrically distressed patients missed by conducting research in the clinic

setting is too small to justify the cost of a community study (Dhadphale, Ellison & Griffin, 1983).

This implies that most individuals with psychiatric problems make use of PHC and other out-patient services and many do so as a result of a problem of psychiatric nature rather than of medical origin (Freeman, 1991a). However, compared to prevalence rates of psychiatric morbidity in community and PHC settings revealed by the research literature, case records show that it is under-diagnosed and inadequately treated at the PHC level. This is largely due to two groups of factors. Firstly, practitioners do not have the knowledge and training to diagnose and treat. Secondly, mental health problems are generally not presented as such, but more often present in somatic form.

1.4.1 DETECTION BY PRIMARY CARE PRACTITIONERS

A review of the research into detection rates by health workers in general health care settings reveal wide variations (Goldberg & Huxley, 1980). This is disturbing in view of research findings that most people with emotional disorders are seen and treated in primary care settings for other problems and their mental illness passes unrecognised by primary care practitioners (Regier, Goldberg & Taube, 1978).

A 1966 study by Shephard, et al. (reported in Goldberg & Huxley, 1980) showed a nine-fold variation between the detection rates of family physicians in London. Since then various other studies conducted in different settings have confirmed this finding (Goldberg & Hillier, 1979). Not only do primary care workers' detection rates show high levels of variation and inaccuracy, they are also much lower than clinical detection carried out in the PHC setting (Freeman, 1991a). These findings have led researchers to look for explanatory factors. Those uncovered either describe the characteristics of the practitioner (Goldberg & Huxley, 1980; Abiodun, 1990), the characteristics of the patient (Marks, Goldberg & Hillier, 1979) or the nature of illness (Krietmann, Sainsbury Morrissey et al., 1961; Goldberg & Bridges, 1988; Shedler, Mayman & Manis, 1993).

Krietmann et al. (1961) investigated the reliability of psychiatric assessments and factors responsible for diagnostic disagreement. They found that likelihood of diagnostic agreement varies according to diagnostic group. Depression showed the highest concordance and higher levels of agreement are attained with more severely disturbed patients.

Goldberg and Huxley (1980) reviewed practitioner characteristics and were able to conclude that health workers most likely to detect psychiatric morbidity accurately are both sensitive to verbal cues and show more concern for their patients. Related factors include superior interview techniques, higher knowledge scores and less conservative personality and attitudes. The results of a study by Marks et al. (1979) appear to confirm these observations where characteristics of empathy, interview techniques and practitioner's orientation towards psychiatry had a significant impact on accuracy of detection as measured against clinical evaluation. Similarly, in Nigeria, Abiodun (1991) was able to identify previous exposure to mental health training and attitudes towards mentally ill patients as important factors in PHC workers' effectiveness in detecting and treating mental disorders. Culture-specific knowledge appears to be a further mediating factor, as demonstrated in Hirst's (1993a) account of the role of traditional healers as helpers (see 5.6.1).

Employment status, gender, age and marital status are patient characteristics that have been found to be associated with the likelihood of detection of psychiatric morbidity by PHC workers, where middle-age, female sex, unemployment and divorce or widowhood are all associated with increased detection rates (Marks et al., 1979). Other patient characteristics associated with increased recognition include initial severity, psychological reasons for attending a general service, recency of onset, diagnostic category and psychiatric co-morbidity (Ormel, van den Brink, Koeter, et al., 1990).

Research studies of detection rates usually measure the health worker's rating of a patient on a scale of varying degrees of psychiatric distress against concurrent clinical assessment of these patients. Psychiatric illness recognised by practitioners is termed 'conspicuous psychiatric morbidity', coined by Kessel in 1960 (in Goldberg et al., 1976). The term 'hidden psychiatric morbidity' refers to those patients who are not perceived as disturbed by their practitioner, but would be classified as disturbed after being assessed by more elaborate case-finding methods (Goldberg et al., 1976).

Goldberg and Bridges (1988) found that hidden psychiatric morbidity accounted for one-third of all disturbed patients in general practice and that patients identified as such were distinguished by their attitude to illness and by their mode of presentation. They were found to present physical symptoms to the primary care practitioner. In a later study, Bridges and Goldberg (1985) found that somatisation accounted for over 50% of undetected disorders and that the

somatic symptoms distracted the health workers from recognising other aspects of patients' social and psychological states. Thus a major patient-related reason for failure to diagnose is somatisation (Katon, 1990; Harding et al., 1980).

1.5 SOMATISATION IN THE PHC SETTING

In the DSM-IV somatisation is represented by defined groups of somatoform disorders in which physical symptoms, with no organic or physiologic reality, appear to be linked to psychological disturbances (APA, 1994). Kleinman (in Goldberg & Bridges, 1982, p. 139) defines somatisation as "the expression of personal and social distress in an idiom of bodily complaints with medical help-seeking." Katon et al. (1982, p. 127) define it as "the presentation of physical symptoms in the absence of organic pathology or the amplification of physical complaints accompanying organic disease beyond what can be accounted for by physiology." These two definitions appear to view somatisation as a mode of expressing distress. Escobar (1987), on the other hand, forwards a conception of somatisation as a trait, occurring alone or in association with other psychiatric diagnoses, and defines it in terms of a set of operational criteria.

1.5.1 SOMATIC PRESENTATION: A MODE OF EXPRESSION

Complete agreement on the definition of 'somatisation' remains elusive in the research literature. The conceptual confusion translates into a lack of standard operational criteria with which to research the condition and may be responsible for the lack of knowledge regarding the relationship between somatisation and psychiatric problems, as well as the epidemiology of somatisation traits (Escobar, 1987). Operationalising somatisation or measuring somatic symptoms is complicated by the need to rule out symptoms resulting from physiological processes, which really requires thorough physical examinations (Murphy, 1990). This may be beyond the scope of many community and PHC surveys.

Further contributing to the complexity of an understanding of somatisation is the evidence that psychological disorder can result in organic problems such as, for example, peptic and duodenal ulcer. Hirst (1990) reports a 1978 estimate of 65% prevalence rate of psychosomatic disorders for illnesses presented to Western medical doctors by both black and white patients in Grahamstown, King William's Town and Alice.

In an attempt to learn something about the determinants of somatisation, Goldberg and Bridges (1988) concentrated their investigation on patients attending primary care practitioners with new episodes of illness. Their results concur with others conducted in the field (Racy, 1980; Kirmayer, 1989) that have found that, where psychiatric disorder is stigmatised, somatic presentation of distress is more likely.

Hirst (1990; 1993b) argues that in cultures evincing a strong group orientation, such as those found in Africa for example, the somatisation of psychological disorders is inextricably linked to, and symbolic of, interpersonal conflict. In these cultures, the human body very often stands for or symbolises the social group and, hence, the somatisation of symptoms (which, in some cases, may have no detectable organic substratum) refers symbolically to problems in critical social relationships. Thus, traditionalist healing in these cultures attempts to redress both the somatic symptoms as well as the social causes by recourse to herbal remedies and religious rituals.

'Somatisers', as opposed to 'psychologisers' (patients who present with psychological symptoms) have been found to be less depressed, report lower levels of social dissatisfaction, social stress and less dependency on their relatives (Bridges, Goldberg, Evans, et al., 1991). This has led researchers to deduce that somatisation of psychiatric illness may function as part of a coping style, as a defense mechanism (Craig & Boardman, 1990; Schedler et al., 1993) and that it is more common where individuals tend to be submerged in the group (Katon, Kleinman & Rosen, 1982). This would seem to be supported by findings from developing countries where the commonest presentation of psychiatric illness is in the form of somatic symptoms (Harding, et al., 1980; Kirmayer, 1984).

However, Kirmayer (1989, p. 329) notes that, "somatization does not occur as an alternative to expressions of emotional distress but as an accompaniment," and that, while people may have bodily and emotional distress simultaneously, sociocultural norms for illness behaviour will determine the idiom of expression.

In a study of somatoform disorders using a sample of 859 adopted women, Sigvardsson, von Knorring, Bohman et al. (1984) obtained research results to indicate that somatisation is strongly associated with some, but not all, forms of psychopathology. In a follow-up study by Cloninger, Sigvardsson, von Knorring et al. (1984), two groups of 'somatisers' were discerned: high frequency somatisers with a high frequency of specified complaints, and diversiform somatisers, with less

frequency but greater diversity of complaints.

Somatisation has been found to be particularly related to mood disorders and various reports and reviews have described the somatic correlates of anxiety and depression states as well as schizophrenia (Binitie, 1987; Katon et al., 1982; Bridges & Goldberg, 1985; Escobar, 1987; Goldberg & Bridges, 1988; Craig & Boardman 1990). In terms of this review mood would be a powerful determinant of both the perception of illness and the decision to consult.

Somatisation is not only seen to be part of a patient's own attributional process. Often health workers will reinforce this behavior by selectively attending to somatic complaints, ignoring the possibility of psychiatric distress. Secondary gain may perpetuate the problem by allowing patients to take on the passive role of a recipient of care, thereby avoiding stressful situations and manipulating social relationships (Katon et al., 1982).

Physical complaints classifiable as somatic symptoms may be grouped into 6 categories; pain, gastrointestinal, cardiopulmonary, conversion, sexual and female reproductive (Murphy, 1990). Characteristic somatic symptom sets vary from study to study, but overlap to a large extent. The commonest somatic complaint appears to be pain. A set of symptoms related to depression include anorexia, weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, decreased energy or libido, decreased ability to think or concentrate and constipation (Katon et al., 1982). A symptom set including frequent bodily complaints, gastro-intestinal tract symptoms, complications of pregnancy and menstruation, conversion symptoms and a belief on the part of the patient that he has been sickly most of his life, is forwarded by Sigvardsson et al. (1984). Harding et al. (1980) found the most common somatic symptoms to be weakness, dizziness, back pain, headache and abdominal pain. Goldberg (1979) notes the 'biological' features of depression as early waking, diurnal variation in mood, loss of libido, slowing down of thoughts and actions as well as anorexia and weight loss.

While some research has focussed on the somatic presentation of psychiatric disturbance, not enough is known about the consequences of failure to detect these illnesses. These may be grouped into two main areas; firstly, the burden on patients having to endure unrecognised psycho-social distress and, secondly, the burden on the NHS of ineffective treatment and chronic disability.

1.5.2 SOMATISATION, DISABILITY AND USE OF SERVICES

'Illness behavior' has been defined by Tuckett (Quoted in Williams et al., 1980, p. 101) as "activities undertaken by a person who has symptoms in order to define the state of his health and discover a remedy." It refers to the way in which given symptoms may be differentially perceived, evaluated and acted upon (Goldberg et al., 1976). Viewing somatisation as a metaphor for personal distress (Katon et al., 1982) would help to explain why individuals with psychiatric disorders are high users of health services and a majority of them present their problems only to primary care providers (Escobar, Golding & Hough, 1987).

In a study of the utilisation of health and mental health services Shapiro, Skinner, Kessler et al. (1984) focussed their attention on the ambulatory care services sought by patients over a six month period prior to psychiatric interviews. They found that total ambulatory care is significantly higher where recent psychiatric disorder was present, and that this finding extended to hospital admissions for physical conditions. The study goes on to investigate the socio-demographic correlates of service utilisation.

While physical illness may coexist with psychiatric illness the somatising patient attributes somatic manifestations to a physical illness and is likely to seek medical help for these somatic symptoms, and not present psychological problems (Bridges & Goldberg, 1985). It has been found that somatisers are more likely to have previously received medical in-patient care (Bridges et al, 1991). Yet Goldberg (1979) notes that early detection of affective disorder that manifests itself in somatic symptoms may shorten the course of illness, thereby reducing exposure to investigative and clinical interventions.

Untreated psychopathology takes its toll on both the NHS and the patient. Research results reveal that, while non-somatising respondents meeting criteria for psychiatric diagnosis are more likely to use specialist mental health services, somatisers with psychiatric diagnoses are more likely to use general medical services (Escobar et al., 1987). As can be expected, research results indicate that, owing to poor treatment response, somatisers are likely to become consecutive attenders at PHC and out-patient facilities (Goldberg et al., 1976) and avid consumers of medical services (Escobar et al., 1987; Katon et al., 1991).

Poor treatment response is also likely to lead to significant disability and loss of productivity.

Escobar et al. (1987) showed that somatisers were more likely to report a restricted level of activity, or more bed days, than non-somatisers. Sigvardsson et al. (1984) discovered that somatisers accounted for 48% of all sick leave occasions in a sample of adopted women. Untreated psychiatric disorder is also likely to lead to chronicity (Goldberg, 1979; Levin, 1994).

Shedler et al. (1993) produced research evidence that psychological defenses may create the 'illusion of mental health' by manifesting as perceived physical conditions. They may eventually also result in actual physical costs through physiological processes that arise from increased levels of autonomic reactivity. Similarly, Bass and Murphy (1990) argue that repeated invasive examinations and the side-effects of various medications may even worsen the physical condition of patients.

The conclusion to be reached from the literature is that it is important to promptly identify somatisation in order to institute proper management. Yet Kirmayer (1989) cautions that it is important to consider cultural variations in the response to psychiatric disorders and emotional distress in relation to management. While an emphasis on somatic symptoms may have certain negative consequences, excessive emotional expression may destabilise social relationships and promote a relapse of major psychiatric disorders in vulnerable individuals. A lack of recognition of distress may mean a lack of stigmatisation and better prognosis. This may be especially so where a person's identity is derived largely from the family or a larger social unit, where the stigma is likely to extend to the rest of the unit.

From the literature it is clear that research should address both the patient-related and health service-related negative aspects of failure to recognise somatisation in the PHC setting. Primary care workers need to have a clear understanding of the mode of presentation that is commonly used to express distress and be able to interpret symptoms presented in instituting sensitive patient management regimens. Thus what is required is a descriptive examination of the symptoms most commonly presented in the PHC settings of a defined area and an exploration of their socio-cultural and psychological correlates.

1.6 PSYCHOPATHOLOGY IN AFRICA

After a literature review constituting a comparative analysis of mental disorder across cultures, German (1987) was able to conclude that the extent of mental ill-health throughout Africa is neither culture bound nor dissimilar to disorders encountered in the Western world, and may even be more prevalent.

Research reports indicate that, although expression of psychiatric morbidity in PHC in terms of somatic complaints is a common mode of presentation in Western countries, in Africa a greater proportion of patients with psychiatric illness present with somatic complaints (German, 1987; Guinness, 1992). Katon et al. (1991) advance three possible explanations for this. Firstly, in many cultures there are no words to describe internal emotional states. Secondly, there are strong sanctions against talking about, and perceiving, emotional states. Thirdly, there may be culturally idiosyncratic explanations for certain affective states. In fact, a review of concepts of mental illness and culture-bound psychiatric syndromes amongst the Nguni Tribes (as referred to by the authors) of Southern Africa has produced a taxonomy of syndromes and concepts which represent versions of mental health problems ranging from ancestral intervention to sorcery, all of which have physical correlates variously experienced by people in all cultures (Cheetham & Cheetham, 1976; Cheetham & Griffiths, 1980; Edwards, Cheetham, Majozi et al., 1982).

Guinness (1991), as part of a four-part study of psychiatric syndromes and their component symptoms in Southern Africa, explored the 'brain fag syndrome' as a minor instance of somatised anxiety. It is a form of morbidity found in upwardly mobile scholars in Africa. As such he found it to be a particularly valuable opportunity for investigating the social origins of mental illness in Africa, due to its accessibility to study.

The conclusions that he draws from this study are supported by those of an earlier study carried out in Soweto (Allwood, 1979) where, in both cases, psychiatric morbidity in Africa was found to be particularly related to societal transition, as signified by high levels of migrant labour and break-up of the traditional extended family structure. He is able to conclude that the findings of his study possibly indicate that the early stages of urbanisation can influence the patterns of mental illness in various ways and that there exists an increased risk of mental illness in transitional societies.

German (1972) presents research data from a number of studies conducted in Sub-Saharan Africa to show that psychiatric problems are neither more nor less prevalent than in industrialised countries of the West and that the relative distribution of disorders also shows some degree similarity. In addition, this finding appears to hold true for different classes within the African social structure (German & Arya, 1969).

Kawanishi (1992) presents the argument that somatisation may be an artifact of the medicalisation of distress, issuing from the Western biomedical doctrine that separates the mental from the somatic. In terms of this argument, presenting with physical symptoms in a PHC setting would be seen as an acceptable form of help seeking and an attempt to gain social support. In the absence of an awareness of alternative services (e.g. psychiatric and social welfare services) and, indeed in the real absence of acceptable alternative services, patients come to know what the medical services expect to hear and what they are most likely to respond to.

Thus, with the mass of patients of all descriptions appealing to the PHC service for help, a variety of treatment options as well as a solid referral structure need to be in place. Accurate local knowledge of both the existing system of health care and the health service needs of the people is required in planning for primary mental health care interventions.

1.7 MENTAL HEALTH CARE IN SOUTH AFRICA

1.7.1 THE EXTENT OF THE PROBLEM

The history of mental health service provision in South Africa is characterised by overcrowded custodial care, the dominance of the traditional bio-medical model and racial inequities in the distribution of resources. A review of the proceedings of a conference on the economics of health care in South Africa (1978) reports statistics related to overcrowding in mental institutions and disparities in government grants to private mental institutions for black and white patients as evidence of inequities.

After a review of the research literature, Allwood (1979) reached the conclusion that the extent of the mental health problem in South Africa was largely unknown and he attributed this to inadequate service provision where, especially in the case of minor psychiatric disorders, facilities are not being provided to meet the need. A more recent review reveals that the data available

is still insufficient to provide a clear picture and that this absence of baseline data has obstructed service planning (Freeman, 1992).

Swartz (1987) makes the point that the criteria for deciding psychiatric 'caseness' vary so greatly from study to study that it is impossible to put together an overall picture and he attributes this mainly to the difficulties of transcultural psychiatric research. Not only is communication between researcher and subject distorted by language barriers, but authors have variously argued that cultural factors may distort assessment and that Western psychiatry is inadequate to accommodate these factors (Swartz, 1987).

Addressing the problems of rural mental health care Malebele (1990) identified various factors that have particularly hindered service delivery in the rural areas of South Africa. These included the attitudes of medical practitioners, the lack of facilities particularly in psychiatric wards in general hospitals in the rural areas, the shortage of staff and the consequent workload, the homeland system and the cultural beliefs, and the right of the patient to mental health care that recognises and incorporates these beliefs.

In its narrowest sense PHC is the first point of contact between the community and the NHS and, as such, constitutes the lowest level in the referral hierarchy. Yet mental health services in South Africa are still largely oriented towards treatment and cure (Sewpaul, 1990; Binedell, 1993), making them inaccessible to the large majority of the people of South Africa. Psychiatric patients seen in psychiatric hospitals, psychiatric units of general hospitals and in specialist psychiatric services constitute only 5 to 10% of the total number of people suffering from psychiatric disorders in the general population (Thom, 1990). Freeman (1990) points out that accessibility is not only related to geographical location and resource distribution, but to the correct diagnosis at front line health points.

Working on an estimated 10-20% prevalence rate Thom (1990) places diagnosable psychiatric disorder in PHC second only to respiratory disorders. Looking at the spectrum of disorder in the primary care setting, she notes a 92% prevalence of a group of disorders including anxiety, mood disorders and substance abuse disorders, with psychoses and personality disorders accounting only for 8%. Yet diagnosis is made difficult by the form of presentation of disorder, which may occur in mixed states of anxiety and depression, present with physical symptoms or be mixed with physical syndromes.

Ethnographic literature from the field of medical anthropology has focussed on the traditional, culturally constructed forms of explaining and expressing distress (Sibisi, 1975; Buhrmann, 1977; Sweitzer, 1977; Hirst, 1990; 1993b) within the *Xhosa* cosmological system (Hammond-Tooke, 1975). A critical investigation of the role of community health workers in psychiatry in PHC in South Africa revealed that community health workers' and community members' explanatory models of psychiatric disorder were greatly at variance with biomedical explanations and that the integration of the two would be a difficult, if not impossible task (Binedell, 1993).

Carothers (1953, p. 133), on the basis of early research literature on psychiatric problems in Africa, reached the conclusion that "Africans have, in general, no genius for directed introspection and no ability or desire to describe subjective states...there are real differences in the quality of psychotic reactions...which makes it impossible to fit them into the accepted nosological framework." Such an approach is likely to hinder progress in extending mental health care into PHC settings and has long since been revised (cf. German, 1972).

It is more likely the case that traditional forms of expressing distress and the use of traditional explanations and concepts of health and illness may not reflect 'tribal' thinking so much as a sense of national pride (Swartz, 1986) and the socio-economic conditions which characterise post-colonial, and now, post-Apartheid South Africa (cf. Hirst, 1990).

It is also the case that primary care workers are generally inadequately trained in the diagnosis and treatment of psychiatric disorders (Eagle, 1990). Vogelman (1990) notes that for a primary mental health care approach to succeed, clinical staff would have to be trained to detect pathology, monitor high risk groups, counsel and be able to assist in aftercare treatment. To this end, traditional healers and community health workers would become valuable mental health care agents. Hirst (1993a) examines the role that indigenous workers could play in complementing Western modes of health care from their positions as part of the social fabric of the local community and possessing valuable local knowledge.

1.7.2 MENTAL HEALTH CARE AND THE SOCIO-POLITICAL CONTEXT

While there is an incontrovertible link between psychology and politics (Vogelman, 1987), the mental health professions, particularly psychology, have been variously criticised for being conspicuously uncritical of the social and political policies of the past and for failing to respond

to the mental health consequences of such policies (Dawes, 1985; Freeman, 1991b; Swartz, 1991; Foster, 1991).

This criticism has been extended to accusations of complicity with, and even support for, policies of Apartheid and associated racist practices (Dawes, 1985; Foster, 1991). Dawes made this claim on the basis of his observation that there was very little work in mainstream South African psychological literature that focused specifically on the problems particular to South African society, and even less that explicitly opposed Apartheid. As a moral responsibility and a remedy he advocates that psychologists develop appropriate research and training and express their standpoints through professional associations.

Following a similar line of argument, Swartz (1987) illustrates the instrumentality of Apartheid in producing mental ill-health and concludes that "to ignore the context may in many cases be to contribute to it" (p. 27). He asserts that the development of a more relevant mental health care in South Africa requires not only the rejection of racism, but an understanding of the workings of racism within the health care context. This is summed up in a closing statement: "Mental health care contains within it both the promise of personal and collective liberation and the inevitability of social reproduction" (p. 245).

Foster (1991) provides an overview of how the issues of "race" and racism have been dealt with by South African psychological disciplines and articulates his discussion in terms of three main areas: (i) segregation in mental health, in which he provides a history of the segregation of services in South Africa; (ii) racist views, in which he describes the evolution of racist ideology and (iii) the analysis of race relations, in which he details research into racial prejudice. On the basis of his overview, he is able to conclude that "South African psychology in terms of both organised and professional activity and academic disciplines has contributed negligibly to any real opposition to racism" (p. 208).

Freeman (1991b), plotting a course forward for mental health professionals in South Africa, elucidates some of the possibilities for extending mental health services to the entire country. This he does in terms of two main elements: (i) socio-political interventions, including increasing public understanding and involvement and influencing government departments, not only the Department of National Health and Population Development, but all departments having an impact on mental health, and (ii) promoting equity in mental health through making care more

affordable, geographically accessible, culturally appropriate and eradicating racism.

Operationalising these objectives is the task of health systems planning. It is now widely agreed that planning takes as its point of reference the consumers of health services. Research into consumer behavior should take into account patterns of utilisation and consumer satisfaction with services.

1.8 HEALTH SYSTEMS PLANNING FOR COMMUNITY-BASED PSYCHIATRIC CARE

Research literature reveals that the growth in community-based mental health services in Westernised countries has come about more through efforts at deinstitutionalising mental patients from specialised psychiatric inpatient institutions than out of the recognition of the problem of non-psychotic psychiatric disorder presenting at PHC level. While deinstitutionalisation may be viewed as part of the change in thinking about mental illness, reflected on in 1.1.3, community psychiatric services have been variously criticised, mainly from an administrative and management perspective (cf. Prior, 1991). In the USA the rate of deinstitutionalisation has not reflected the rapid growth in the demand for community-based psychiatric services, the consequence of which has been an increased rate of homelessness amongst deinstitutionalised patients (Kennedy, 1990; Dennis, Buckner, Lipton et al., 1991; Levine, Toro & Perkins, 1993).

Hansen (1987) reports that in Scandinavia psychiatric and PHC services have developed in isolation from one another, with little integration or co-operation. Where this integration was achieved, however, there was a recorded 18% reduction of admissions to mental hospitals over a two-year period.

The incorporation of psychiatric services at primary care level may take on many different forms. Since the coming into being of the Community Mental Health Centres (CMHC) Act of 1963, the CMHC's have been the primary service units of community-based psychiatric care in the USA, although they have undergone reductions in central government funding from the 1980's (Humphreys & Rappaport, 1993). This movement represents an attempt to provide a comprehensive range of mental health services that are available to communities as a first point of referral. Yet Levine et al. (1993) report under-utilisation of community mental health services by identified high risk groups because they are provided on the medical model. The functional

and physical separation of CMHC's from the other community-based health facilities results in problems of fragmentation and lack of co-ordination of mental health services with other health services (Rydman & Rydman, 1983).

Further problems associated with the CMHC system relate to the administrative constraints on staff having to meet funding agency requirements which are predicated on the medical model (Baldwin, 1990) as well as budgetary constraints which demand increased service efficiency (cf. Ebben, Bliss & Perlman, 1991 and Humphreys & Rappaport, 1993).

In Britain, where general practitioners form the cornerstone of PHC provision, most research studies into psychiatry at this level have been concerned with improving the GP's psychiatric expertise through developing closer professional links with psychiatrists and by helping other members of the primary care team deal with psychiatric problems more effectively (Tyrer, Sievewright & Wollerton, 1984). Here, too, the organisational changes involved in the transition away from hospital-based and towards community-based forms of care for the mentally ill were brought about partly out of a concern for deinstitutionalisation and a revision of the role of the psychiatric hospital in the care of the mentally ill (Prior, 1991). Research findings in the UK indicate that a large proportion of the psychiatric patient load in the UK can be effectively managed by a primary care team without any need for increased staff or resources (Tyrer et al., 1984; Tyrer, 1984).

An important lesson to be derived from the experiences of other countries is that if a community mental health care approach is to work it must be combined with existing general health services. Although much research and review has focussed on the management and planning implications of integrating psychiatric services at PHC level in Western, industrialised countries, there appears to be a dearth of comparative literature on developing countries.

1.8.1 SOCIAL INDICATORS AS DEMOGRAPHIC CONSTRUCTS OF PSYCHOPATHOLOGY

Through a recognition of the relationship between socio-demographic variables and psychiatric morbidity, various researchers have focussed on the use of socio-demographic indicators in mental health service planning. This represents one possibility in assessing the need for mental health services, other methods being community surveys and demand or utilisation-based methods

(Cagle, 1984).

The underlying assumption of the socio-demographic indicators approach is that portions of the population at greatest risk of mental illness can be identified using demographic data, thereby projecting the need for mental health services (Warheit, Holzer & Robbins, 1979; Cagle, 1984).

Such is the reasoning behind the Mental Health Demographic Profile System (MHDPS) developed by researchers at the National Institute of Mental Health (NIMH) in the USA. This system facilitates inferences about the needs of communities through a description of 'social areas' in terms of 150 social indicators (Warheit et al., 1979).

Reviewed research reveals that social indicators such as age, gender, living arrangements, race, marital status and socio-economic status (SES) are particularly related to rates of mental illness (Dohrenwend & Dohrenwend, 1974; Camasso & Camasso, 1986) and that interaction effects among variables, such as gender and marital status, are significantly related to observed variance in defined populations (Warheit, Holzer, Bell et al., 1976; Joseph & Hollett, 1993). Camasso and Camasso (1986) show that the inverse relationship between SES and psychiatric morbidity is mediated by stressful life events and availability of social supports, and, therefore, advocate for interventions in disadvantaged classes that address both stressor and social support processes.

Some authors question the validity of social indicators as a needs assessment method in health service planning, however, emphasising the importance of considering the particular circumstances of defined geographic areas and their constituent communities (Joseph & Hollett, 1993). Social indicators are more useful in demographically homogeneous, rather than in heterogeneous communities. Such information is also subject to time constraints and needs to be updated frequently (Warheit et al., 1979). Failure to take these considerations into account may result in a situation where the use of social indicators perpetuates the inequalities that they are supposed to reveal (Cagle, 1984).

Arguing along similar lines, Bigelow, McFarland and Olson (1991) propose 'quality of life' as a valid criterion for evaluating mental health services, and operationalised this concept in terms of the Quality of Life Questionnaire. The performance of mental health programmes is assessed against their capacity to bring about real changes in the ability of recipients to fulfill needs, meet social expectations and access opportunities.

1.8.2 A CONSUMER PERSPECTIVE ON HEALTH SYSTEMS PLANNING

There is an extensive body of literature dealing with community-based mental health systems planning, and focussing on organisation and management issues such as resource management, attention to system goals, monitoring and feedback, the promotion of desirable working conditions, inter-organisational cooperation and finding the optimal fit between patient and health service characteristics (cf. for example, Anthony, Cohen & Kennard, 1990; Sheinfield & Weirich, 1981; Polcin, 1990; Sue, Fujino, Hu et al. 1991; Greenley, 1992).

Most authors concur, however, that planning and administration must be guided by a consumer perspective, or client orientation. These authors have recognised that consumer satisfaction has both service utilisation (Hershorn, 1993) and political implications (Chamberlin & Rogers, 1990) and that it is most effectively established by engaging the participation of the community in line with the PHC approach.

The client oriented approach, as well as accountability to the funding sources and communities, requires greater emphasis on programme evaluation, which includes; needs assessment, surveys of consumer satisfaction with services and client outcome evaluations (Pallak, 1990). Programme evaluation should also include systematic reviews of programmes, costs and revenues and should research the effectiveness of planning methods (Ebben et al., 1991).

The determination of service deficiencies and service requirements for a community necessitates a reasonable assessment of the psychosocial and health statuses of the general population (Sundel, 1983). Psychosocial conditions within a community are likely to be reflected in such information as employment and poverty rates, marital status and rate of marital break-up, levels of violence and alcoholism within the community, age, gender and racial distributions (cf. Warheit et al., 1976).

Several consumer satisfaction surveys have been conducted using a simple self-reporting or interview format (cf. Justice & McBee, 1978; Corrigan, 1990 and Carscaddon, George & Wells, 1990). Authors have, however, cautioned about the tendency of patients to use response sets. In any survey there may be an inclination on the part of clients towards acquiescence or social desirability through the fear of having the service withdrawn (Justice & McBee, 1978; Lebow, 1982). Thus evaluation may benefit from a more collaborative approach that incorporates family

members and the community (Carscaddon et al., 1990).

Although most of the literature on service planning emanates from developed, Western countries, there are themes which are especially applicable to planning for community mental health care in South Africa.

Beigel (1983) notes that in developing countries, where resources are scarce and the existing PHC system is already likely to have considerable acceptability from the population, as well as professionals and government, it makes no sense, organisationally, to create a separate community service. In fact, this is corroborated by the American experience where a separate CMHC system has caused service discontinuities within the state health system as a whole (Hudson, 1990).

Keogh (1988) outlines a framework for the role of the community nurse in the prevention and treatment of psychiatric disability in South Africa. The goals for service delivery within this framework rely heavily on the relationship that the community nurse is able to develop with the community and the consequent trust and acceptance of the service by community members. The reorientation of PHC workers in the delivery of primary mental health care requires (i) a reorientation in the method of dealing with help seekers to include mental health care (both detection and treatment), and (ii) direct access and availability of higher generalist and specialist services (Diekstra & Jansen, 1990). A study conducted by a WHO research team found that the training of general health workers in developing countries to provide mental health services greatly increased the availability of these services (Murthy & Wig, 1983).

Friedman (1992) focuses on the potential role of NGO's in popularising innovations in health care in South Africa. Working from an understanding of the ecological issues related to ill-health, he provides an outline of the role of community health workers in a holistic, intersectoral approach to health and development.

Available literature highlights the potential for collaboration between community mental health services and other sectors and services in dealing with issues pertaining to: (i) maintaining the chronically mentally ill within the community (cf. East, 1992 and Ford, Young, Perez et al., 1992), (ii) enhancing child welfare and mental health services for the family (cf. Knitzer & Yelton, 1990; Lourie & Katz-Leavy, 1991; Melton, 1991 and LeCroy, 1992), (iii) fighting social-ills such as

drugs (cf. Humphreys & Rappaport), and (iv) addressing the behavioural aspects of AIDS (and other sexually transmitted diseases [STD's]) prevention, and acceptance of HIV and AIDS victims within the community.

Clearly, the research demands are numerous and the vast regional differences that exist in South Africa demand of health systems planning for primary mental health care specific local knowledge of prevalence of psychiatric symptomatology, its characteristic presentation, its sociocultural and demographic correlates, as well as its relation to consumer behavior.

CHAPTER 2 - THE STUDY AREA

The area under study encompasses the Bisho - King William's Town portion of the Border-Kei area within the Eastern Cape Region (formerly known as Development Region D). A consideration of economic development and health status indicators related to the study area and to the larger Eastern Cape Region will serve to position and direct a discussion of health service provision in general, and mental health services in particular, within the context of the research study.

2.1 POPULATION DEMOGRAPHICS

A literature study compiled by the Border-Kei Planning Consultancy Team, revealed a number of population statistics for a portion of the Eastern Cape region incorporating the Bisho-King William's Town area. These factors have important implications for service provision. The study was conducted in 1993 on behalf of the Border-Kei Development Forum as part of the planning process.

The area has an average population density of 71 people per square kilometer. Approximately 43% of the population are below 14 years of age and females constitute the majority of the adults resident in the area with males comprising only 44.6% of the adult population. The average number of dependents per potentially active person is 3.5.

Of the economically active population in the area, 22.4% had no education, 38.3% had primary, 33.4% had secondary education and 5.9% had tertiary education. An estimated 26% of the population are considered to be functionally illiterate.

While around 80% of the population of the Region as a whole lives in the rural areas, the estimated rural / urban split in the population for the study area is 46% and 54% respectively. This split is weighted more in the urban direction in the study area as a large proportion of the population is considered to be functionally urbanised. Much of the rural area may be considered part of the urban areas in so far as consumerism and migrancy are concerned. Urbanisation is estimated at around 2% per annum.

The two most important economic activities in the area are manufacturing and community and

social services. Manufacturing accounts for 26% of the economic base. This sector may, however, be on the decline since the abolition of the homeland system. Taxation incentives, exemptions from certain requirements of the labour legislation and subsidised labour offered to factories in the former Ciskei are no longer available. Many factories situated in the industrial sites of Dimbaza and Fort Jackson (both situated 30km outside King William's Town) have had to close down as a result. These provided employment for many people in the communities within the study area. The estimated unemployment rate is around 23%, while the unemployment rate of 25% for the region as a whole is considered the highest in the country (Southall, 1992).

Approximately 45% of the population is considered to be potentially economically active, which includes 95% men and 55% women aged 15-65. While an estimated 77% of the de facto labour supply is employed, this is supposed to constitute only 44% of the potential labour force.

Although all of the above factors have a bearing on the health of a population, access to basic subsistence facilities are key determinants of personal health status and general quality of life (Southall, 1992). The provision of these services to rural populations is particularly poor in the Eastern Cape region as depicted by the following indicators which represent the percentage of the rural population with access to facilities for 1991 (NHPD, 1992):

safe drinking water	60%
effective latrine facilities	21%
effective refuse removal facilities	33%
effective stormwater drainage	52%

Since these statistics do not incorporate those for the former Ciskei and Transkei homelands, the actual figures may be estimated to be somewhat lower than depicted.

An estimate of figures for domestic latrine facilities in Region D, including the Ciskei and Transkei areas, is 13% of the rural population; for safe drinking water, about 36% and, with regard to housing, an overcrowding rate of 64% (Southall, 1992).

2.2 EXISTING HEALTH SERVICES IN THE STUDY AREA

There are approximately 10 PHC clinics in the defined study area, two hospitals and five mobile clinics in operation. These facilities operate under various health authorities. The King William's Town Health Department operates under the local municipality and supervises PHC clinics in King William's Town (in the town and in Schornville), Ginsberg and Breidbach. These clinics provide a comprehensive range of services including ante-natal, TB, childcare and immunisations, treatment of sexually transmitted diseases, family planning and minor ailments. Promotive and preventive services include geriatric counselling, STD treatment and counselling, infectious diseases surveillance and control and nutrition. A single equipped mobile vehicle visits the outlying industrial and commercial areas and communities on a biweekly basis, making approximately 16 stops and providing a primarily family planning and immunisation service (ReHMIS, 1994).

The clinics are operated by nine clinic sisters, who also make home visits, and two nursing assistants. Three health advisers conduct fieldwork in the townships, performing an educative function. The clinics operate from 08H00 to 16H30 (ReHMIS, 1994). Approximately 75% of the clientele utilising this service comprises females and 25% males, who attend mainly for treatment for STD's and minor ailments. The split between children and adults is approximately 50%. This proportion has increased in recent months with the availability of free health care to children 6 years old and younger (personal communication, clinic staff 1995).

All patients attending the Ginsberg clinic are black as are most of the patients attending the town clinic, while some are coloureds and a few are Indians. The Schornville clinic, which operates only one morning a week, services a coloured community, as does the Breidbach clinic, where the patient breakdown is approximately 80% coloured, 15-20% blacks and a few whites, who travel from King William's Town (personal communication, clinic staff 1995).

All clinics draw patients from the immediate community as well as from the surrounding townships and locations, including Tshatshu, Ndevana, Tyutyu, Speedwell, Quzini Location, Thembeni Location, Peelton and Zwelitsha (personal communication, clinic staff 1995).

All suspected psychiatric patients are referred to Grey Hospital Psychiatric Community Services, with whom the King William's Town Health Department maintain close liaison. Few patients

are referred, however, due to problems in identifying cases. While obvious psychiatric problems like psychoses are normally referred, the more non-specific symptoms are not identified. The limited consultation time and lack of psychiatric training among clinic staff are limitations in the identification of cases (personal communication, clinic staff 1995).

The psychiatric team from Grey Hospital visit each of the clinics once a month, where they see the psychiatric patients from the community, assess their condition and review medication. The team also makes home visits in each of the communities once a month. Yet this service remains a secondary referral service (personal communication, clinic staff 1995).

The Kei-Road and Emthonjeni clinics are administered by the Amatola Regional Services Council. These clinics operate on the same basis as those of King William's Town, with a clinic staff complement of two professional nurses, two health educators (*nomphilo*) and a clerk/interpreter. There are also five community health workers from a local NGO which work in the community. These clinics draw patients from the local communities as well as from the Border Post Settlement, Amabili, and other rural communities in the district. A breakdown of the patient load reveals that more than 80% of patient visits are accounted for by rural patients for both clinics and black patients constitute almost the entire load. The rural areas are visited by a mobile clinic which makes six-weekly rounds to the farms and rural communities (personal communication, clinic staff 1995).

Psychiatric Community Services manage the psychiatric patients in the community. Up until recently this system of management included issuing the medications to the local clinics from where they were dispensed to the patients. Clinic staff are, however, not trained to monitor these patients for changes in the condition or side-effects of the medication, with the result that these patients were merely maintained and not treated. Due to this problem the clinics are no longer issuing the medications, psychiatric patients must now go to Grey Hospital Psychiatric Community Services in King William's Town for their medications and check-ups. It is, however, the case that many patients are not in a position to travel due to disability or financial difficulties and may fail to arrive the relevant service. Clinic staff recognising these problems emphasised the great need to integrate the two services and had been requesting psychiatric training for nursing staff (personal communication, clinic staff 1995).

The Tyutyu clinic in Bisho falls under the Division of Community Health (formerly of the Ciskei

Health Department) and has a staff complement of a senior professional nurse, two professional nurses and four nursing assistants. Bisho town has a population of around 50000. The clinic services a black patient population from the local community (6000) as well as from the neighbouring communities of Balasi, Bisho Gardens, Lolo Park, Bisho Park and Hanover. Mental health services are provided in the clinic on a monthly basis when a visiting psychiatric team from Bisho Hospital conduct follow-up visits of psychiatric patients and 'new patient' visits, where referred patients are assessed. Each of the hospitals in the former Ciskei have a psychiatric clinic in the outpatients department run by psychiatric nurses and a visiting psychiatrist. Community health workers operate in the communities on a voluntary basis and clinic sisters make home visits where necessary (personal communication, Bitalo 1995).

2.3 NEEDS IN PRIMARY MENTAL HEALTH CARE

During consultation with clinic staff areas for possible mental health care intervention at primary care level were identified on the basis of a consideration of the psycho-social problems experienced by the local communities.

i. In the King William's Town, Ginsberg and Breidbach clinics AIDS counselling has been initiated on group and individual levels. The target groups are STD and ante-natal patients. Clinic staff emphasise the dire need for such counselling which reaches into the community, also targeting men, who are less likely to attend the clinics.

ii. Also identified as an important aspect of the PHC service is the interpersonal style with which patients are treated. It was noted that follow-up is very much dependent on the attitude of the nurses and the way the case is dealt with. Greater accessibility, increased awareness and style of patient management were recognised to be crucial factors in reducing the number of TB defaulters.

iii. Staff at the Breidbach clinic noted the importance of a service that supported home care for chronically ill and disabled patients and geriatrics. Plans had been initiated in this regard, where a trained nurse and four health workers would operate such a service in the communities.

iv. Dagga and alcohol abuse was often brought to the notice of clinic staff in cases of

patients seeking treatment for withdrawal symptoms or substance abuse-related physical problems. The increasing use of mandrax, noted by Breidbach clinic staff, has resulted in cases of over-dose and even death. There is therefore a need for some intervention in this area.

v. A major problem identified by clinic staff was the inadequacy of the referral structure. Social welfare services are provided by the municipality and the Child Welfare Society. Yet clinic staff recognise that these services are not able to deal with the large proportion of abuse, and other, cases seen in the clinic because of the small number of social workers available. Many patients referred to social welfare services or to Grey Hospital do not comply and are lost to the support system. It was felt that a closer liaison with referral services would facilitate follow-up of cases.

vi. Clinic staff confirmed that most psychiatric distress ranges from mild to moderate in severity and that for a primary mental health care approach to work detection and management would have to operate at all service points, the smallest of these being the various stopping points of the mobile clinics that operate in the rural and industrial areas.

Clinic staff are in a position to identify a number of social stressors and problems within the communities from their interactions with patients attending the clinics. The most frequently identified are unemployment, family abuse and alcoholism. These factors are in many cases interrelated. Since the factories in the former Ciskei and in King William's Town had started closing down unemployment has been rising steadily. It was felt that there exists an urgent need for a shelter for abused women and children, however, there is no such facility in King William's Town. Also identified as problem areas are the cultural traditions related to a woman's status and the reluctance of women to use contraceptives or consider sterilisation without the consent of the husband, which is seldom forthcoming.

Administrative problems related to service delivery have been encountered in integrating the 'top-down' style family planning services of the old health system into a comprehensive PHC service. Before health system restructuring, family planning was a centrally co-ordinated service. Family planning staff are having to be trained to deliver a comprehensive PHC service and comply to the requirements of local authorities, under whose administration they now fall.

CHAPTER 3 - METHODOLOGY

3.1 RESEARCH GOALS

3.1.1 GENERAL AIMS OF THE STUDY

The following aims were formulated to guide the collection and analysis of data;

i. to construct a picture of psychiatric symptomatology in terms of prevalence and presentation, as it occurs in PHC settings of the defined study area,
ii. to assess the possible association of psychiatric symptomatology with factors considered relevant to planning for primary mental health care in the study area,
iii. to provide a meaningful account of psychiatric distress within local conceptual frames, and
iv. to evaluate the appropriateness of the screening instruments for cross-cultural application in the defined study area.

3.1.2 HYPOTHESES

Research aims are operationalised in terms of the following hypotheses:

Hypothesis 1

Patients with psychiatric symptomatology seen in the PHC setting present with identifiable patterns of somatic symptomatology. Here a picture of somatic symptomatology (as defined by the WHO) is derived from the SRQ symptom profile, PSE syndrome profile and case materials from PSE interviews.

Hypothesis 2

Psychiatric symptomatology seen in the PHC setting is associated with certain socio-demographic characteristics. Characteristics assessed include gender, age, number of children, marital status, employment status, level of education and academic success.

Hypothesis 3

Patients with psychiatric symptomatology seen in the PHC setting utilise health resources

less appropriately than patients without psychiatric symptomatology. Here 'health resource utilisation' is operationalised in terms of sub-hypotheses.

3.1 Patients with psychiatric symptomatology spend more time at the clinic than patients without psychiatric symptomatology.

3.2 Patients with psychiatric symptomatology receive more medical treatment than patients without psychiatric symptomatology.

3.3 Patients with psychiatric symptomatology are less compliant with medical directions than patients without psychiatric symptomatology.

3.4 Patients with psychiatric symptomatology report more physical illnesses requiring treatment than patients without psychiatric symptomatology.

3.5 Patients with psychiatric symptomatology report more sick bed days than patients without psychiatric symptomatology.

Hypothesis 4

Patients with psychiatric symptomatology seen in the PHC setting perceive PHC services to be less satisfactory than patients without psychiatric symptomatology. Here psychiatric screening results are compared to patient perceptions of the quality of personalised care received in the clinic.

3.2 DESIGN

The study takes the form of an independent groups quasi-experimental design. Psychiatric assessment was executed according to a two-phase screening process for the presence or absence of symptoms indicating psychopathology. The two-stage process has been found to reduce the number of false positive cases that occur when a single self-response screening instrument is used (Sen et al., 1987). Participants were assigned to one of three groups on the basis of their measure on the independent variable, psychiatric symptomatology: (i) participants testing negative at stage one, those with minimum symptomatology; (ii) participants testing positive at phase one and negative at stage two, those with some psychiatric distress, and (iii) participants testing

positive at stage two, those with diagnosable psychiatric distress. These groups represent degrees of psychiatric symptomatology. (See appendix 2 for diagrammatic representation of the research design.)

Dependent variable measures on patient satisfaction with health services and utilization were assessed for each participant as were socio-demographic variables. Somatic symptoms were derived from selected items constituting the SRQ and PSE schedules using WHO guidelines.

Information derived from case notes taken during PSE interviews and from semi-structured interviews with clinic staff was used to contextualise and enrich quantitative findings.

3.2.1 TRIANGULATION AS A RESEARCH STRATEGY

Robottom and Colquhoun (1993, p.47) attack the "heavy use of and reliance on statistics and quantitative procedures" and highlight the "real need for alternative approaches within the health research area." Some authors have presented a strong argument for the use of multiple, complementary methods as a research strategy (Jick, 1983; Smith, 1975), and particularly as a strategy of investigation of health services (Miller & Crabtree, 1992). This multi-method research approach has been called "triangulation", a form of which is the use of field or qualitative data collection and analysis techniques in conjunction with more quantitative techniques (Jick, 1983; Smith, 1975).

These authors concur that an objective or atheoretical research strategy is an impossibility, pointing out that different methods merely provide different perspectives or 'selective experience' and that all are to a greater or lesser degree value-laden. They also point out that qualitative and quantitative methods are not clearly distinguishable and may be more accurately conceptualised as the opposite ends of a continuum.

Both survey and qualitative techniques have their own disadvantages. These relate to their different levels of standardisation and generaliseability and the amount of information that they yield.

The advantages of this integrated form of investigation for the research problem under study include its potential for providing a holistic interpretation and enriched explanation of statistical

results by contextualising findings. Further, if the results of different methods are found to be convergent, the validity of findings is strengthened (Miller & Crabtree, 1992; Jick, 1983).

In this case an attempt to integrate fieldwork and survey methods was considered the most appropriate option for investigation of broad research objectives within a largely unstructured primary care setting. This would allow for the development of both the exploratory and explanatory aspects of the study, including the identification and description of psychiatric symptomatology, and the testing of possible relationships, which may have significant implications for the reshaping of primary care services in the Eastern Cape Region.

This research strategy recognises the status of the fieldworkers in the clinic setting as 'participant-observers', working within the setting and not just with clinic patients, and thereby becoming part of the clinic environment. The criterion of informed consent meant that fieldworkers were not passive receivers of data but engaged in meaningful interaction with staff and patients. Fieldworkers were able to experience the patient management systems of the various clinics, the interactions between staff and patients, and note the types of services provided, all of which constitute field observations and were recorded as field notes.

3.3 SAMPLING

Subjects were drawn from the patient population 16 years and older attending PHC clinics in the Bisho-King William's Town area of the Eastern Cape region. The sampling methodology makes use of both convenience and probability techniques.

Convenience sampling was used to identify the clinics. There are 10 PHC clinics in the defined area. The seven clinics chosen for the sample include the Kei-Road and Emthonjeni clinics falling under the Amatola Regional Services Council, the King William's Town Community Health Centre, Breidbach Community Health Centre and the Ginsberg and Schornville clinics falling under the King William's Town Health Department, and the Tyutyu clinic in Bisho falling under the former Ciskei Community Health Department.

A probability technique was used to sample patients within the clinics. On the basis of attendance estimates of an average of 40 clients per day, and working at an estimated data collection rate of 15 minutes per patient for the first stage and one hour per patient completing

the first and second stages, every fifth patient was systematically selected for the sample. In the peri-urban areas where the patient flow is slower every third patient was sampled. The projected sample size was 175 subjects. Thirty days of fieldwork were planned for.

3.4 RESEARCH TOOLS

Three instruments were used to gather data on identified variables. Psychiatric screening for symptoms indicating psychopathology, the independent measure in the design, is comprised of two instruments, the Self-Reporting Questionnaire (SRQ) in the first phase and the Present State Examination (PSE) in the second phase. Dependent variables were assessed by means of a Self-Response Schedule (SRS) developed specifically for this study, and selected items on the SRQ and PSE.

3.4.1 THE SELF-REPORTING QUESTIONNAIRE (See appendix 3.)

The SRQ was chosen as a first stage screening instrument for the present study for reasons demonstrated in the research literature:

i. The instrument has a number of demonstrated advantages over its predecessor, the GHQ, such as easier response format and shorter administration time (cf. Sen et al., 1987 and Mari & Williams, 1985).

ii. It was developed specifically for use in primary care settings in developing countries (Harding et al., 1980).

iii. It has been translated with demonstrated success (Sen et al., 1987; Rumble, 1994) and used in primary care surveys in Africa (Dhadphale & Ellison, 1983; Dhadphale et al., 1983).

iv. Is has been found to be easy to administer to patients with little formal education since items are easily understood (Sen et al, 1987).

v. Items are not likely to arouse defensiveness which means that the non-consent rate is very low (Dhadphale et al., 1983).

vi. Previous research has demonstrated a strong correlation between the total SRQ score and overall clinical assessment by a psychiatrist at a population level (not necessarily at individual level) (Mari & Williams, 1986).

vii. The instrument can be successfully administered by lay fieldworkers with a few hours of

training (Harding et al., 1980).

The research literature also reveals some negative factors related to the use of the SRQ which have relevance to this study:

i. The SRQ tends to produce a high rate of false positives, and it has been shown that the sensitivity of the instrument is lower than its specificity (Rumble, 1994).
ii. Scores are susceptible to help-seeking behaviour and response sets (Rumble, 1994).
iii. While the SRQ is easily translatable, there may be some problem with obtaining the semantic exactness of all items (Rumble, 1994).

The SRQ was standardized and validated in a study carried out by a WHO sponsored research team led by Harding (1980) as part of the baseline observations in the WHO Collaborative Study on Strategies for Extending Mental Health Care (WHO, 1979). It constituted part of an effort to develop and evaluate low cost methods of mental health care within general health services in developing countries.

The instrument consists of 25 items which were selected from four instruments used in different cultural settings. These include; the Patient Self-Report Symptom Form (PASSR), the PGI Health Questionnaire N2 (in Harding et al., 1980), the General Health Questionnaire (GHQ) (Goldberg, 1972) and the "symptoms" items on the shortened version of the PSE (Wing et al., 1974). From an original list of 32 items, 20 were selected by consensus between investigators (Harding, 1980).

The SRQ is a self-response rating scale which can be filled out by the literate patient in original or translated form, or administered as a structured interview in the case of illiterate patients. The object of using this instrument is to identify patients with some degree of psychiatric distress on the basis of a psychiatric symptomatology rating.

Validation coefficients for the SRQ have been established in a number of studies by comparing its results against those of a standardised psychiatric interview. The cut-off point used in these studies was determined by calculating the sensitivities and specificities for large values of the threshold for caseness. Calculated sensitivity and specificity of the instrument at the cut-off point selected for each study range between 73% and 83% in Harding et al. (1980) and Mari and

Williams (1986) to 89.2% in Dhadphale et al. (1983) for sensitivity, and between 72% and 85% in Harding et al. (1980) and Mari & Williams (1986) to 93% in Dhadphale et al. (1983) for specificity. In most cases the chosen threshold was a cut-off score of 7-8 and this was found to provide the best trade-off between sensitivity and specificity (Sen et al., 1987). Mari and Williams found a strong correlation (r=+0.70) between the total score and the overall clinical assessment made by the psychiatrist.

3.4.2 THE PRESENT STATE EXAMINATION

The second psychiatric screening instrument is the ninth edition of Wing's Present State Examination (PSE). The original version of this clinical instrument was developed with the purpose of standardising both the interview technique by which symptoms are elicited and the set of symptom definitions applied. Further, a system was developed by which to condense symptoms into syndromes, thereby establishing standard criteria by means of which to make diagnoses (Wing et al., 1974; Wing, 1983).

The object of this structured clinical interview is to assess the present mental state of adult patients. The interview is conducted according to a schedule which systematically covers all the phenomena likely to be considered during a psychiatric examination. Although the interview requires substantial standardisation, the wording of each question would, to a large extent depend on the answer to the previous one (Wing et al., 1974).

The validity of the PSE ninth edition items was established by demonstrating a satisfactory degree of association between the symptoms that they uncovered and the syndromes to which they were allocated (Wing et al., 1974). After a validity study of the instrument, Luria and McHugh (1974) found it to provide a valid, clinically meaningful psychopathological profile.

In view of the PSE's intended purpose as an aid to reliable diagnosis Wing et al. (1974) conducted reliability studies for the various stages of the diagnostic process. The mean inter-rater reliability rating for each individual item was found to be 0.77 (Wing, 1974). While Luria demonstrated, on the basis of an across-patient inter-rater reliability, a high and significant reliability. These findings are confirmed by Wing et al. (1977) where the Product-Moment correlation coefficient for two sets of total PSE scores was recorded as 0.73.

Although originally standardised on a clinical sample of psychiatric patients, reliability data indicate that PSE syndrome scores are similarly reproducible in inpatient, outpatient and general population settings (Wing et al., 1977). Binitie (1975) points out that because the interview may be analysed at the level of symptoms, cross-cultural comparisons become more meaningful. The PSE ninth edition has been used by non-psychiatric interviewers in non-clinical settings. The training procedures are the same and inter-rater reliability between psychiatrists and non-psychiatrists confirms that no significant biases exist between raters (Cooper et al., 1977). This means that, for the purposes of this study, non-psychiatric interviewers with proper training would be able to use this version of the PSE in PHC settings.

3.4.3 THE SELF-RESPONSE SCHEDULE (See appendix 4.)

The third instrument is a 30-item self-response schedule which is the shortened version of the 45-item schedule used in the pilot study. The instrument was compiled by the researcher as a face-valid operationalisation of the identified variables. Before being used in the field it was distributed to community fieldworkers employed by a King William's Town non-governmental organisation for critical comment.

All items have face validity. They are closed-ended, providing for multiple response options on a self rating scale. Items are divided into three sections headed; 'personal particulars', 'health service utilization' and 'quality of service' respectively. The form elicits biographic information that builds a socio-demographic picture of the patient population, assesses health service utilisation by patients and patient satisfaction with health services and facilities. The form is also designed to elicit additional information on preferences for consultation, attitudes towards psychopathology and sources of referral to the clinic that may contribute to an explanation of the observed set of results.

3.5 PROCEDURE

The study entails a two-stage screening process for symptoms indicating psychopathology as well as a survey of three hypothetically related constructs. Each identified clinic was visited by the fieldwork team on successive days until a specified quota of PHC patients were systematically sampled. Fieldwork took place over a 22 day period from 31 October to 1 December 1994 and over a six day period from 19 to 26 January 1995. Fieldwork was conducted in clinics on days

negotiated with clinic staff and the relevant health authority.

So as not to disrupt the clinic procedures, fieldworkers first familiarised themselves with the system of patient management and endeavoured to work within this system.

The SRS and SRQ forms were numbered, paired and administered to identified patients in the waiting room prior to their appointments. A fieldworker approached every fifth patient as they were seated and explained the process clearly, elicited informed consent, preferred language medium and ascertained level of literacy (by asking patients to read the first few questions aloud). Participants were presented with a blank SRQ form, either a translated or original version, a blank SRS form and pencil. Literate participants worked through the forms in approximately ten to fifteen minutes. In the case of illiteracy a fieldworker worked through the forms with the participant in approximately ten minutes. SRQ and SRS testing followed the same procedure of administration.

The SRQ was scored during the consultation period and participants were identified as scoring below of above threshold. Directly after consultation those identified as scoring above threshold underwent the 30-45 minute standardised psychiatric interview (PSE) as the second stage psychiatric screening. The interview took place in a private or semi-private area of the clinic where the fieldworker and participant were able to interact confidentially. This was usually the records room or an allocated consulting room.

When the psychiatric interview was administered in *Xhosa* the researcher took the role of the main interviewer. Although able to understand much of the interview the researcher was not able to pose questions in the vernacular. Translations were therefore carried out by the research assistant.

Written permission to conduct research in PHC clinics was obtained from the relevant health authorities. Applications were submitted with copies of the research proposal and instruments and consultation with authorities took place where further clarification of the study was required. Applications also contained the assurance of confidentiality and the commitment to submit a summary report upon completion of the fieldwork.

Testing was administered by trained fieldworkers fluent in the mother tongue of participants as

either first or second languages, so as to facilitate translation and provide for cases of illiteracy. Participation by patients was subject to their informed consent. This required fieldworkers to introduce themselves personally to each patient, briefly explaining the purpose of the study and highlighting the potential value of participation, so as to minimize the possibility of refusal to participate. Participants were also assured of the strictest confidentiality. Fieldworkers were clearly identified by name card. In the event of a patient refusing to participate, the next patient on the consultation waiting list was sampled so as to minimize any bias in the statistical randomisation of the sample. Ten patients refused to participate in the first stage of the fieldwork.

Patients testing positive for psychopathology on the basis of the two-phase screening process were notified of the findings where psychopathology was immediately apparent and given the option of referral to appropriate specialist services. After completion of the fieldwork, semi-structured interviews with the senior professional nurses of four of the clinics visited were conducted. This provided the opportunity for focussed, open-ended, informal discussion guided by the researcher. Field notes were recorded in writing during the interviews.

3.6 DATA ANALYSIS

3.6.1 QUANTITATIVE ANALYSIS

Data capturing, processing and representation was executed by computer. Encoded data was captured onto a Quattro spreadsheet format and analysed on the BMDP statistical software. The data was subjected to both descriptive and inferential analysis. Descriptive summaries of data are presented in graphic and tabulated form. Graphs and frequency distributions were generated by the Stat-Graphics computer programme.

The study takes the form of an independent groups quasi-experimental design in which hypothesised differences between groups are tested. The independent variable, psychiatric symptomatology, is analysed on three levels as a non-manipulated factor. The screening procedure sorts respondents into three independent groups on the basis of SRQ and PSE scores.

To infer whether the groups differ significantly on each of the identified variable measures, both F- and chi-square statistics were calculated for each variable. The significance level for the

admissibility of research results was set at $P < 0.05$.

Items 1, 2, 5, 7, 18, 19, 20 and 25 on the SRQ measure somatic symptomatology (hypothesis 1). Biographic information is recorded on items 1-8 of the SRS (hypothesis 2) and items 13 and 23-28 on the SRS provide a face valid measure of patient satisfaction with PHC services (hypothesis 4). Utilization of health services is assessed by items 8-12, 14-16, 19 and 21 on the SRS. Responses to these items reflect various aspects of service utilization (hypotheses 3.1 - 3.5).

Raw scores from completed PSE's were analysed using the PSE-ID-CATEGO computer programme. The first stage of processing generates a symptom-syndrome print-out for each PSE wherein the 140 items constituting the PSE, representing the symptoms, are sorted into 38 syndromes (see appendix 9). Through this process a complete symptom-syndrome profile for each PSE is generated. This output was used to compile a syndrome profile for all 57 patients interviewed. Also indicated in the output at this stage of processing are four subscores and a total score for each PSE derived from the 38 syndrome scores (see appendix 8).

The final output presents the data according to a number of dimensions for each PSE computed.

i. A summary of the score data according to the four syndrome groupings (delusional and hallucinatory, behaviour, speech and other, specific neurotic and nonspecific syndromes) is presented, along with the total score.

ii. An index of definition (ID) provides an indication (on an eight level scale) of the certainty with which a classification can be made from the available syndrome information. Where level 1 represents the absence of PSE symptoms, level 5 represents the 'threshold level', usually providing a minimum basis for a PSE classification (or 'caseness'), and levels 6, 7 and 8 provide increasing degrees of certainty that the symptoms present can be classified into one of the functional psychoses or neuroses, as defined by either clinical judgement (guided by the WHO glossary) or by using the CATEGO programme.

iii. Each PSE is allocated to one of 50 subclasses, which can be condensed into broader classes. Each PSE syndrome profile is generally be allocated to only one CATEGO class. This class allocation is really a descriptive summary of the original clinical

condition rated in the PSE (See appendices 8 and 9 for listings of the classes and sub-classes).

iv. Finally a tentative diagnosis is made in terms of the ICD-8 diagnostic system for PSE's with an ID of 5 or more (Wing & Sturt, 1978). (Symptom details documented in the ICD-10 Symptom Checklist for Mental Disorders (version 1.1) and the ICD-10 Symptom Glossary of Mental Disorders indicates that the earlier version, on which the PSE ninth-edition is based, is comparable with the latest diagnostic system.)

Profiles of SRQ symptoms and PSE syndromes were compiled for the patient sample.

Following analysis of results, four variables; age, marital status, ambulatory services utilised and formal educational level, were re-coded and subjected to post-hoc analyses.

3.6.2 INTERVIEWS AND CASE NOTES

Qualitative data derived from identified sources, was analysed in terms of its relevance to the quantitative results and its implications for the integration of community psychiatric services into existing PHC services provided by clinics in the study area.

3.6.1.1 Case notes

Cases were extensively documented in field notes taken by fieldworkers for each psychiatric interview. These are discussed in terms of their cultural and socio-economic context.

Each psychiatric interview proceeded with the patient as the point of reference, first prompting the patient to elaborate on any problems presently being experienced. In most cases a range of issues were raised which had identifiable medical, psychiatric and social correlates. These were used as a starting point and provided structure for questioning, which meant that items on the schedule were not worked through sequentially. At relevant points in the interview discussion would be entered into before questioning resumed. This approach reinforced the co-operation and participation of the patient. While working through each interview schedule, fieldworkers took down hand-written case notes.

Excerpts from case materials have been used extensively to substantiate findings and enrich the discussion (see chapter 5).

3.6.1.2 Interviews with anthropologist/traditional healer

The case notes constituted the basis for a series of in-depth discussions with a local anthropologist, Dr H., involved in on-going research among the *Xhosa* people of the Eastern Cape. The purpose of the first part of these discussions was to contextualise the observations within the traditions and culture of the local people and relate findings to the present social setting.

As an initiated traditional healer, and having conducted extensive research among the traditional healers of the Grahamstown townships in the 1970's, Dr H. was also in a position to take the discussion into a consideration of the case content from a traditional healing perspective. This part of the discussion serves to provide insight into the form and content of presentation of problems in the PHC setting.

3.6.1.3 Interviews with PHC workers

Semi-structured interviews (see appendix 5) were held with four primary care workers who provided insights into the functioning of PHC services and the possibilities and challenges of incorporating primary mental health care into PHC. These interviews were guided by questions relating to the nature of services provided by the clinic, the administration of these services, the composition of the patient population and perceived health and mental health service needs of patients and their communities.

3.6.1.4 Other sources

Ethnographic literature on the culture and traditional cosmology of the *Xhosa* have been used extensively to contextualise findings. The form and presentation of somatic symptoms receive special attention and are compared with the presentation and treatment of problems in the traditional healing setting. Cases are considered from the perspective of traditional healing approaches to deepen an understanding of problems presented and their dynamics.

Qualitative analysis was complemented by ReHMIS (1994) data for health services in this area.

Finally, results are reconsidered in terms of a critical evaluation of the applicability of the SRQ and PSE as techniques of case detection for the patient population sampled.

3.7 THE PILOT STUDY

Prior to the commencement of the study proper, a pilot study was conducted.

3.7.1 OBJECTIVES

The objectives of the pilot study were as follows:

i. to 'trial run' the procedure and time the administration of instruments to facilitate planning for the main study,
ii. to familiarise fieldworkers with the procedures and instruments,
iii. to evaluate responses to SRS items and adjust the self-response form for the patient population under study,
iv. to 'trial run' the SRQ and PSE for the patient population under study and evaluate translated versions of the instruments, and
v. to establish the suitability of the cut-off point for the first stage screening to minimise the possible occurrence of false negatives.

3.7.2 THE STUDY AREA

The study was piloted in the Komgha magisterial district of the Eastern Cape Region amongst the patient population of the two PHC clinics that service this area. One of the clinics is situated in the town and the other is situated in the black township of Qumrha, which borders on the town. Both clinics are administered by the Amatola Regional Services Council. While the majority of patients visiting the Komgha Town clinic are from the surrounding rural areas, (mainly the Transkei), most of the patients visiting the Qumrha Location clinic are from the local urban community.

At the time of testing 516 whites, 281 coloureds and 6000 blacks were resident in the town

(including Qumrha). Approximately 70% of patients attending the town clinic are from the area formerly known as the Transkei. Due to the inadequacy of health services in the Transkei area patients travel up to 80km to the Komgha clinic. This accounted for an estimated 3000 minor ailments cases during 1994. A further estimated 700 visits are from the farming areas within the district (personal communication, clinic staff 1995).

A breakdown of patient visits for the town clinic indicates a total of 3339 black patients, 228 white patients and 65 coloured patients for 1994. All patients attending the location clinic are black (clinic records, Amatola Regional Services Council, 1994). Females account for approximately 70% of the clinic visits and, in the town clinic, the free child care service has caused a sharp rise in the number of under 18 visits. These now account for an estimated 65% to 70% of consultations (personal communication, clinic staff 1994).

Both clinics operate from 07H30 to 16H30 with an hour lunch break between 13H00 and 14H00. These clinics offer the comprehensive set of PHC services including; ante-natal, post-natal, family planning (including sterilisation) geriatric services, genetic services, child care (including the range of immunisations), minor ailments and a referral service (ReHMIS, 1994).

Psychiatric medications are distributed to psychiatric patients in the community from both clinics. A psychiatric nurse from Psychiatric Community Services in East London visits the Qumrha clinic once a month to monitor the psychiatric patients (personal communication, clinic staff 1995).

3.7.3 METHOD

The pilot study was executed in two parts. The design, instruments and procedure for conducting the pilot study were to reflect that of the main study as far as possible so as to establish the suitability of the methodology for addressing the goals guiding the main study. Part one of the study was executed over a two-day period, 19 and 20 October and part two was subsequently executed over a four day period from 24 to 27 October 1995.

Fieldworkers interacted with subjects in the same way as that designed for the main study and the same standards of informed consent and confidentiality applied (see 3.5). Sampling and data-analysis procedures were adjusted to accommodate the objectives.

3.7.3.1 Sampling

The sample for the pilot study was drawn from clinics falling outside the area in which the main study was to be conducted and so does not bias the main sample.

In the first part of the pilot study SRQ's and SRS's were administered to the population of psychiatric patients of the Qumrha location (n=13). Community health workers went into the community and asked psychiatric patients to attend the fieldwork sessions. (It is understood that most of the patients attended.) The questionnaires were administered as structured interviews and patients were prompted to elaborate on their understanding of items.

Subjects for part two of the pilot study were drawn from the patient population of the Komgha town clinic. Subjects 16 years and older who were attending the clinic were systematically sampled on a one in five (1:5) or one in two (1:2) basis to make up a sample size of n=31.

3.7.3.2 Data analysis

Encoded data was captured onto a computer spreadsheet programme.

The following analyses were performed:

i. Biographical data was descriptively analysed to construct a picture of the patient sample.
ii. SRQ scores for psychiatric patients were compared to the proposed cut-off point to determine its suitability.
iii. Responses to items constituting the SRS were analysed to determine patients' understanding of them.
iv. Raw data from the PSE ninth-edition interviews were transcribed onto coding sheets, captured and analysed on the PSE-ID-CATEGO computer programme.

3.7.4 RESULTS

SRQ and SRS forms were successfully administered to 13 psychiatric patients during the first part of the pilot study. Thirty one patients were sampled during the second part of the study and 11 PSE interviews were conducted on patients scoring above threshold on the SRQ-20, of which

three did not reach PSE-CATEGO threshold for classification.

The following are the results of the analyses:

i. The average age of patients participating in the first part of the study (psychiatric patients) was 48 years while that of patients participating in the second part of the pilot study (general PHC patients) was 30 years. The ratio of men to women in the first part is 3:10 and 4:27 for the second part. The split between married and unmarried persons for the second part is approximately even, while none of the psychiatric patients were married at the time of testing; three patients indicated that they were divorced, seven were unmarried and three widowed.

ii. All psychiatric patients scored seven or above on the SRQ-20 and 11 of the 13 indicated some symptomatology on the SRQ-5. Thom et al. (1993) found a statistically significant relationship between a cut-off score of 7 or more on the SRQ-20 and the presence of a psychiatric disorder.

iii. The SRS was found to be lengthy and required some adjustments (see section 3.7.5.3)

iv. Appendix 6 shows the output table generated by the PSE-CATEGO programme for the PSE interviews conducted. Of the eight positive cases, four were classified as neurotic depression, two as retarded depression and two as schizophrenic psychoses.

Twenty one of the patients in part two of the pilot study reported some 'psychotic' symptomatology, 15 indicated experiencing interference with their thinking and 9 reported experiencing hallucinations. Discussion of patients' understanding of items confirms that responses to the five psychotic items may be culturally influenced. Classification of these symptoms as psychotic may, therefore, be problematic within the *Xhosa* cultural context (see chapter 6).

3.7.5 IMPLICATIONS FOR THE MAIN STUDY

3.7.5.1 Sampling procedure

The sample for part two of the pilot study was selected from the universe of all patients attending the clinic. The sampling ratio was adjusted to 1:2 for two of the fieldwork days when patient flow was particularly slow. This is higher than the ratio anticipated for the main study (1:5) because of the slow flow of patients through the clinic.

3.7.5.2 Testing procedure

Patients completed the questionnaires in the waiting area before their consultations and SRQ's were scored during the consultation period. Subjects scoring above threshold could then be approached for an interview as they emerged from consultation. Therefore while one fieldworker was administering questionnaires, the other was able to score them. Illiterate subjects were administered the questionnaires in the form of a structured interview.

Completion of both questionnaires required approximately 15 minutes and completion of the second stage interview required between 30 and 60 minutes, depending on the severity and number of symptoms.

3.7.5.3 The instruments

Each of the instruments were piloted according to the methodology planned for the main study and results analysed in terms of the main objectives for the pilot study.

a. The Self-response schedule

Specific points of focus in the analysis of the SRS were the length of the schedule, patients' understanding of items and the value of information elicited by items.

It was found that PHC patients are generally not accustomed to completing forms and some complained about the number of questions. In reducing the length of the form from 45 to 30 items it was decided to root out problematic items and consolidate items found to be similarly interpreted. The following changes were made to the form:

i. The items chosen for elimination were those most consistently misunderstood or misinterpreted for their use of vague terminology, e.g. 'usually', 'physical disability', 'long-term illness', including 14, 15 and 39.

ii. Items 18, 20, 22, 24, 26 and 27, were found to provide little additional information and the 'yes/no' response options frequently produced a response set. These were also eliminated.

iii. Items 30, 37 and 38 were eliminated because of the frequency with which they evoked defensiveness and suspicion, thereby jeopardizing continued co-operation of the patient. They investigate perceptions of personal and family mental health, e.g. "Do you believe that you are presently suffering from...?".

iv. Items 41, 42 and 43 were consistently answered identically as all three investigated personal service preferences ("Who would you feel most comfortable consulting with?", "Where would you suggest...?", "...would you prefer...?). Thus 42 and 43 were eliminated as redundant.

v. Items 31 and 35 were consistently interpreted similarly, since both enquired about previous hospitalisation, and patients experienced them as redundant. They were therefore consolidated into a single, more general, item ("Have you ever been hospitalised?"). Their contingency items were likewise condensed into items enquiring into frequency and duration of hospitalisation.

vi. Certain of the items with multiple response options were reformulated to make the form more user friendly. In the case of items requesting the respondent to choose from lists of services and health care personnel (8, 34, 41 and 45) response options were made uniform throughout the form.

vii. Subjects were uncomfortable about making finer discriminations on a 5-point Likert scale and consistently polarised to either end of the scale (items 11, 17 and 40). These items were reformulated as 3-point scales ('yes', 'sometimes' and 'no').

viii. Items 4, 5 and 6 were found to provide insufficient information when applied to the

patient sample. Further categories were added to the response options of these items.

ix. Some rearrangement of items under the headings 'personal particulars", 'health service utilisation' and 'quality of service' served to systematize and structure the form for use in the main study.

b. The Self-Reporting Questionnaire

Items constituting the SRQ were generally easily understood and readily responded to on a logical 'yes/no' scale, arousing neither defensiveness nor confusion. A large number of patients recorded positive responses to the SRQ-5 sub-scale of psychotic items; 21 (6 patients), 23 (17 patients) and 24 (13 patients), considered indicators of psychotic symptomatology. Due to the observation that responses to these items were generally found to be culturally determined, and in view of the practical impossibility of administering PSE interviews to over two-thirds of the projected patient sample, it became necessary to consider only the scores obtained on the SRQ-20 (non-psychotic items) as the first stage screening criterion.

c. The Present State Examination

The administration of a *Xhosa* translated version of the PSE in the PHC setting posed certain challenges (see 6.2).

Due to the non-psychiatric nature of the sample, rating on psychotic items was rare and seldom proceeded past the cut-off points for psychotic symptomatology.

In some instances interviews were limited by time constraints on patients having to return to work or rely on public transport back to the rural areas.

3.7.6 CONCLUSIONS

It was decided on the basis of the pilot study that:

i. A 30 item version of the SRS would be used to assess patient satisfaction with PHC services and patterns of utilization.

ii. The SRQ-25 would be used as the first stage screening instrument with a cut-off score

of 7 for the non-psychotic symptoms.

iii. Positive responses to SRQ-5 items would be worked into the total SRQ score and not be considered sufficient indication for second stage investigation on their own.

iv. The PSE would constitute the second stage screening instrument and special attention would be paid to items in the Xhosa translation found to be problematic.

v. Field notes documented during psychiatric interviews would be subject to qualitative analysis.

vi. Specific focus on somatic symptomatology during psychiatric interviewing would investigate forms of somatic expression of psychological distress.

vii. Unstructured interviews with clinic staff would complement the qualitative analysis of psychiatric interviews and construct a picture of the functioning of PHC services in the study area.

Discussion of the cases took place between fieldworkers and an experienced psychiatrist at intervals during the pilot study to critically evaluate the administration of the psychiatric interviews. Further practical training was provided by the same psychiatrist and psychiatric staff at Psychiatric Community Services in East London and the psychiatric ward of Frere Hospital before the commencement of the main study.

3.8 FIELDWORKER TRAINING

The nature of the fieldwork required a team of two fieldworkers. To this end, funding was procured from the Health Systems Trust for the salary of a research assistant as a second fieldworker, on the condition that the position develop the academic career of a black student from the Eastern Cape Region.

Training took place in Grahamstown at Fort England Psychiatric Hospital, in East London at Community Psychiatric Services and at the psychiatric ward of the Frere Provincial Hospital under the supervision of an experienced psychiatrist.

Fieldworkers' (the researcher and research assistant) underwent training in questionnaire administration and psychiatric interview skills which extended over a six day period, accounting for approximately 33 hours. Training included observation of psychiatric interviews and supervised practice in the administration of the PSE. Theory was covered in self-study and included questionnaire administration, case-studies, the structure of psychiatric interviews and a background to the development of the PSE and its administration, including a glossary of symptoms. A wide range of cases were observed covering the spectrum of disorders likely to be encountered in the PHC setting. Through observations fieldworkers were trained to recognise symptom and symptom clusters. Regular report-back sessions were held during the fieldwork period where case material was discussed.

CHAPTER 4 - RESULTS

4.1 DESCRIPTION OF THE PATIENT SAMPLE

During the main study 148 patients participated in the first stage screening process, completing the SRQ and SRS, and 57 patients participated in the second stage PSE psychiatric interview. This sample was drawn from seven clinics in the King William's Town - Bisho area, at the time of testing, falling under three separate health authorities.

The sample comprises 88% black patients and 12% coloured patients. Women outnumbered men 88% to 12%. The age range of the sample falls between (and including) 16 and 82 years. Most of the patients (n=69) fall within the 20-29 years age range, with an average age of 28 years (see figure 4.1a).

Most patients indicated that they had completed primary school, the first six years of formal education. Of those patients who had at least some formal education, an average of one of year of schooling had been failed. Twelve percent of patients sampled had not proceeded further than junior primary school (3 years of formal education) and 7.5% of patients had no formal education.

A total of 28.3% of the patient sample indicated that they were married, 58.6% unmarried, 5.6% divorced or separated and 7.6% widowed. The average number of children per patient over the age of 20 is 2.5, which is a conservative estimate as the upper limit within the multiple response option for number of children was set at "more than six", which was taken to be seven children. Most of the respondents, 72.6%, were unemployed at the time of questioning, 22.2% were employed and 5.2% were pensioned. (Table 4.1 provides a summary of all socio-demographic data.)

Figure 4.1b presents a profile of the ambulatory services utilised by the patient sample at the clinics. This profile does not reflect the relative differences in 'minor ailments' and 'family planning' consultations across clinics in the urban as opposed to the outer-lying areas. In the King William' Town clinics, especially the town clinic, the largest portion of the patient load is comprised of family planning visits as most of the minor ailments complaints go directly to the outpatients department of Grey Hospital, whereas in the Tyutyu, Kei-Road and Emthonjeni

clinics the majority of visits are classified as minor ailments. 'Minor ailments' is non-descript category referring to all patient visits which are not classifiable in terms of other ambulatory service categories.

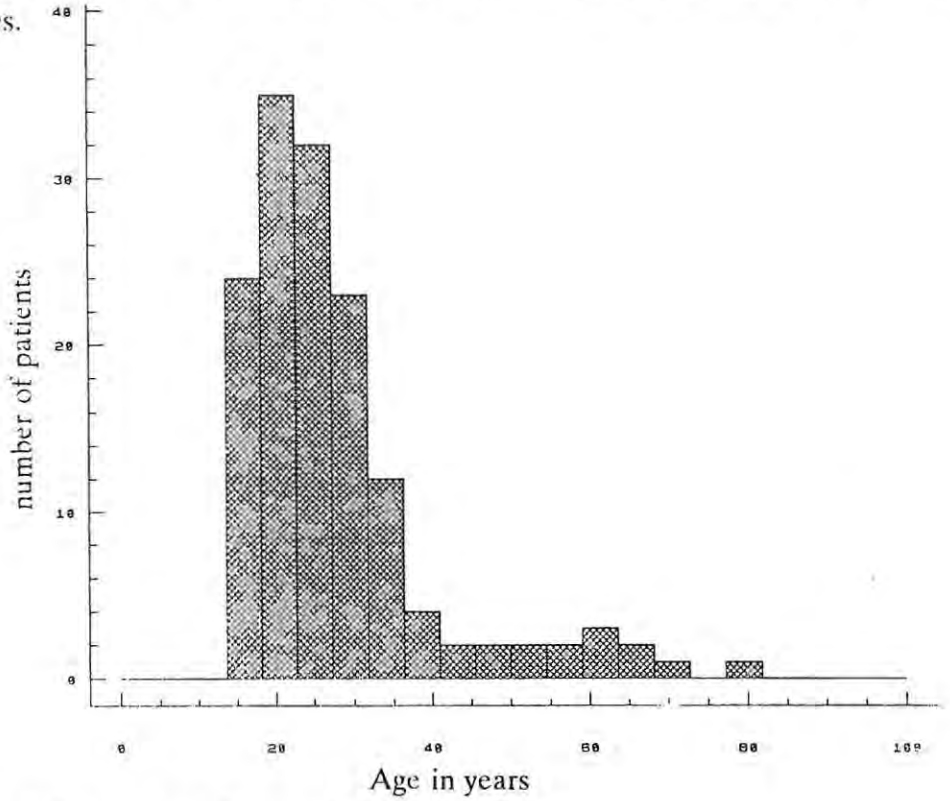


Figure 4.1a Age distribution of the patient sample.

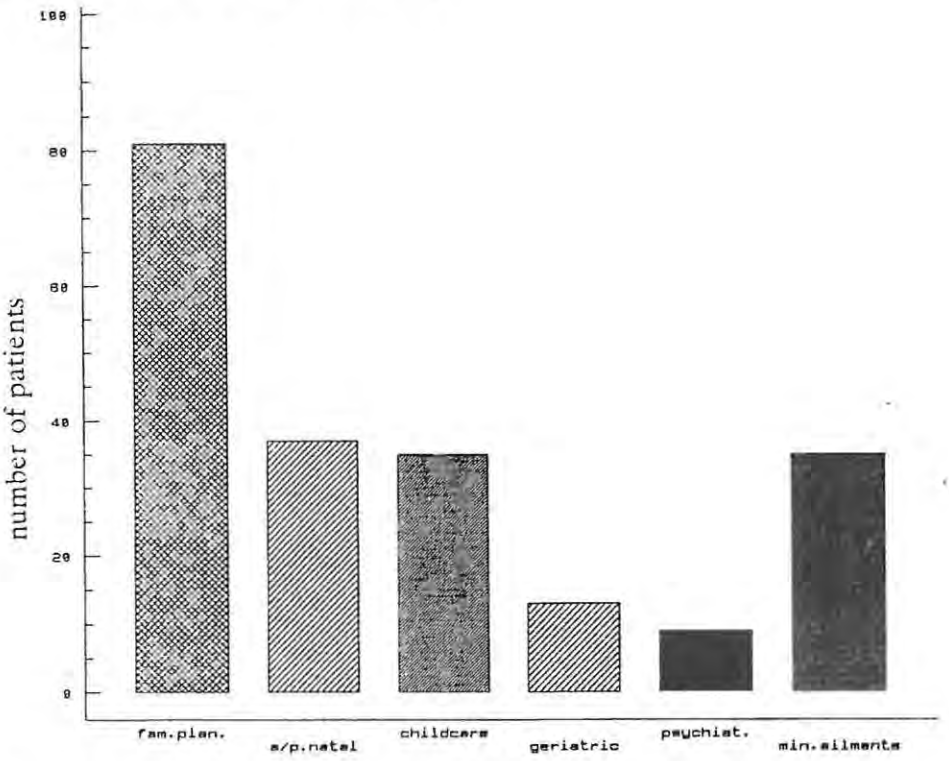


Figure 4.1b Profile of clinic services rendered to patients.

Table 4.1 Summary frequency table of socio-demographic data for the PHC patient sample.

		group1	group2	group3	total	
RACE GROUP	blacks	64	35	31	130	
	coloureds	7	3	8	18	n=148
GENDER	males	6	9	3	18	
	females	65	29	36	130	n=148
AGE GROUP	16-19 years	19	10	4	33	
	20-29 years	32	21	16	69	
	30-39 years	13	4	9	26	
	40-49 years	3	2	1	6	
	50-59 years	0	0	4	4	
	60 or more yrs	2	1	4	7	n=145
NO. OF CHILDREN	none	24	13	8	45	
	one	19	10	7	36	
	two	7	4	4	15	
	three	9	5	9	23	
	four	2	3	1	6	
	five	6	1	4	11	
	six	1	1	2	4	
	more than six	1	0	3	4	n=144
MARITAL STATUS	married	18	5	18	41	
	divorced	1	2	1	4	
	widowed	3	4	4	11	
	separated	3	0	1	4	
	unmarried	44	26	15	85	n=145
EMPLOY. STATUS	employed	11	12	7	30	
	unemployed	51	22	25	98	
	pensioned	1	0	6	7	n=135
EDUCATION LEVEL	none	3	1	4	8	
	junior primary	0	3	2	5	
	senior primary	9	6	14	29	
	junior high	39	21	15	75	
	matriculated	15	5	3	23	
	tertiary	2	1	1	4	n=144

group1=patients scoring below threshold on the SRQ - no psychiatric distress (n=71)
group2=patients scoring above threshold on the SRQ and below threshold on the PSE - some psychiatre distress (n=38)
group3=patients scoring above threshold on the PSE-identified psychiatric disorder (n=39)

4.2 RESULTS OF THE PSYCHIATRIC SCREENING

On the basis of the screening process 71 patients were allocated to group one, 38 patients were allocated to group two and 39 patients were allocated to group three. While the non-consent rate (patients refusing to participate in the study) in the first stage screening was negligibly low at 10 (6.8%) the non-consent rate at the second stage screening was somewhat higher at 20 (25.9% of those scoring 7 or above on the SRQ-20). Non-consenting patients and patients not achieving the PSE-CATEGO identification index threshold for caseness on the PSE were grouped together to constitute group 2.

The revealed prevalence rate of psychopathology (as diagnosed by the PSE) for the sample is 26.4%, which is comparable with prevalence rates revealed in similar studies (cf. Ndetei & Muhangi, 1979; Orley & Wing, 1979; Dhadphale et al., 1983, and Dhadphale and Ellison, 1983). However, the small sample size, high non-consent rate and no control group make generalisations problematic. Non-consent may itself be an indication of low levels of suffering even if SRQ scores were above threshold.

4.2.1 SRQ SYMPTOM DISTRIBUTION

Figure 4.2a depicts the SRQ symptom profile for the patient sample. Items 1, 4, 12, 18, 19 and 20 were rated positively by at least 40% of patients while items 5, 10, 16, 17, 21, 24 and 25 were rated positively by less than 20% of the patient sample. The most frequently reported symptom is the tendency to become easily tired (item 20), scored by 53% of patients, and the least frequently endorsed symptom is fits or convulsions (item 25), scored by 7.5% of patients.

Sixty-three percent of patients indicated at least some symptomatology on the SRQ-5 (psychotic symptoms), 23% of patients indicated two or more symptoms and 9.5% of patients indicated three or more symptoms. The most frequently reported psychotic symptoms are grandiose delusions, with 35% of patients reporting believing that they were more important than what other people thought (item 22), and 28% of patients reporting experiencing interference with their thinking (item 23). The argument is presented that this symptom distribution more accurately reflects certain cultural and interpretational factors (see chapter 6), which reflect on the validity of the SRQ-5 for screening for psychotic symptoms among the patient population under study. Refer to appendix 3 for SRQ items.

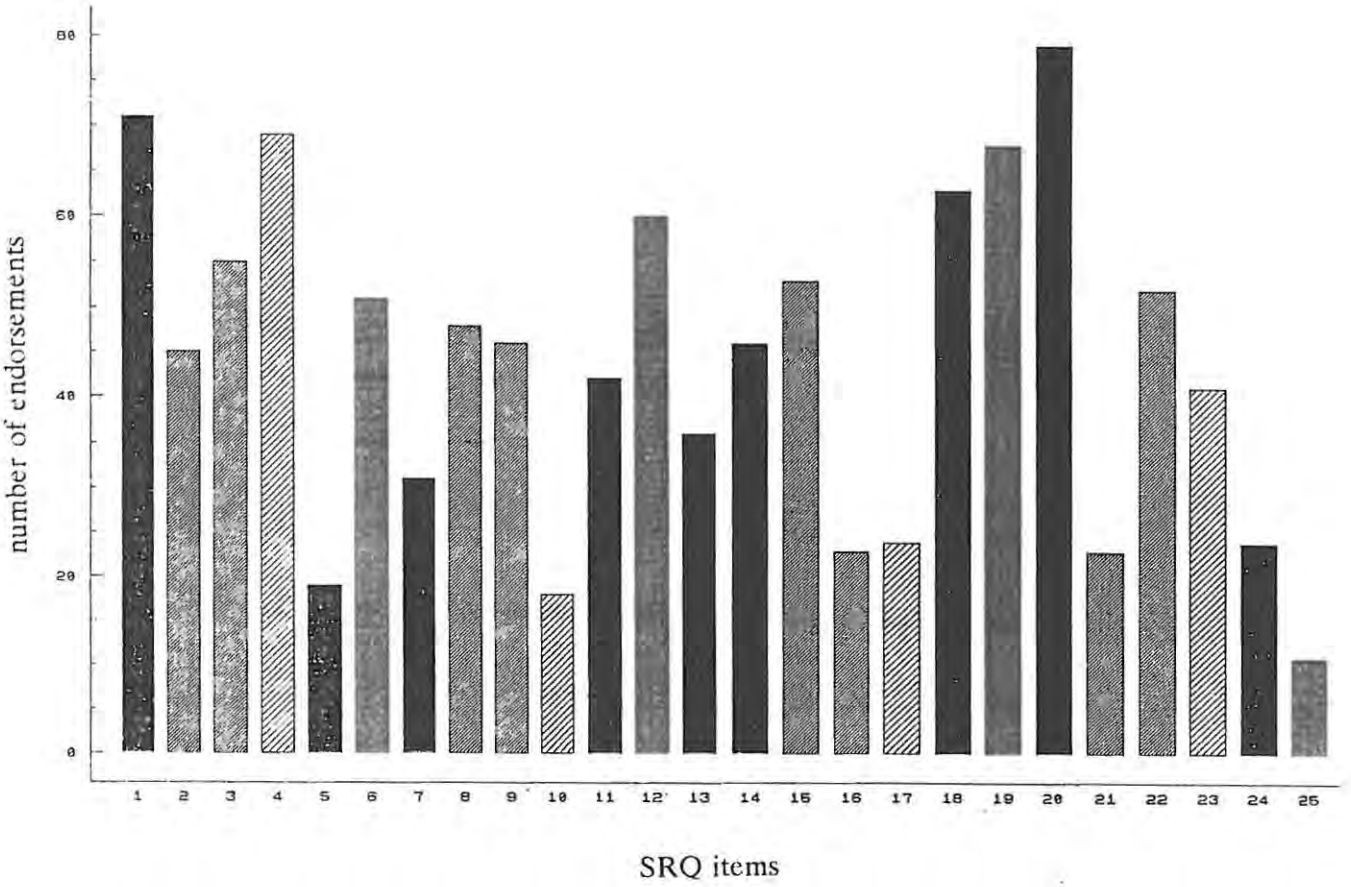


Figure 4.2a SRQ symptom profile for the PHC patient sample. (See appendix 3 for SRQ items.)

4.2.2 PSE-CATEGO RESULTS

Analysis of PSE-CATEGO classification of cases reveals depression to be the most frequently diagnosed disorder (46.2% of the indentified cases indicated some form of depressive disorder). Of these, the most frequently diagnosed is retarded depression (10 cases). The most frequently diagnosed PSE-CATEGO class is manic and mixed affective psychoses (11 cases). Affective and anxiety disorders account for 87.2% of all cases. (See appendix 7 for the computer-generated PSE-CATEGO output table.) Figure 4.2b depicts the distribution of cases in terms of the PSE-CATEGO system of classification. (See appendix 8 for definitions of the diagnostic classes.)

Analysis of the syndrome profile (figure 4.2c) for PSE interviews shows that the syndromes most frequently scored as present are simple depression (SD), tension (TE) and worrying (WO). Appendix 9 lists the 38 PSE syndromes and their constituent symptoms.

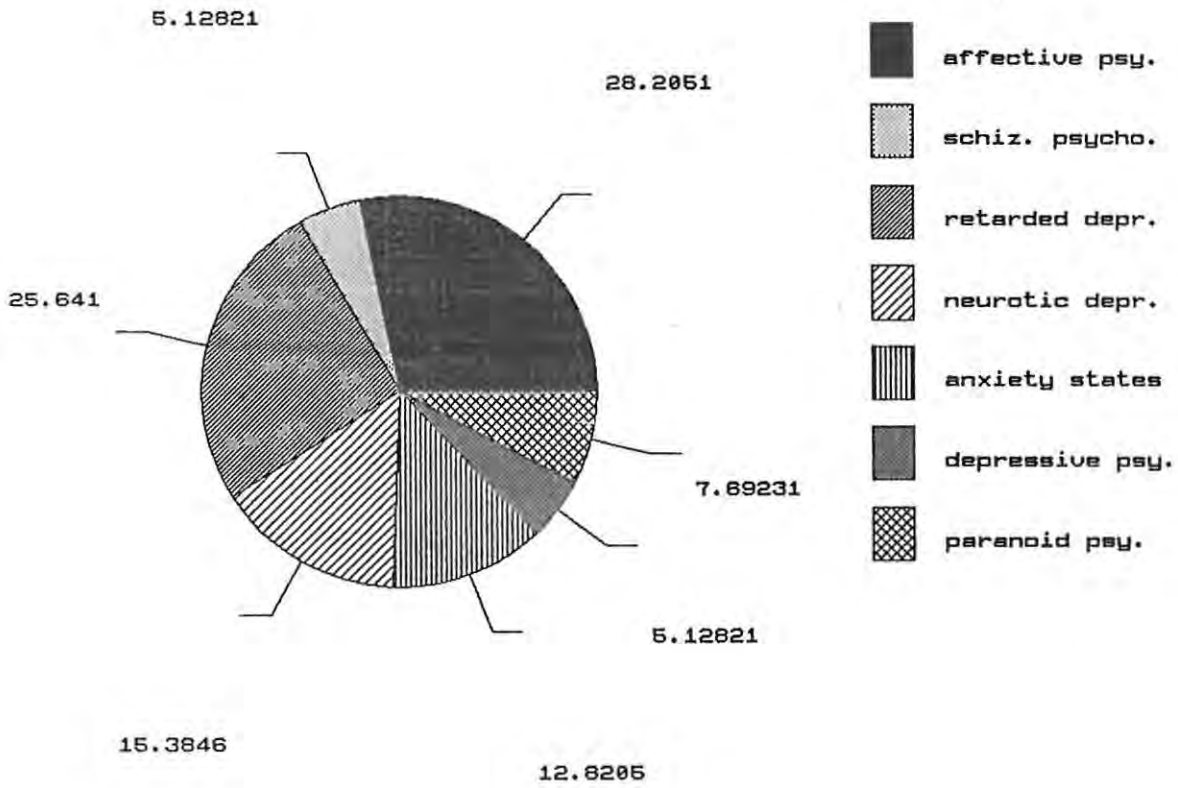
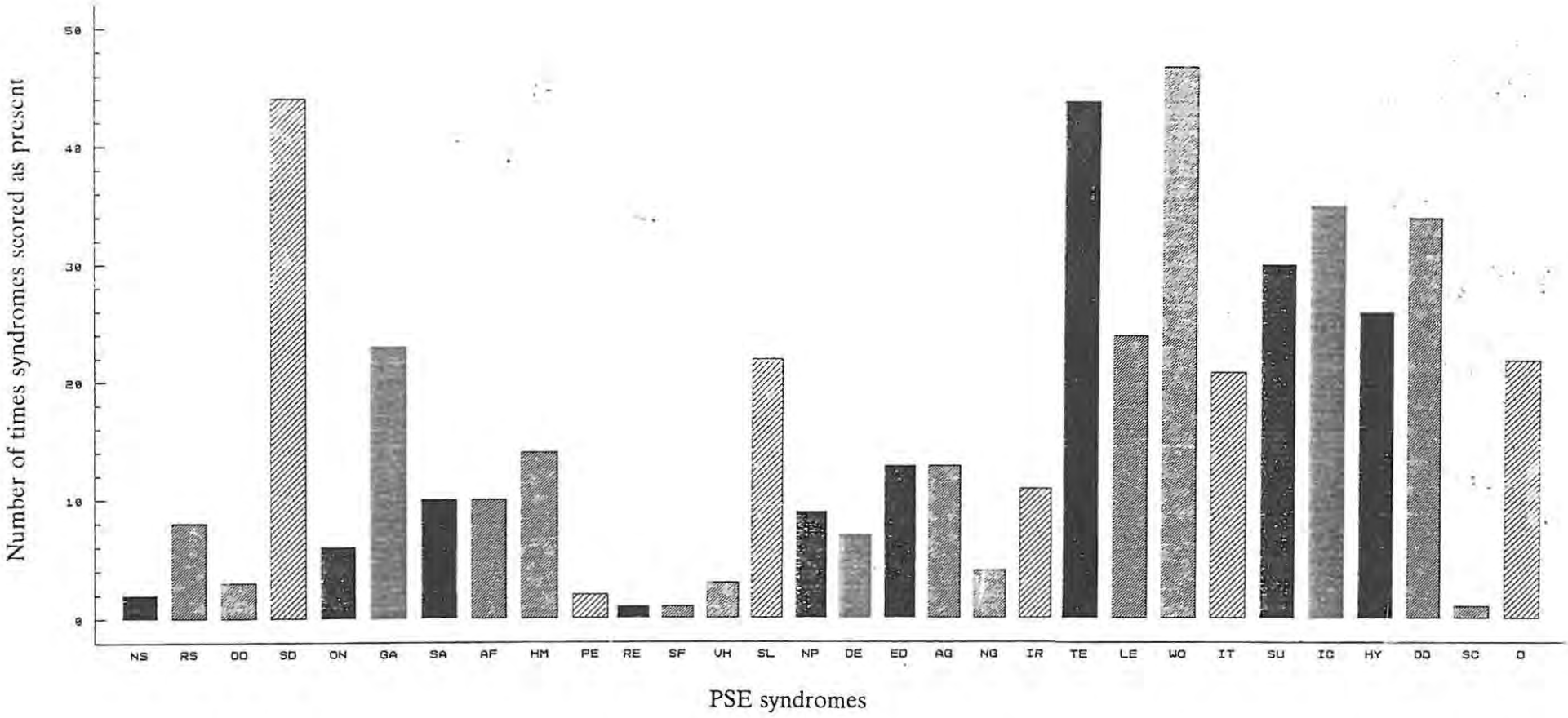


Figure 4.2b PSE-CATEGO classification of cases, ICD-8.



NS	nuclear syndrome	RE	delusions of reference	TE	tension
RS	residual syndrome	SF	sexual and fantastic delusions	LE	lack of energy
DD	depressive delusions and hallucinations	VH	visual hallucinations	WO	worrying
SD	simple depression	SL	slowness	IT	irritability
ON	obsessional neurosis	NP	non-specific psychosis	SU	social unease
GA	general anxiety	DE	depersonalisation	IC	loss of interest and concentration
SA	situational anxiety	ED	special features of depression	HY	hypochondriasis
AF	flattening of affect	AG	agitation	OD	other symptoms of depression
HM	hypomania	NG	self-neglect	SC	'subcultural' delusions or hallucinations
PE	delusions of persecution	IR	ideas of reference	D	doubtful interview/misleading answers

Figure 4.2c PSE-CATEGO syndrome profile.

4.3 PSYCHIATRIC SYMPTOMATOLOGY AND SOMATISATION

Certain of the somatic symptoms appear to occur with relative consistency in relation to psychiatric symptomatology.

Somatic symptoms measured by the SRQ include headache, poor appetite, shaking hands, poor digestion, tiredness, uncomfortable feelings in the stomach and convulsions. Headache, tiredness and stomach discomfort are the somatic symptoms most frequently indicated by SRQ. The PSE syndromes most frequently scored describe characteristic sets of somatic symptoms presented by patients during PSE interviews (see appendix 9). The five most frequently scored PSE syndromes, simple depression (SD), tension (TE), worrying (WO), loss of interest and concentration (IC) and other symptoms of depression (OD), describe sets of symptoms largely constituting physical complaints.

4.4 RELATIONSHIP TO SOCIO-DEMOGRAPHIC VARIABLES

An examination of the chi-square statistics calculated for each of the socio-demographic variables reveals significant relationships between psychopathology and age, gender, marital status, employment status, educational level and two of the ambulatory services received by clinic patients. No significant results were obtained for the relationship between psychopathology and number of children, number of failures at school and three of the ambulatory services received by clinic patients.

i. While there appears to be a statistically significant association between gender and psychiatric symptoms scored, these results are difficult to interpret, probably due to the small number of males sampled. Although males constituted only 7.7% of group three (patients testing above threshold on both screening instruments), they constituted 23.7% of group two (patients reaching threshold for psychiatric symptomatology on the SRQ but not on the PSE). The sample of males may not be a typical group because they are not at work during the day.

ii. Age was found to be significantly positively related to psychiatric symptomatology. While 19.5% of patients younger than 30 years scored positively on the PSE, positive scores were obtained for 8 of the 11 patients aged 50 years and older (73%).

iii. The analysis indicates that the group most likely to suffer from psychopathology are married women. The large majority of the respondents were unmarried persons, most of whom were in their teens and early twenties. The groups constituting divorced, widowed and separated persons made up only a small percentage of the sample (13.2%). In a post-hoc analysis divorced, widowed and separated persons were grouped together. The results reveal a significant positive relationship with psychiatric symptomatology.

iv. Analysis of the observed frequency table for the relationship between educational level and psychiatric symptomatology shows this variable to be a particularly reliable indicator. Patients at higher educational levels are consistently less likely to suffer from psychiatric symptomatology.

v. While no significant difference was found between employed and unemployed persons in terms of psychiatric symptomatology, persons receiving pensions were at a significantly greater risk of experiencing psychiatric symptomatology.

vi. Supporting the above finding are the results which indicate that general clinic patients receiving geriatric services and psychiatric services (very likely patients already receiving pensions) were significantly more likely to report psychiatric symptomatology. Two of the nine patients sampled for the study, who were already receiving psychiatric treatment, were not detected by the screening process. This may bring into question the sensitivity of the screening process or indicate that the patients' medication was effective in reducing symptomatology.

Table 4.4 Probability values for the relationship of psychiatric symptomatology with socio-demographic variables.

SOCIO-DEMOGRAPHIC VARIABLES	SRS item	PC stat.	D.F.	prob.val.
gender	1	6.367	2	0.0414*
age	2	19.6212	10	0.0330*
number of children	3	14.440	14	0.4175
marital status	4	16.108	8	0.0409*
employment status	5	16.221	4	0.0027**
level of education	6	19.226	10	0.0375*
failures at school	7	4.925	6	0.5534
AMBULATORY SERVICES				
family planning	8	2.694	2	0.2600
antenatal/post natal care	8	0.064	2	0.741
child care services	8	4.276	2	0.1179
geriatric services	8	13.253	2	0.0013**
psychiatric services	8	13.117	2	0.0014**
minor ailments	8	2.298	2	0.3169

PC stat. = Pearson Chisquare statistic
D.V. = degrees of freedom
prob.val. = corresponding probability value
* $P<0.05$
** $P<0.01$

4.5 RELATIONSHIP TO HEALTH SERVICE UTILISATION

The study investigated five aspects of health service utilisation in relation to psychiatric symptomatology. A statistically significant relationship was found to exist between psychiatric symptomatology and time spent in consultation, treatment for physical illnesses as well as sick bed days. No significant relationship was found between psychiatric symptomatology and amount of medical resources used or compliance with medical directions.

i. While no statistically significant relationship was uncovered between frequency of visits and psychiatric symptomatology, the length of time spent in consultation appears to be significantly positively related to psychiatric symptomatology. Patients with more severe psychiatric symptomatology reported spending more time in consultation at the clinic.

ii. When the relationship between psychiatric symptomatology and treatment for various

types of physical illnesses was investigated, the relationship with digestive problems was found to be strongest, psychiatric symptomatology appears to be significantly positively related to treatment for digestive problems. Digestive problems also accounted for the largest proportion of illnesses, with 23.3% of the total patient sample indicating that they were receiving treatment for digestive problems (see figure 4.5 for the distribution of illnesses reported). This would appear to correlate with the distribution of SRQ symptoms where 21% of patients indicated suffering from digestive problems and 46% reported experiencing uncomfortable feelings in the stomach.

iii. Psychiatric symptomatology was found to be strongly related to productivity in terms of working days. There exists a statistically significant positive relationship at the 0.2% probability level (P=0.0021) between psychiatric symptomatology and the amount of time patients reported feeling ill enough to stay in bed.

Table 4.5 Probability values for the relationship of psychiatric symptomatology with aspects of health service utilisation

HEALTH SERVICE UTILISATION	SRS item	PC stat.	D.F.	prob.val.
treatment for tuberculosis	9	0.079	2	0.9610
treatment for arthritis	9	5.442	2	0.0658
treatment for circulatory prob's	9	3.625	2	0.1632
treatment for diabetes	9	1.119	2	0.5714
treatment for digestive problems	9	11.397	2	0.0034**
treatment for respiratory prob's	9	3.528	2	0.1714
treatment for other problems	9	1.624	2	0.4439
visit frequency	10	2.753	4	0.6000
time spent in consultation	12	20.552	6	0.0022**
treatment - medication/injections	14	2.522	2	0.2833
previous hospitalisation	16	0.974	2	0.6145
treatment - nerves/emotions	19	0.739	2	0.6912
compliance - appointments	11	5.753	4	0.2183
compliance - medication direction	15	5.846	4	0.2109
sick bed days	21	16.826	4	0.0021**

PC stat. = Pearson Chisquare statistic
D.V. = degrees of freedom
prob.val. = corresponding probability value
* P<0.05
**P<0.01

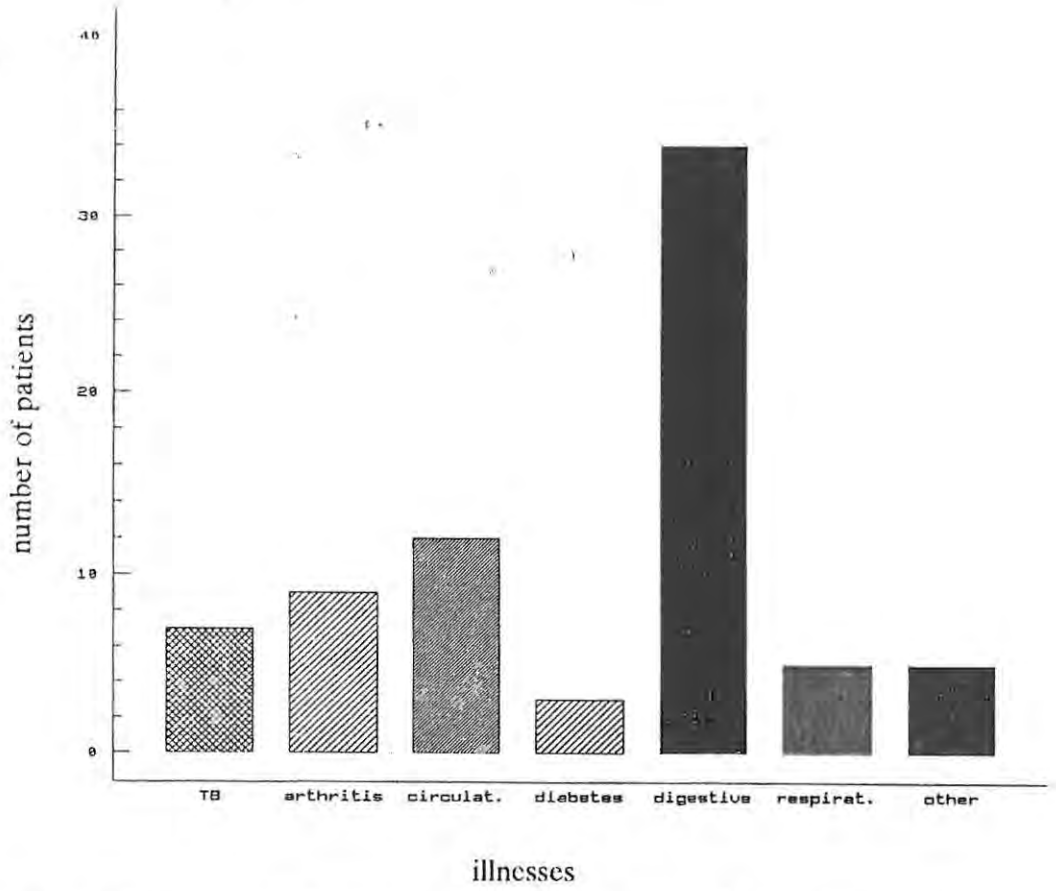


Figure 4.5 Frequency distribution of reported illnesses for which patients receive treatment.

4.6 RELATIONSHIP TO SATISFACTION WITH SERVICES

Patient satisfaction with services received in the PHC clinics was found to be unrelated to psychiatric symptomatology. When the items measuring this variable were analysed individually a statistically significant association was found between psychiatric symptomatology and one of the dimensions of patient satisfaction. This result is, however, difficult to interpret. While patients constituting group 2 (those scoring above threshold on the SRQ) were less likely to feel that they could talk privately to clinic staff if they wanted to, this relationship did not hold true for group three (those scoring positively on the PSE).

Analysis of the frequency tables reveals that patients indicating psychiatric symptomatology may be less satisfied with explanations of illness and treatment given at the clinic, perhaps due to lower levels of intellectual functioning. However, this relationship only holds true at the 10% probability level.

See figure 4.6 for a profile of general patient satisfaction levels with various aspects of PHC provision in the clinics. This graph clearly shows the low levels of satisfaction with the length of

consultations, with many respondents indicating that they felt consultation periods were too short.

Table 4.6 Probability values for the relationship of psychiatric symptomatology with patients' satisfaction with the PHC service.

HYPOTHESIS 4	SRS items	PC stat.	D.F.	prob.val.
addressed in own name	23	1.827	2	0.4012
addressed in own language	24	0.174	2	0.9166
comprehension of explanations	25	4.806	2	0.0904
asked about home and family life	26	1.332	2	0.5139
able to talk privately	27	7.995	2	0.0184*
able to talk about problems	28	2.217	2	0.3300
satisfaction with consultat. time	13	1.936	2	0.3799
all of the above taken together		15.075	14	0.3731

PC stat. = Pearson Chisquare statistic
D.V. = degrees of freedom
prob.val. = corresponding probability value
* $P<0.05$
** $P<0.01$

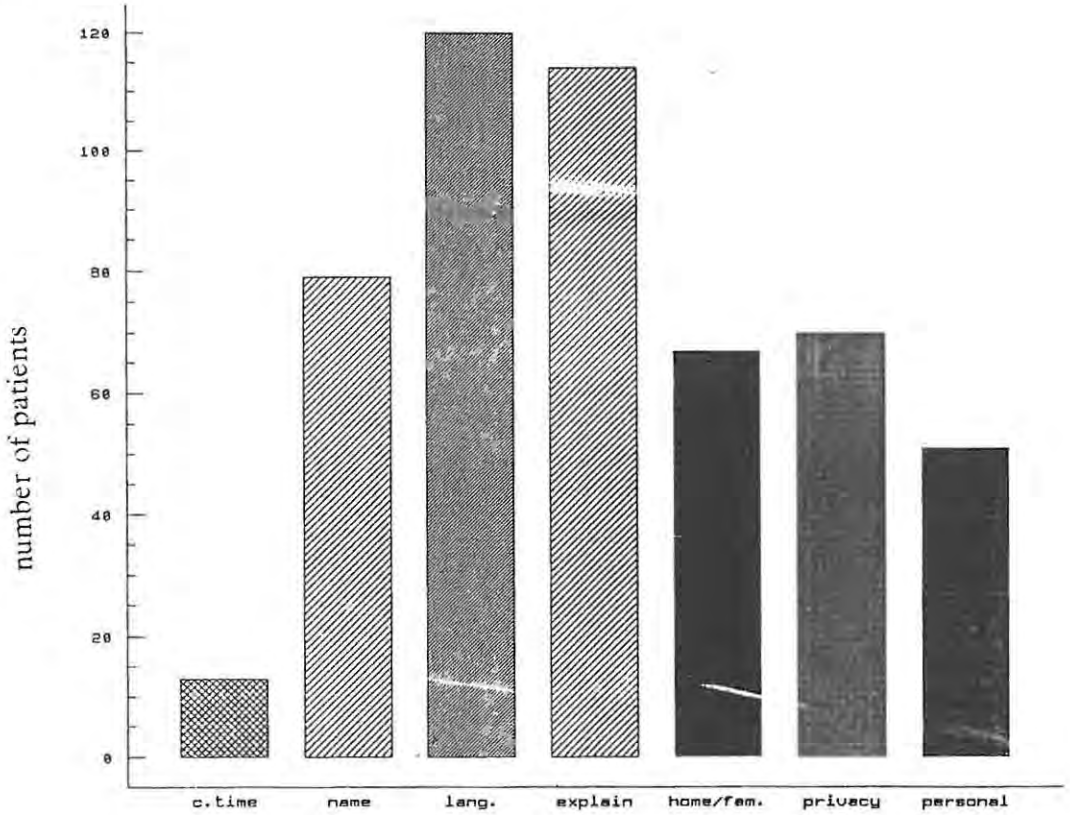


Figure 4.6 Profile of levels of patient satisfaction with aspects of PHC provision.

4.7 FURTHER VARIABLES RELATED TO PLANNING FOR PRIMARY MENTAL HEALTH CARE

Variables considered to have relevance to the discussion on health systems planning were analysed descriptively.

i. An analysis of frequency tables indicates that, while 32% of the patient sample would be reluctant to disclose suffering from nerves, 43% would feel this way about mental illness and similarly, 44% with regard to alcoholism.

ii. Figure 4.7a depicts a profile of the identified sources of referral to the clinic as reported by the patients sampled. Self-referral accounts for 37% of cases, referral by a community health practitioner (community nurse or community health worker), 30%, and referral by a family member, 24%.

iii. Figure 4.7b depicts a profile of preferences for consultation as reported by the patients. Most patients report preferring to consult with either a nurse or a doctor (35% and 34% respectively) while little support is shown for traditional healers. This finding may be somewhat different if the nature of the problem for which consultation was sought had been defined.

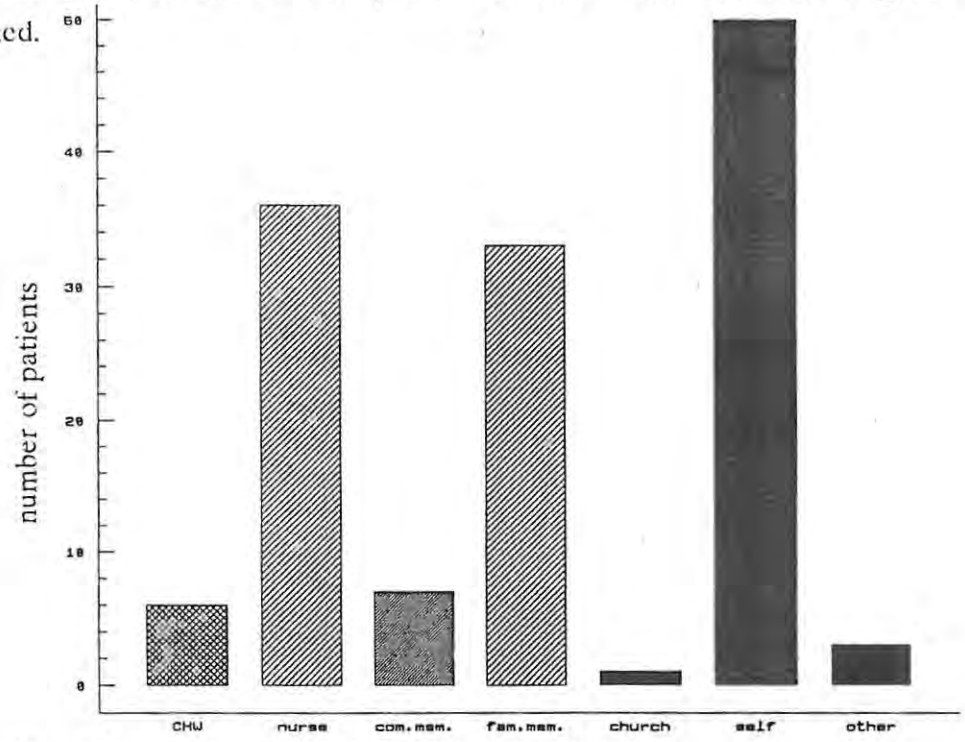


Figure 4.7a Profile of identified sources of referral to the clinic.

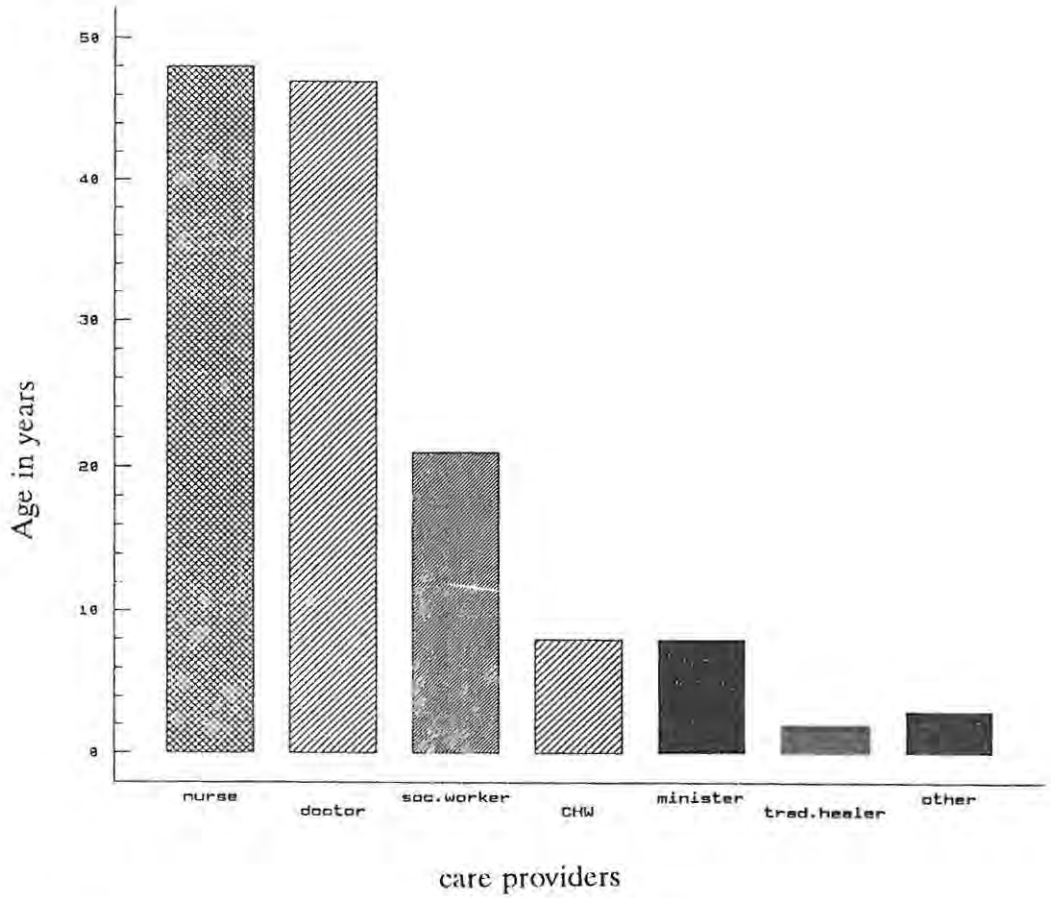


Figure 4.7b Profile of patient preferences for consultation.

CHAPTER 5 - DISCUSSION OF RESULTS

Quantitative and qualitative analysis of the results of the psychiatric screening describe psychiatric symptomatology as it occurs in the PHC setting. Results show that a large portion of the symptomatology appears to be accounted for by what the research literature terms 'somatisation' and, within the defined study area, this takes on significance as a mode of expressing distress (H1). Socio-demographic variables found to be statistically related to psychiatric symptomatology (H2) include age, marital status and educational level. Certain aspects of health service utilisation were found to be statistically related to psychiatric symptomatology, thereby supporting sub-hypotheses comprising H3. Patients with psychiatric symptomatology were found to have significantly longer consultation periods (3.1), receive treatment for more illnesses (3.4), and spend a greater number of days in bed with illness (3.5). No statistically significant relationship was found to exist between psychiatric symptomatology and amount of medical treatment received (3.2) and compliance with medical directions (3.3). Thus on the basis of research results hypotheses 3.1, 3.4 and 3.5 were accepted, and 3.2 and 3.3 were rejected. While research results do not support hypothesis 4, psychiatric symptomatology was found to be statistically associated with perceptions of privacy in the PHC setting.

5.1 METHODOLOGICAL CONSIDERATIONS

5.1.1 DEFINING AND OPERATIONALISING THE INDEPENDENT VARIABLE

Research literature shows that up to 40% of general health care patients suffer from psychological problems if minor (subthreshold) mental disorders are included, and that a large proportion are chronic and associated with substantial disability (including personal and social costs) and increased utilisation of health care (Sartorius et al., 1993). As noted earlier (see 1.3.1) symptoms and disorders presented in PHC and community settings are less specific than those presented in clinical settings, and this is to some extent a function of the case detection techniques used in psychiatric epidemiological research (see 1.3.2).

Also, there exists no normative data on the SRQ and PSE for the population under study, which further problematises psychiatric case detection, although studies conducted in other parts of the country have produced some positive evidence of their accuracy (see 3.4.1 and 3.4.2).

It therefore makes sense to deal with psychological problems in PHC settings at the level of psychiatric symptomatology since both instruments assess psychological functioning at the level of symptomatology. Psychiatric symptomatology is therefore operationalised as the independent variable in the present study in terms of three levels of severity, defined by the cut-off points for each of the screening instruments. Until more accurate normative data is collected, these cut-off points may be considered indicators of amount of symptomatology experienced by PHC patients.

5.1.2 METHODOLOGICAL CHALLENGES IN THE RESEARCH SETTING

German (1972) and Joseph and Phillips (1984) document some of the difficulties of conducting health systems research in developing countries and many of these apply to the context in which the fieldwork for the present study was carried out. The receptivity of the respective communities to the fieldworkers became an important consideration. In a single instance the relevant health authority had not notified a particular clinic, situated in a rural area, of the impending fieldwork through the correct community structures. Clinic staff warned that the suspicions of community members may be aroused by fieldworkers asking questions in the community, which meant that fieldwork could not be carried out in the clinic.

Clinic staff and patients were generally not accustomed to the idea of research as it appeared that this was the first survey of its kind in the area. Thus was required an appropriate explanation of the significance of the information being requested and the procedures according to which confidentiality would be ensured. It was made explicit that the fieldworkers were not part of the clinic staff and would not be reporting back to them.

The limitations of the communications infrastructure, especially in the rural areas, made follow-up of cases nearly impossible. Many of the patients attending the clinic are not reachable either by road or telephone, which meant that all fieldwork had to be conducted in the clinic setting. Also, each patient had to be dealt with on a single occasion since the clinics did not operate on an appointment basis.

Cox (1977) identifies some qualities of a good interpreter including, the ability to understand the culture of both the researcher and the patient, a thorough knowledge of the languages used, a familiarity with psychiatric terminology and an unhurried approach. All of these criteria were met in the present survey and, since the team remained unchanged throughout the fieldwork

period, fieldworkers were able to achieve a high level of standardisation and develop a thorough understanding of each other's interpersonal styles. In fact indirect communication through an interpreter may have been an advantage considering the differences in ethnic background between the researcher and the patients (cf. Cox, 1977, p. 215).

The following discussion proceeds from a perspective aptly summed up by Weiss and Kleinman (1986);

> "Cosmopolitan frames are essential for comparative analysis within and across cultures, but are incomplete without the local conceptual frames derived from indigenous experience that renders such comparison valid and meaningful." (p. 193)

5.2 SOCIO-ECONOMIC FACTORS AND PSYCHIATRIC SYMPTOMATOLOGY

Socio-economic status, stressful life events and availability of social supports have all been shown by the research literature to be related to psychiatric morbidity (cf. Holmes & Rahe, 1967; Masuda & Rahe, 1967 and Cagle, 1987). Extrapolating from this observation, Camasso and Camasso (1986) suggest that chronic strains experienced by disadvantaged classes contribute positively to psychological illness at this level. However, in most instances the relationship between social characteristics and mental illness is based primarily on data derived from treatment settings (Dohrenwend & Dohrenwend, 1974). More accurate indications of requirements for primary mental health care are to be derived from epidemiological field studies (Cagle, 1984). Case notes from the interviews as well as quantitative analyses of results attest to the important role played by social and economic stressors contemporary to the peoples of the Eastern Cape in causing and defining distress and determining its prevalence.

While the Eastern Cape Region as a whole is particularly economically depressed in relation to the rest of South Africa, the population of the Bisho-King William's Town area have experienced additional stressors related to the homeland system (which operated up until April 1993, incorporating Bisho as the capital of the former Ciskei), increasing levels of violent crime (especially taxi violence and armed robbery), migrant labour, etc.

Certain features of the patient sample differ from the demographic description of the population of the study area as a whole (see 2.1), which may reflect some defining characteristics of the PHC patient population. For instance, while 44% of the potential labour force of the region are employed, only 22% of the PHC patient sample were employed at the time of questioning.

Similarly, levels of education attained by the patient sample (52% primary education, 16% secondary and 3% tertiary), are somewhat lower than those indicated for the general population of the region (38% primary, 33% secondary and 6% tertiary). Table 5.2 compares some demographic characteristics of the patient sample for the present study with an Eastern Cape sample of patients of Psychiatric Community Services.

Table 5.2 Comparison between PHC patient sample and a psychiatric patient sample (Eastern Cape Region) on specified socio-demographic variables (expressed as percentages).

AGE GROUP	PHC SAMPLE	PSY SAMPLE
16-19 years	22.8	2.6
20-29 years	47.6	22.4
30-39 years	17.9	35.9
40-49 years	4.1	23.7
50-59 years	2.8	9.6
60 or more years	4.8	5.8
MARITAL STATUS		
unmarried	58.6	66.4
married	28.2	22.8
divorced/sep.	5.6	7.0
widowed	7.6	3.8
NO. OF CHILDREN		
none	31.3	41.8
one	25.0	15.2
two	10.4	16.5
three	16.0	10.8
four	4.2	5.7
five	7.6	5.7
six	2.8	1.9
more than six	2.8	2.5

PHC sample = primary health care patient sample (n=148)
PSY sample = psychiatric patient sample (n=158)
(Statistics for psychiatric patient sample derived from Esterhuysen & Levin, 1995)

Joseph and Hollett (1993) found rates of revealed mental illness to be higher in communities with higher rates of unemployment and lower housing status, considered measures of SES. While results did not indicate a relationship between psychiatric symptomatology and unemployment,

patients receiving a pension were significantly more likely to suffer increased levels of psychiatric symptomatology. There also appears to be a significant relationship between psychiatric symptomatology and educational level which, considering the high rates of unemployment in the region, may be a more sensitive measure of SES.

Interaction effects were not investigated in this study, yet it is possible that such a relationship exists between gender and marital status, as was shown in a study conducted by Warheit et al. (1976), where divorced widowed or separated women were found to be at greater risk. Research results do show that divorced, widowed and separated persons as a group are statistically significantly more likely to suffer from psychiatric symptomatology. This result may be anticipated from the research literature which documents the magnitude of the social readjustments required of persons in these categories (Holmes and Rahe, 1967). Further, married persons were found to be at a significantly greater risk than unmarried (not including divorced, widowed and separated) persons, a finding not anticipated by the research literature (cf. Cagle, 1984, p. 397). Certain stressors particular to married women attending PHC clinics in the study area may account for this finding. These were identified in the interviews and are discussed in relation to psychiatric symptomatology in 5.2.2.

While men were found to be significantly more likely than women to score above threshold on the SRQ, very few scored positively on the PSE. It may be that increased levels of symptomatology are experienced by men who, for whatever reason, are not employed, since they are at the clinic during the day. Low scores on the PSE may reflect evasiveness on the part of males who are likely to be reluctant to be interviewed by women. Research literature shows that, even though there may be differences between the sexes for specific diagnoses, results of actual differences in prevalence of mental illness between the sexes are inconclusive (Dohrenwend & Dohrenwend, 1974; Dohrenwend et al., 1980). While the same is said to hold true for age as a social indicator of psychopathology (Cagle, 1984), the results of the present study demonstrate a statistically significant positive relationship between age and psychiatric symptomatology.

The PHC patient population in the study area experiences many of the socio-economic stressors that previous research has shown to be concomitant with increased levels of psychopathology, and therefore constitutes a high-risk sub-group of the general population. In addition, the demands of social change evidenced by rates of urbanisation (see 2.1), changes in the traditional family structure and economic system, and political change, entail stressful adjustments likely to increase

the vulnerability of the population to psychiatric distress (cf. Miller, 1972). Guiness's findings from research conducted in Swaziland (1992) lead him to conclude that there exists an increased incidence of mental illness in transitional societies.

5.2.1 ECONOMIC INFLUENCES ON SOCIAL CHANGE

From the foregoing it becomes evident that the results of the study must be viewed within the context of social and cultural change. Traditionally within *Xhosa* culture there is a strong emphasis on community. Sharing and reciprocity provide security against poverty. However, modern economic realities are not conducive to traditional community and family systems, and this has been instrumental in the breakdown of the traditional family unit. Declining economic circumstances have impinged negatively on the structure of the extended family, family and marital relations and social relationships in general (personal communication, Hirst 1995).

Therefore, modes of sharing and co-operation may be changing as the reciprocal relationships within the community are weakened and capitalist values become more widely adopted. Murphy (1982) (in Weiss and Kleinman, 1986) argues that the shift from more mutually supportive social settings toward increased competitiveness in various societies accounts for an increasing incidence of non-bipolar affective disorders. In the context of this study the transition is not uniform or complete and there exists a strange mix of the new and the old along a continuum (personal communication, Hirst 1995).

The most obvious evidence of the adoption of capitalist values is in the tendency of some patients to relate to a materialistic form of self-worth. Feelings of self-depreciation and lack of self-confidence were often expressed in relation to lack of material resources like money, furniture and school uniforms. In the study area, where poverty levels are high, there was much concern about invoking the jealousy or resentment of others by appearing to have more than them. This is summed up in the response of a female patient to the question "Do you feel that people are against you?": "No, I have nothing that people want so they can't be against me."

Yet the sense of community and relationship that binds people together is evident in the responses to questioning about symptoms of grandiose ideas and actions, which constitute part of the complex of expansive mood and ideation. When asked if they felt that they had extraordinary powers and talents that others did not have, patients frequently responded: "No,

I am not better than anyone else."

Social and cultural change is nowhere more evident than in the accounts of family break-up and disharmony, too numerous to be dealt with individually, but together constituting a picture of abuse, neglect, gender inequality and most significantly, economic desperation.

5.2.2 CHANGING GENDER ROLES AND MARITAL DISHARMONY

The traditional family system of the *Xhosa* is agnatic and patrilocal. Customs surrounding family processes such as marriage and childbearing mediate family relationships and provide the normative infrastructure for social control. Conflict within the family poses a serious threat to the unity of the group and so is kept to a minimum and dealt with through recognised procedures. Because of the social and financial implications of marriage for the family as a whole, much is done to avoid family violence and neglect (Wilson, 1974; personal communication, Hirst 1995).

These traditional arrangements have not survived social and economic change. Some of the problems within the family may be attributed to fewer social controls due to the breakdown of traditional authority and changes in the economic roles of the sexes. Wilson (1974) uses the custom of *lobola* to demonstrate how traditional practices have become distorted through changing relationships between generations and between men and women, which itself is largely a function of economic change. In addition, laws which restricted movement of blacks and promoted migrant labour in the past are also responsible for much of the dissolution of the family (Wilson, 1974).

A reading of the case material from psychiatric interviews conducted in the present study provides strong evidence of the relationship between family problems, economic desperation and psychiatric distress. Familial and marital relationships are particularly vulnerable to economic factors. While childbearing and marriage remain important in achieving status as a woman, depression and anxiety amongst women was frequently found to be associated with marital disharmony, husband's infidelities, family violence and alcohol abuse, which in turn were often concomitant with economic desperation and unemployment.

The following accounts provide some indication of how these factors interact. They also suggest

that illness is women's socially approved way of communicating distress. Medical help seeking may alleviate social distress, thereby reducing anxiety and tension (an argument dealt with in 5.4.2). On the other hand, it has been suggested that drinking is a socially approved way for men to cast off their problems and anxieties. Among the *Xhosa*, especially, of the Eastern Cape Region, drinking is seen as a particularly male activity, and is not to be criticised by women (cf. Hirst, 1990). These cases also demonstrate the operation of a number of the other socio-economic variables already mentioned.

CASE 21: The patient (female, 25), classified as suffering from retarded depression and presenting with symptoms of both anxiety and depression, identifies her problem as her husband. The couple have two children but the husband is having an affair and so there is not enough money to maintain the household. Husband and wife always fight, this fighting started when she was pregnant and the husband is now wanting to end the marriage. The husband denies that the last born child is his. Last week he hit her and as a result she is now living with her father.[1]

CASE 115: The patient (female, 47, PSE-CATEGO classification of retarded depression) begins her account of her problems with her husband's violent behaviour. Her husband drinks and becomes violent towards his wife and children (5 children). When she tries to stop her husband from beating the children he turns on her. When the couple are fighting the husband goes into the street and shouts about the problem to the neighbours which embarrasses and humiliates the patient. One of the children (a daughter) has already left home and gone to Johannesburg because of the 'problem' and is 'moving' with a group of friends who all drink. For this the husband blames his wife.

CASE 145: The patient (female, 33), classified as neurotic depression and presenting with symptoms of depression and some anxiety, is married and both herself and her husband are unemployed. She has two children but the second child, four years old, is handicapped, for which the family receive a small state grant. The husband takes the money for drinking. The patient has no sexual relationship with her husband even though she is not pregnant or breast feeding (traditionally periods of celibacy). Her husband recently attacked her with a sickle and she is presently living in fear of her husband's death threats. For this reason her parents have asked her and her child to go back and live with them.

Although beyond the scope of this study, there are many extraneous factors which, if further explored, could explain important aspects of the cases cited above. (This comment would in fact apply to all cases cited in the present study.) For instance, whether the couple were married traditionally, in Church, or in court would to a large extent mediate conflict and break-up, alcohol may play an extraneous role in relation to psychosomatic symptoms like impotency, and, besides family disruptions, economic considerations are often responsible for children leaving home and moving to the larger centres, where they may become 'street children'.

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[1] Here the patient's husband seems to imply that she is guilty of sexual infidelity.

The present study did not distinguish between the various forms of marriage. Although a high proportion of respondents indicated that they were unmarried (57%) when presented with the options of 'married', 'divorced', 'widowed' 'unmarried' and 'separated', a proportion of these may be married according to the *Xhosa* custom (tribal marriage), but not have registered this marriage as a legal contract. This distinction becomes important in that it holds certain legal and social implications for the wife.

The woman's role in the home and the condition of her homestead remain an important part of her identity (personal communication, Hirst 1995). In many instances during PSE interviews women related that the times that they felt the best and had the most energy was when they were working hard in the home. Since the home is a source of pride, disruptions in the home are related to anxiety, which may underlie many of the problems that women have with men in the social context, where women are wanting to maintain a state of order. This seems to be an important part of the distress experienced in the following account.

CASE 102: This patient (female, 27, two children), diagnosed as retarded depression with symptoms of social withdrawal, complains that her husband is drinking too much and doesn't want to give her money for the home. At the end of the month when he gets paid her in-laws go to her husband's work and get his money, which leaves nothing for the family. Now she can't pay the accounts and her house is empty because the furniture shops have repossessed her furniture. She explains that since her miscarriage nine months previously nothing has gone right in her life. She is her husband's second wife and feels that his family have never properly accepted her.

The breakdown of family ties is in many cases linked to fighting about money. Women are beginning to become more economically active and in many instances are the sole breadwinners of the family, probably largely in an effort to maintain the state of the homestead. This has seriously affected the identity of males whose economic role is no longer dominant to that of females. Thus has emerged a form of female dominance in the communities where woman are asserting control over their own needs (mainly in the urban areas). This trend is both evidenced and facilitated by the increase in female-headed households and female-headed community projects. (These suggestions are based on the personal observations of the researcher and supported by personal communications with Hirst, 1995.)

In the traditional setting there was not much room for female self-assertion outside of household matters but their positions were secured through strong norms of social reciprocity. Because of looser social ties a woman's role within the extended family system is now often fraught with

conflict and jealousies. As an outsider to the patriarchal group she is often blamed for the ills or misfortunes that befall the group or members of the group. These are typically interpreted in terms of witchcraft accusations which are directed more often at women than at men because the former are 'strangers' in their husband's homesteads. Witchcraft is a way of projecting blame for misfortune on an outsider and it is effectively a means of breaching a social relationship (personal communication, Hirst, 1995; see also 5.4.3 for a discussion of witchcraft and possession states and their symptom complexes). This is evident in the dynamics shaping the following account.

CASE 18: The patient (female, 36, PSE-CATEGO classification of schizophrenic psychoses) describes herself as a worrier and lately cries a lot because of her problem. Her husband hits her with his hands and she has started experiencing stomach cramps and sleep problems. She blames herself for having seven children and getting married young. However, she is now sterilised. Her husband's brother has been accusing her of witchcraft and so she has had to leave her husband and "return to her parents' home to talk about the problem with the traditional healers." She hears voices but can not make out the words.

This case points to another social stressor. Single parenthood is becoming more prevalent as a result of family breakup or desertion and affairs outside of marriage. A total of 38% of the female respondents were single parents. This may be a source of some stress since unattached women with children may be downgraded and socially stigmatised (personal communication, Hirst 1990).

A full 25% of all respondents were unmarried mothers. Unmarried girls who fall pregnant are often reluctant to disclose the identity of the father because of the possibility of his denial of the fact, the threat of parental disfavour, the threat of violence as well as the possibility of legal litigation. They are also reluctant to disgrace their own family and the family of the father, especially if the father is a married man, which is often the case. This means that they do not have access to maintenance.

5.3 PSYCHIATRIC SYMPTOMATOLOGY OCCURRING IN THE PHC SETTING

As could be anticipated, mood disorders, predominantly depression, and anxiety states constituted the bulk of the PSE-CATEGO classifications (see fig. 4.2b). This was found to be the case in the results of studies conducted by Bridges and Goldberg (1985), Goldberg and Bridges (1988) in Western general health care settings and the predominance of neuroses at PHC level has also

been found in studies conducted in developing countries by Harding et al. (1980) and, more specifically, in Africa by Binitie (1975) and Ndetei and Muhangi (1979).

5.3.1 PROFILE OF SOMATIC SYMPTOMS

Research reports emphasise the frequency with which psychiatric problems, particularly affective disorders are presented in somatic form. However, in terms of the definition of somatisation (see 1.5), there are obvious problems associated with operationalising the construct reliably in the absence of thorough physical examinations to rule out possible physical explanation for symptoms. Therefore, for the purposes of a descriptive analysis, the present study used the somatisation section of the Composite International Diagnostic Interview-Primary Health Care Version (CIDI-PHC) (a WHO instrument) as a guide in identifying somatic symptoms measured on the SRQ.

Table 5.3 represents the somatic symptom distribution as measured by the SRQ across groups. From the between groups comparison it can be seen that, relative to the other symptoms, shaking hands and poor digestion show large proportionate increases between groups 1 and 3 (more than a four-fold increase) and the reporting of fits or convulsions shows an eleven-fold increase. Such a comparison may suggest which symptoms are the most sensitive indicators of psychiatric distress and points to a potential research problem which may be addressed in the future.

A comparison of the SRQ symptom profile and the PSE syndrome profile (see figures 4.2a and 4.2c) reveals a prototypical set of complaints occurring frequently in the research literature. In the present study physical symptoms are among the most frequently reported symptoms on the SRQ, which include headache (item 1), easily becoming frightened (item 4), difficulty making decisions (item 12), uncomfortable feelings in the stomach (item 19) and symptoms of tiredness reflecting decreased energy levels (items 18 and 20). While becoming easily frightened is not a physical symptom, during PSE interviewing patients would describe this experience in terms of symptoms relating to autonomic arousal, including dizziness, sweating, pressure on the chest and upset stomach.

The most frequently scored syndromes on the PSE-CATEGO system are simple depression (SD), tension (TE), worrying (WO), loss of interest and concentration (IC) and 'other' symptoms of depression (OD). Tension and worrying were also found to be the highest scored syndromes

amongst a community sample of elderly coloured persons in Cape Town, with 'other' symptoms of depression and simple depression scoring among the top six syndromes (Ben-Arie, Swartz, Teggin et al., 1983). The symptom formations constituting these syndromes include sleeping disorders, poor appetite, mood and motivational problems, inefficient thinking, including concentration problems, tension pains and symptoms of increased autonomic arousal, tiredness or decreased levels of energy, loss of libido and premenstrual exacerbation (see appendix 9).

These symptoms are similar to those documented by Binitie (1975) in a comparative study of depression across Western and African cultures, who lists a set of complaints including, among others, insomnia, loss of interest and concentration, retardation and loss of insight. He found motor retardation to be a common component of depression in Africa. Sigvardsson et al. (1984) identified headache, backache and abdominal distress to be related to psychiatric impairment in an adoption study of somatoform disorders.

German (1987) reminds the reader that it is possible that symptoms presented represent culturally determined assessments of priority or relevance. In the PHC setting, seen as an extension of the medical system, it may be regarded as more appropriate to present with physical complaints in appealing for help. If mood disorder accentuates somatic symptoms, and promotes help seeking, as proposed by Craig and Boardman (1990), it is reasonable to expect that appeals for help will most often come to the PHC service.

While the instruments used have been shown to standardise assessment for cross-cultural research, a closer look at the content of the PSE interviews from an ethnographic perspective in the context of the present study points to some culturally defined forms of expressing distress. These modes of expression may be confusing to PHC workers unfamiliar with the local idiom of distress and untrained in the detection of psychiatric problems, particularly somatised forms of affective illness.

Table 5.3 Somatic symptom distribution as measured by the SRQ

i. Expressed as percentage of each group reporting a specified symptom as present.

symptom	item	group1	group2	group3
headache	1	35.2	60.5	59.0
poor appetite	2	15.5	39.5	48.7
shaking hands	5	5.6	15.8	23.1
poor digestion	7	9.9	21.1	41.0
tired all the time	18	16.9	68.4	64.1
stomach discomfort	19	26.8	60.5	66.7
easily tired	20	31.0	73.7	74.4
fits / convulsions	25	1.4	10.5	15.8

ii. Expressed as percentage of the whole sample reporting a specified symptom as present.

symptom	item	group1	group2	group3	total
headache	1	16.9	15.5	15.5	48.0
poor appetite	2	7.4	10.1	12.8	30.4
shaking hands	5	2.7	4.1	6.1	12.8
poor digestion	7	4.7	5.4	10.8	20.9
tired all the time	18	8.1	17.6	16.9	42.6
stomach discomfort	19	12.8	15.5	17.6	45.9
easily tired	20	14.9	18.9	19.6	53.4
fits / convulsions	25	0.7	2.7	4.1	7.5
percentage of total group:		48.0	25.7	26.4	n=148

group1 = patients scoring below threshold on the SRQ - no psychiatric distress (n=71)

group2 = patients scoring above threshold on the SRQ and below threshold on the PSE - some psychiatric distress (n=38)

group3 = patients scoring above threshold on the PSE - identified psychiatric disorder (n=39)

5.3.2 PHYSICAL ILLNESS AND PSYCHIATRIC DISTRESS

A consideration of the reasons for which clients consult diviners leads Hirst (1993b) to remark that,

> "..among the Cape Nguni, psychosomatic and psychological disorders very often present themselves with a rich overlay of physical symptoms." (p. 104)

He argues that when problems are interpreted on a purely organic level by the medical system, and treated as such, they are not relieved and the diviner is consulted.

Traditionally defined disorders have certain symptom complexes which may present as a baffling array of physical complaints to the medical health professional. Such complaints include various aches and pains such as stomach-ache, headache and backache, spells of madness, attacks of anxiety and fainting, dreams and visions requiring interpretation and convulsive conditions (not epilepsy) (Hirst, 1993b).

These complaints may constitute complexes such as *ukuthwasa* and *amafufunyane*. The latter was encountered in some patients during fieldwork, especially in clinics drawing a clientele from the rural areas, where traditional beliefs are stronger, and describes a state of possession which results from bewitchment (Hirst, 1993b). Characteristic features of such a condition are discussed in 5.4.3.

A symptom complex commonly encountered in both the urban and rural areas is *umbilini* or attacks of anxiety, often called '*i-nerves*' (discussed in 5.4.2). Also encountered and documented in field notes, although less frequently, were symptoms which appear to relate to what Hirst (1993b) calls 'river sickness' (*umlambo*). Those documented in the case notes include sores, swollen legs, menstrual disorders, various aches and bad dreams.

The causal relationship between physical symptoms and psychological distress is not always altogether clear. Some physical symptoms which are related to a diagnosed physical condition may have resulted from a state of psychological distress which increased autonomic arousal over an extended period of time. Sustained increases in autonomic arousal may result in psychosomatic disorder, e.g. duodenal ulcer and hypertension. It was suggested that the high incidence of digestive problems reported in the present study (see 5.3 and fig. 4.5) is related to

depression through eating disorders. This follows from the observation that overeating is a culturally determined response to depression, in that depression represents a craving and eating is the most accessible means of satisfying a craving. Overeating disrupts digestion, resulting in digestive problems (personal communication, Bitalo 1995).

The converse may also be true where a physical condition may increase personal and social stress levels, putting the person at higher risk of developing a psychiatric disorder. This may result in patients moving backwards and forwards between Western medical and traditional services, as was the case with some patients interviewed in this study, who reported having already consulted traditional healers for a particular ailment.

The following case demonstrates the interrelationship between physical illness and psychological distress and the importance of PHC services being able to deal with problems speedily and knowing where to refer patients for the necessary specialist treatment. It also demonstrates how patients may become consecutive users of health services with serious or chronic conditions if they do not receive appropriate treatment.

CASE 10: (male, 24, no children, PSE-CATEGO classification of anxiety state) This patient has been coming to the clinic for three years for the "problem of drop", which he describes as a venereal infection, perhaps sexually transmitted. This problem, which has caused his penis to swell and become extremely sensitive to the point of not being able to urinate, leaves him unable to attain an erection and has prevented him from going to circumcision school.

He reports experiencing dizziness when looking down, "palpitations", dry mouth, trembling, headache, tiredness and vomiting gall. He describes himself as shy on meeting people because he suspects that they are laughing at him. Further he related what appears, in the absence of epilepsy, to be panic attacks (described as "fits when he is around people") as well as a somatic symptom characterised by a pressure on the chest which is released with a loud cry.

The patient is almost definitely referring to syphilis in local jargon ('drop'). If this venereal disease is untreated neurological complications affecting the central nervous system are expected in the later phases of the disease. Additionally, males who are not circumcised do not achieve status as men, which itself is likely to be the source of significant social stress. Here mental illness would have both social and organic origins and chronic illness would also constitute a major drain on health resources in the long term.

5.4 CULTURALLY MEDIATED MODES OF EXPRESSING DISTRESS

Cheetham and Cheetham (1976) note that insanity or mental illness is not recognised as such within the traditional belief system of the rural *Xhosa*, it is a concept that is gradually being conveyed to them through contact with Western medicine. However, Hirst (1990) points out that there are *Xhosa* words which denote madness (*ukugeza*) and craziness or insanity (*ukuphambana*), and commonly recognised behaviours that constitute these states, which would seem to support the viewpoint that in widely different cultural settings, sanity is distinguishable from insanity (Murphy, 1976). Within the range of what would be considered mental illness, abnormal behaviour and abnormal emotion are cause for the greatest concern and most urgent treatment. These forms are traditionally dealt with by the diviner. In the absence of a more refined psychiatric nosology, clues to conditions such as anxiety and depression are to be found in the symptom complexes presented in the clinic setting.

5.4.1 SOMATISATION AS METAPHOR

Kahn (1994) describes a psychiatric case of a female who, among her symptoms, experienced worms coming out of her vagina. While this was taken as an hallucination by the medical team, traditional healers who heard the case were able to relate this symptom to the *ufufunyane* possession state and her husband's infidelity. It was hypothesised that this was a communication that she felt dirty and defiled by the other women with whom her husband had had intercourse. Kahn (1994) writes:

> "The diviners view Ms G's 'psychotic' behaviour as evidence of her increasingly desperate and unsuccessful attempts to resolve the social conflicts of her domestic situation." (p.17)

It may be the case that somatic symptomatology provides valuable clues to possible sources of distress and that this relationship is culturally mediated. The body becomes a medium of communication.

A clearly somatic set of symptomatology manifests itself in the symptom complexes experienced by patients who became ill and were no longer able to work, as the following case demonstrates.

CASE 22: (female, 33, PSE-CATEGO classification of neurotic depression) The patient's first and most pressing complaint is her bad health. She explains that she can not work because she becomes ill. She reports on the SRS that most of the time she feels sick enough to stay in bed. She also explains that her husband is not working and she has five

children to support. Her husband neglects the family and most of the time she is crying because there is no food. Sometimes she fights with her husband and then he hits her. Recently she has been getting nightmares.

From responses to other items in the interview and the SRS it appears that this patient is not receiving treatment for any ailment nor has she been diagnosed as having an identifiable physical condition. She presents with clear depressive symptomatology and experiences a set of typically somatic symptoms: tension pains, weight loss due to poor appetite, delayed sleep, subjective anergia and retardation, loss of libido and possibly premenstrual exacerbation. It is, however, not clear from the interview to what extent the patient was malingering, which may be the case where patients are hoping to qualify for a disability grant (observed frequently during training at Psychiatric Community Services in East London). This is itself a cry for help!

Patients 94 and 115 (5.2.2) demonstrate the coexistence of social and economic problems and somatic symptomatology. In both cases the symptomatology appears to be related to the demands of work. Patient 94 complains of a nerve in the neck and lame arm when working. Patient 115 complains of a pain in the breast, headache and short sightedness, along with the fact that she is earning R66 a week for eight hours of work a day and must walk a distance of about 3km to and from work. These patients may be communicating an inability to cope with the stressful demands of their jobs through their physical symptoms.

In the following case an adolescent boy presents an interesting physical correlate to what may be stress associated with the demands of school and possibly also associated with the threat of the upcoming *abakhwetha* initiation which he was to have entered a month after the interview.

CASE 97: The patient is an adolescent (male, 19, PSE-CATEGO classification of neurotic depression) presently writing his year-end school examinations. He is about 50-60kg overweight (120-130kg). He describes himself as "shy and silent" and a loner. He cuts himself off from world by wearing dark glasses ("to cut people out") and listening to music. He is self-conscious about his obesity and explains that he eats a lot because he feels frustrated. Even though he wants to stop eating so much, because he realises he is getting fatter, he walks to town and buys himself sweets when he wants to be alone. His two greatest fears are having to pass his examinations and having to go to circumcision school. When thinking about circumcision his thinking "becomes blocked because he gets scared." He is not interested in girls because he "feels inferior." Although he hears voices calling him and speaking he "realises that they are in his mind."

While it seems that this patient finds comfort in eating and has developed an eating disorder which is causing his obesity, his nervousness and self-consciousness may be exacerbated by the

stressors he had been experiencing.

In fact, this case demonstrates some symptoms of a condition referred to in the research literature as 'brain fag syndrome'. It has been observed among African student populations and is described as a form of somatised anxiety and depression, sometimes accompanied with brief reactive psychoses (German & Arya, 1969; Guiness, 1992). Social correlates appear to relate to social change, an emphasis on education as an agent of change and the breakdown of the extended family support systems through urbanisation. Categories of culturally relevant symptoms include somatic (shown to correlate with SRQ symptoms), cognitive (impaired concentration and memory and inefficient thinking) and spiritual (suspicions of bewitchment and dissociative hallucinations) (Guiness, 1992).

Kawanishi (1992) provides a critical perspective of somatisation as a product of Western ethnocentrism, which conceptualises human functioning in terms of the mind-body dualism, and is therefore able to make the distinction between somatisation and psychologisation (which refers to the presentation of symptoms reflecting introspection of one's psychological processes). This perspective is supported by research findings which show that patterns and prevalence of somatisation are not reliably different across culture and class (Kirmayer, 1984; Goldberg & Bridges, 1988). Kawanishi suggests that the observed differences between Western and non-Western cultures are related to (i) different styles of causal attribution for physiological arousal, (ii) patients' perceptions of what may be considered legitimate symptoms to present at the available health care settings and (iii) a restricted understanding, on the part of researchers, as to the cultural metaphors that shape expression. Culturally mediated forms of expressing distress may have their own sophistication (cf. Kirmayer, 1989). Where psychologisation is more accessible to cultures which place much emphasis on the individual (Kawanishi, 1992) traditional African concepts focus more on the place on the individual within his social context. Therefore traditional healing more often uses techniques which readjust the individual within his social network (see 5.6.1), and may be likened to the principles of family therapy (Guiness, 1992). While certain patient management principles may be applicable across cultures, Kawanishi cautions that it is also important for physicians to treat the patient on the level of somatic complaint in order to demonstrate respect for the patient's subjective distress.

5.4.2 NERVES AND THE EXPRESSION OF DISTRESS

"Nerves" (*umbilini*, or *i-nerves*) were often reported during PSE interviewing in relation to feelings of anxious foreboding and had certain predictable autonomic correlates; shaking, palpitations, sweats, short breath, dizziness, feeling of butterflies in the stomach. Other associated symptoms reported on the PSE include the complaint of "thinking too much" (possibly brooding on one's problems), social withdrawal or not wanting to be around people and loss of appetite. The literal translation of *umbilini* refers to feelings of anxiety in the solar plexus region or to the internal organs of the body, specifically, the intestines (Schweitzer, 1985). These symptoms are reported in the following case report.

CASE 60: This patient (female, 26, PSE-CATEGO classification of retarded depression) explains that she is the first born of a family of six children but they do not have a father. She is single and living in King William's Town. She has one child but she cannot support the child because she is not getting maintenance from the father. She appears to be distressed about recently having lost her job and now sleeps during the day but not at night.

She explains that she was hoping that the clinic sisters would recognise that she is suffering from nerves and relates her symptoms as; lower abdominal pains, night sweats, trembling, butterflies in the stomach, and difficulty breathing. "Thinking makes (her) worried." She is socially withdrawn and lacking in self confidence "because (she) is no longer working and (her) mother does not have a husband." She has also experienced a weight loss because of drinking and reports having stopped taking drugs (Cannabis) two weeks previously.

A friend who had accompanied her to the clinic told a fieldworker that the patient was involved in prostitution to get money and that she was still drinking alcohol heavily.

Katon et al. (1982) point out that besides somatisation, alcoholism and drug abuse are also correlates of depression and anxiety states. The above case demonstrates the inter-relatedness of physical symptoms, psychological problems (anxiety and depression) and behavioural disorders (alcohol and drug abuse), as well as the involvement of social factors (family breakup, single parenthood and unemployment) in the etiology of disease. Her hope of being identified by the nurses as a "nervous person" may indicate that her consultation at the clinic was an attempt to get some treatment for symptoms of withdrawal.

A body of research in the field of medical anthropology has examined the use of nerves as a popular illness term across cultures. These are some of the debates.

Low (1985) proposes that the term 'culturally interpreted' accurately describes the process by which symptoms, which are taken to indicate nerves, may be understood in terms of the cultural content of symptom formation, expression and meaning.

Research literature concurs that nerves is a signal of distress as evidenced in the high incidence of this complaint among societies experiencing familial, social and cultural disruption (Lock, 1991). Van Schaik (1985) focuses specifically on an interpretation of nerves as an expression of social relations rather than as an illness, suggesting that it functions as a form of communication. Lock (1991) extends this conception and describes nerves as a language of the disempowered (especially women) and a means of mediating between distressing social events, disvalued emotional states and somatic symptomatology. (It is significant that the examples cited in the literature as constituting these three elements share striking similarities with the social and somatic complaints, as well as the emotional states, i.e. feelings of loss of control and social withdrawal, already cited in the case descriptions.) Further support for this hypothesis is provided by Racy's (1980) account of somatic complaints in Saudi Women, amongst which 'nerves' features prominently. He concludes that the observed pattern of complaints may be characteristic of cultures in which women occupy socially inferior positions and medical help-seeking provides the only acceptable outlet. This is arguably an almost identical account of the context in which distress occurs in the present study, especially in view of the dominant role played by socio-economic stressors in the manifestation of this symptom complex. It also confirms observations made in the present study and by the research literature already cited, of the tendency of distressed patients to present their suffering in the PHC setting in somatised form, thereby procuring treatment, which functions to acknowledge and legitimise the suffering.

Ludwig (1982) offers an elucidating account of nerves as a conglomerate diagnosis of chronic anxiety without panic, mild depression without despair, neurasthenia without malaise, some hypochondriasis and much illness behaviour, all superimposed on a passive, dependent, asocial or inadequate personality type with borderline normal intelligence. Six characteristics of nerves are identified in the research literature; sense of inadequacy and non-assertiveness, hapless but not completely hopeless, the absence of social protest, easy-startle response, somatic nonspecificity and constricted world view.

These appear to correspond strongly to the complaints and symptoms identified in the psychiatric interviews constituting syndromes of simple depression (inefficient thinking, depressed mood and

hopelessness), worrying (worrying, tiredness, nervous tension) and social unease (anxiety on meeting people, social withdrawal, lack of self-confidence), as well as the group of other symptoms of depression describing somatic non-specificity (see appendix 9). All four syndromes are amongst the six most frequently scored syndromes in the present study (see fig. 4.2c). The characteristics listed above also describe components of non-psychotic PSE-CATEGO diagnostic classes; retarded depression, neurotic depression and anxiety states, which together account for 54% of cases identified in the second stage psychiatric screening.

Lock (1991) makes the point that this conception of nerves must acknowledge the commonality with other culturally constructed complexes including (in the case of the present study) spirit possession, accusations of witchcraft and gossip.

5.4.3 BEWITCHMENT AND SPIRIT POSSESSION STATES

Sibisi (1975), considering spirit possession in *Zulu* cosmology and its incidence, suggests that it may be used to account for the increased incidence of psychoneurosis associated with social change, without attributing responsibility for the condition to the individual or making individuals feel that there is anything wrong with their minds.

Personal distress may be interpreted as an indication that the individual's relationship with the ancestral shades is disturbed (indicated by strange experiences and behaviour). In such instances equilibrium may only be restored through treatment which re-establishes meaning in the relationship and a sense of well-being. Thus the treatment utilises ritual which includes the components of integration and resolution of conflict, which occur on the spiritual as well as the interpersonal and social levels (Schweitzer & Buhrmann, 1978). Hirst's work into the healing approach of the Cape Nguni diviners is the real affirmation of this position (cf. Hirst, 1990).

O'Connell (1982) notes that possession states appear to have somatic, physical and social correlates. Hirst (1990) proposes that possession states may be seen as ways of coping with social conflict and occur most often in the case of individuals who have little social or material resources to improve their social standing and status. They also afford the individual secondary gains. In this way they may be seen as a way of dealing with role stress, usually domestic (O'Connell, 1982). Hirst (1990), analysing the *intwaso* possession state, notes that the identified signs and symptoms point to problems in interpersonal relationships and are used as a means of

manipulating significant interpersonal relationships and related social networks. The following case demonstrates these signs and symptoms.

CASE 14: The patient (female, 37, four children, PSE-CATEGO classification of schizophrenic psychosis) identifies herself as a traditional healer and wears the characteristic white neck band. Her presenting complaints are kidney problems, for which she receives medication, and pains in the womb. She describes herself as a strong believer in *Xhosa* traditions and therefore the ancestors play an important role in her life. Although she is a church goer she does not believe in the church.

She complains that people were jealous of her because she was progressive and trying to better herself. She experiences feelings of inferiority as she does not have a husband and therefore is not recognised as a person. She was accused of killing her husband by poisoning him. Although some people have been trying to poison her, they are not successful because she has consulted other traditional healers.

She reports that while she was "sick" she saw people in her house who were already dead. These people were there to protect her. She also experienced the sensation of someone touching her.

While the two cosmologies appear to be contradictory, many traditional healers are also nominal or practicing Christians (cf. Hirst, 1990, 1993b). This patient reports a culturally standardised symptom complex (second paragraph) and may suspect that she needs to perform some traditional ritual or undergo initiation as a diviner (*igqirha*) (personal communication, Hirst 1995).

Ufufunyane is a possession state attributed to bewitchment and normally indicates conflict with someone within the patient's social network not considered kin (Hirst, 1990). This state was reported by four patients that were interviewed. In many other cases the symptom complex reported appeared to indicate the experience of this state. Often, however, when questioned as to whether or not this was the case, patients would act ambivalent or deny it. The research assistant, herself a *Xhosa* woman and daughter of a psychiatric nursing sister, explained that, although some patients may suspect that this was the case, they may be reluctant to admit it because it could not be dealt with appropriately in the clinic setting. There may be dangers attached to admitting to suffering from *amafufunyane* (plural) if one is not prepared to deal with the problem properly.

The *ufufunyane*, as described by traditional healers, is normally located in the stomach of the patient, as evidenced by swelling of the stomach and wind. It may at times move into the head causing dizziness and fainting. This may be experienced as a snake moving around in the

stomach and then into the head. The eyes of the patient become red and the person may behave in a very antisocial, and disruptive and violent way. The *amafufunyane* may be heard to talk foreign languages through the afflicted person. Although the afflicted person will appear to be talking, another voice is heard coming from the stomach of the person (Schweitzer, 1977; Thorpe, 1982; personal communications, clinic patients 1994/5). Characteristic symptoms include hearing voices in a dream state or while sleeping, or noises in one's ears, backache and headache, sensations of something crawling around in one's head or stomach and vomiting (Sibisi, 1975). These symptoms would indicate a number of possible conditions (including psychosis) in a medical setting.

The following cases, reported to have been previously diagnosed by traditional healers as *amafufunyane* possession, demonstrate many of the characteristics of this state as well as the role played by socio-economic instability in the manifestation of symptoms.

CASE 94: (female, 28, PSE-CATEGO classification of either psychoses or neurotic depression) The patient's presenting complaint is a pain in the neck, headache, butterflies in the stomach and sometimes, when working, her arm becomes lame. She was given medication for hypertension but reports not taking the treatment. She had to stop working because of the nerve in her neck for which she has received pills from the doctor. She went to the traditional healer with the same problem and was diagnosed as having *ufufunyane*.

She hears voices speaking in her bedroom while she is asleep but can not hear what they are saying. She also dreams things before they happen and has been told by the traditional healers that she has the power of prophecy. At the time of interviewing she was separated from her husband. Her parents had taken her away from him after he had threatened her. They had been supporting her and her three children. She reports that her symptoms started on the day that she was married. And that she has had to be treated for 'nerves' in the past.

CASE 130: (female, 81, PSE-CATEGO classification of anxiety state) The patient is an old woman who describes herself as having been born in "the year of the thunderstorm" (which is estimated to be 1914). She has seven children. Her presenting problem is diarrhoea, cramps in her foot, waist and legs and she experiences palpitations and butterflies in the stomach every evening. At the time of questioning she was receiving treatment for hypertension and complains of "thinking too much."

She describes an attack of, what the traditional healer diagnosed as, *ufufunyane*. She had been hearing voices which she did not recognise, calling her by name. These voices had warned her of the death of her children. She relates that during the period in which she was hearing these voices she had received a wound on her chest (this appeared to be a deep knife wound). She was not aware of how it happened but attributes the wound to the *amafufunyane*. The treatment that she received from the traditional healer made her "vomit out insects."

CASE 18: (Described in 5.2.2) After suspecting that her neighbour was trying to poison her the patient consulted a traditional healer who diagnosed her as having the *ufufunyane*. The proposed treatment was to chase out the *amafufunyane* with the amakhosi which would cost her R150 and which she would receive from the traditional healer on the Thursday following the interview (two days later).[2]

The *amakhosi* is regarded as a milder and less dangerous form of spirit possession and a much easier condition to treat traditionally. The powers of the *amakhosi* may be harnessed and modified to the benefit of the patient (Thorpe, 1982).

CASE 61: This case (female, 26, one child) failed to reach threshold for PSE-CATEGO classification, yet provides an illustration of a form of bewitchment identified by the patient as *impundulu*, for which she received treatment from the traditional healer. She complains that she had been bewitched by a friend in Dimbaza. Among the other problems that she recounted, her husband had been cheating on her and she was wanting a divorce from him, and she had been experiencing heavy bleeding during menstruation.

This case provides the clearest demonstration of how traditional complexes provide a socially acceptable means of expressing distress and identifying the source of this distress. *Impundulu* (the lightning-bird) is a witch familiar which can appear in the form of a beautiful young man. Along with *uthikoloshe*, the *impundulu* is a category of familiar which is highly sexual in nature and with whom witches are believed to have sexual intercourse (Hammond-Tooke, 1975). Hirst (1990) notes that married women may be afflicted by *impundulu*, particularly when their husbands have moved in with another woman and are no longer contributing to the homestead economically.

Bewitchment often involves contact with or ingestion of poisons by the victim. A patient (during the course of conversation and not during an interview) recounted that she knew of someone from whom one could purchase cancer in a bottle. This poison could be used against one's enemies in a number of ways, requiring ingestion or contact. Thus traditional methods of dealing with bewitchment will always involve, among other things, the ingestion of medicines (*imithi* or *amayeza*) to counteract the effects of poisons. It may be that medications received in the PHC setting hold a similar significance. Patients are usually very concerned about receiving some form of medication when they attend the clinic, preferably injections, but pills are also popular (personal communication, clinic staff 1995).

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[2] This case provides an example of a patient moving between medical and traditional services seeking help for the same problem (see 5.6).

Within the context of the present study which views possession states as an indication of distress, symptoms known to constitute these states may present themselves in the PHC setting in a confusing array of physical symptoms. As in the case of 'nerves', this may be effective as help seeking in a medical context.

5.5 PROVIDING A COMPREHENSIVE FRONTLINE SERVICE

Meeting the needs of PHC patients suffering from psychiatric symptomatology requires an understanding of patterns of health service utilisation and patient satisfaction with services. Clearly, these two are interrelated concepts. It has been shown, for instance, that client satisfaction plays a mediating role in relation to continuation and compliance with treatment (two aspects of health service utilisation) (Lebow, 1982). Patients suffering from psychiatric symptomatology may experience the health system differently from other patients if their health needs are not being met and this may be reflected both in patterns of utilisation and satisfaction with the service.

5.5.1 UTILISATION AND SATISFACTION

Health service utilisation has been measured in many different ways in various studies. It was necessary to delimit which aspects of construct would be assessed in this study. Therefore, there are a number of possible relationships which have not been investigated. Yet those relationships confirmed by the results of this study hold important implications for health systems planning in the study area.

Patients with more psychiatric symptomatology were statistically significantly more likely to report receiving treatment for various illnesses. When the results were analysed further it was found that digestive problems in particular accounted for much of the observed variance in that psychiatric symptomatology and reports of receiving treatment for digestive problems were found to be significantly positively related. Shedler et al. (1993) would identify in this finding, what they termed 'the illusion of mental health', which is maintained by people who, although psychologically distressed, do not present as such but manifest with actual physical conditions through defensive denial. In the present study digestive problems, such as duodenal ulcers, may be seen as a predictable outcome of increased and prolonged autonomic arousal through stress.

Using time spent in consultation and number of visits made to the clinic in a month as a measure of clinic resources utilised, it was found that patients with increased psychiatric symptomatology reported spending significantly longer in consultation with the clinic nurse than those with fewer psychiatric symptoms. In terms of their research findings, Escobar et al. (1987) and Katon et al. (1991), explain this relationship by showing that psychiatric distress and somatic symptomatology translate into avid consumption of medical services. This explanation may also hold true for the statistically confirmed relationship between psychiatric symptomatology and patient reports of sick bed days in the present study, as proposed by Sigvardsson et al. (1984), who used a measure of sick leave occasions. Results of the present study show that patients with increased psychiatric symptomatology reported more often feeling sick enough to stay in bed.

While research results do not conclusively show that consecutive attendance is related to psychiatric symptomatology, as indicated by Goldberg et al. (1976), a month may be too short a period over which to reflect clinic attendance. Results also do not support the relationship between psychiatric symptomatology and hospital admissions (contrary to findings of Shapiro et al. [1984]), medication received, or compliance with medical directions. The latter observation may be a function of social desirability bias, in that patients being questioned in the clinic setting may be reluctant to admit to defaulting on treatment.

Any revealed relationship between psychiatric symptomatology experienced by PHC patients and patterns of health service utilisation is likely to be compounded by a number of factors. For instance, Hershorn (1993) found recent life stability to be related to compliance with treatment directions among Community Mental Health Centre intakes and also discusses a number of demographic and socio-economic factors shown to be related to treatment utilization. Joseph and Phillips (1984) document social class, income level, age, gender, and ethnicity as having a differential effects on health service utilisation.

Another related variable is patient satisfaction with health services. The study hypothesised that patients experiencing psychiatric distress and appealing to PHC clinics for help may be less satisfied with the service received, since it is not addressing the whole problem. This relationship presents itself in research results from a previous study showing an association between client satisfaction and symptom amelioration in a general health care setting (Carscaddon et al, 1990).

When this relationship was operationalised for investigation in the present study, though, the

hypothesis was not supported by the findings. Since questioning took place in the PHC clinics, social desirability may have been operating as a response set for patients who were anxious about being too critical of the service. This is one of the drawbacks of using a self-response format for consumer satisfaction surveys as pointed out by Justice and McBee (1978) and Lebow (1982). All items measuring satisfaction were worded positively, whereas negative wording for some items may have detected such response sets.

Nevertheless, consumer satisfaction remains an important consideration in planning for primary mental health care and has been found to reflect characteristics of staff, treatment services, physical environment as well as patient characteristics (cf. Corrigan, 1990).

Descriptive analysis of the results of the consumer satisfaction survey in the present study shows that 36% of patients experienced their consultation periods as too short. Some nursing staff of clinics in urban areas complained of the need to process patients quickly due to the large patient load and staff shortages, which means that there is insufficient time to discuss personal problems in instances where this is suspected to be the case (personal communication, clinic nurses 1995). This provides a possible explanation for why 61% of patients reported that they did not think that clinic staff properly understood their personal problems and 50% reported not being asked about their home and family life. Forty-eight percent of patients did not feel that they could talk privately to clinic staff if they wanted to, which perhaps reflects the crowded conditions in the clinics as well as the interpersonal styles of pressurised clinic staff.

5.5.2 PLANNING FOR PRIMARY MENTAL HEALTH CARE

Katon et al. (1982) suggest that the care-giver in the general health care setting may represent the only stable relationship in the patient's life who may care to listen. From the preceding discussion it would appear that women in particular have a real tendency of expressing suffering through physical affliction, perhaps due to the fact that there are no other socially acceptable outlets for their frustrations. Thus the health care system, the most accessible point being primary health care, becomes particularly crucial in identifying these problems.

This point is highlighted further by the large proportion of patients who were self-referred to the clinic (37%) or referred by a family member (24%), indicating that for most patients the PHC clinic is the first point of contact with the health care system. This contact is likely to set the

tone for future patterns of health service utilisation.

Psychopathology appears to carry a stigma in the *Xhosa* culture and there is a reluctance to admitting to suffering from a mental disorder for fear of being labelled a 'mental case' (personal communication, clinic staff 1995). While 32% of patients sampled in the study indicated that they would not like the rest of the community to know if they, or someone in their family, were suffering from 'nerves', 43% felt this way about 'mental illness' and similarly, 44% in relation to alcoholism. The stigma extends to the family members of an afflicted individual (personal communication, Bitalo 1995). This was often evidenced in the Qumrha psychiatric patients' reports of treatment by other members of the community after their return from the psychiatric hospital. Some reported being treated as social outcasts or being gossiped about when it became known that they had been institutionalised in a psychiatric hospital (personal communication, Qumrha psychiatric patients 1994). This may become as distressing as the original complaint and may contribute to high rates of readmission. Psychiatrists at Fort England complain of problems reintegrating patients back into the community, particularly in substance abuse cases (personal communication, Hirst 1995).

While medical services appear to be largely acceptable to the PHC patients in the study area, as evidenced by the large proportion of patients indicating that they would feel most comfortable consulting with either a nurse (35%) or a doctor (34%), psychiatric services may be seen as alien to normal community processes. This notion is confirmed by research conducted in a Western setting where an ordinary hospital and ordinary doctor were more highly evaluated than a mental hospital and psychiatrist. Further, patients suffering from physical problems were more highly evaluated than were those suffering from mental illness or disability (Graves, Krupinski & Stoller, 1970).

Part of the explanation for this observation in the present study may be found in the physical and functional separation of traditional, PHC and psychiatric services. The local PHC service was completely unaware of the case details of the patients of Psychiatric Community Services, even though psychiatric patients were assessed by a visiting psychiatric nurse in the clinics once a month. In the Qumrha clinic the PHC service is headed by a professional nurse who had received psychiatric training. She expressed her frustration at her inability to work with psychiatric patients in the community because of the way the service is organised. Clearly the solution lies in bringing psychiatric care closer to the community, both physically and functionally,

and in designing a service that is acceptable to its clientele. This means understanding the utilisation of general and mental health services as well as alternative options such as the use of traditional healers, particularly in pluralistic settings (Weiss & Kleinman, 1986).

5.6 UNITING TRADITIONAL AND MEDICAL PRACTICES

Hirst (1990) notes that,

> "..even if successful, Western medical treatment does not necessarily prevent a future recurrence of the illness or misfortune, particularly if it is considered to result from witchcraft and/or neglected ancestral spirits." (p.72)

Often Western and traditional healing services are used simultaneously or in some combination. In the present study it was more often the case that if medical help failed, traditional healers were consulted. Farrand (1984) reports that some black patients falling ill first went to outpatient services and if the condition did not improve this would be taken as an indication that the problem lay in the domain of traditional healing. In addition, a large proportion of psychiatric patients would prefer to consult with both psychiatrists and traditional healers (Farrand, 1984). Hirst (1990) notes that consulting Western and traditional healers simultaneously was seen to cross one's bets of being cured.

It is the case that, while Western medicine may be able to address physical and psychological conditions, the causes of the illness, in terms of the traditional belief system within which the patient is operating, may not be sufficiently addressed. This may hamper full recovery and open the way for misunderstanding and misinterpretation (Farrand, 1984). The following case demonstrates this point.

CASE 62: The patient (female, 24, PSE-CATEGO classification of manic- or mixed-affective psychoses) complains of family and boyfriend problems as well as having to drop out of school because of there being no money. She has a child but it is staying with the father and she is worried about this. She reports symptoms of anxiety and feelings of loneliness. She receives the nuristerate injection (hormonal contraceptive) from the clinic. She complains that she has been vomiting blood and thought that this was the blood that she was supposed to be menstruating. She explains that when she told this to the clinic sisters they said that this was incorrect and that the blood should be coming out of her ears and nose if this was the case.

This form of hormonal contraceptive has, as one of its side effects, the cessation of menstruation. It was not clear whether this is really the explanation given by the clinic sister or if what had been

said was misinterpreted by the client. Considering the presence of clear anxiety symptoms, it is possible that this patient is suffering from a stomach ulcer as she reports receiving treatment for digestive problems on item 9 of the SRS.

There appears to be an increased interest in the integration of biomedicine with traditional healing practices and various authors have considered options for the creation of a mutual referral network between Western medical practitioners and traditional healers (cf. Swartz, 1987). A closer look at traditional healing practices in the Eastern Cape Region, in the light of problems presented by patients in the PHC settings, shows that integrating the services may provide an worthwhile challenge in addressing the psycho-social needs of patients attending PHC clinics in the study area.

5.6.1 THE TRADITIONAL HEALING APPROACH

One of the fundamental distinctions between Western and traditional healing approaches is the conception of causation. Ethnographic and psychological literature indicates that the traditional healing approach will normally locate the source of illness, distress or misfortune external to the individual. The traditional *Xhosa* healing approach generally works from the position of external causation for personal distress, illness or misfortune. This is evident in the explanations and recommended treatment. Traditional healing approaches normally include some combination of herbal medicine and ritual (personal communication, Hirst 1995). The articulation of personal distress in physical terms is more accessible to the position of external causation.

Hirst (1990) and Low (1985) describe how illness and misfortune among the *Xhosa* speaking peoples is considered to be an iatrogenic response to conflict within the social network. The source of the conflict within or outside of the family will determine the symptom complex, diagnosis and treatment. This would appear to be consistent with patients' tendency to somatise personal or psycho-social distress, and with the traditional treatment regimen which combines ritual and herbal medicine.

The diviner plays a central role within the traditional belief system by interpreting the cosmological universe and mediating the relationships between human beings and the cosmological elements (Hammond-Tooke, 1975). At all times the diviner works, not only from his/her position as a member of the community and the social networks which constitute and

extend beyond the community (Hirst, 1993a), but also from a position of authority legitimated by the ancestral shades through the experience of *thwasa* (cf. Hirst, 1990 for a description of terms relating to the condition of *intwaso*).[3]

Hirst (1993b), on the basis of field observations of the work of traditional healers in the Eastern Cape Region, is able to identify two levels on which the traditional healer (diviner) deals with psycho-social problems. On the conceptual level the diviner interprets the client's experience of illness and misfortune in terms of ancestral wrath and witchcraft which constitute a set of culturally shared beliefs. On the social level the diviner mediates the social relations and social behaviour of clients.

Patients consult the traditional healer along with a whole range of individuals with whom the patient participates in daily life - relatives and friends know something about the difficulty being experienced (Hirst, 1993b). This practice recognises the importance of one's social network in both diagnosing and redressing complaints.

In the traditionalist worldview or cosmology rituals play an important role in the passage from one life stage to another during the course of the life-cycle. Ritual therapy also plays an important role in the traditional healing process and appears to perform two functions; it reestablishes one's spiritual links to the ancestors as well as one's status within the social order through the participation of significant others in the ritual (Hirst, 1990).

After considering the difference between medical and traditional methods of interpreting a psychiatric case, Kahn (1994) remarked that the most obvious distinguishing feature was that "the diviners grounded the patient's experiences within (his/her) social situation" and that "the interaction alone seemed to provide her some relief from (the) condition" (p. 39).[4] An important part of divination is the explanation given for why the illness or distress occurred, providing an interpretation and cure within the traditional belief system (Farrand, 1984). Consequently, there

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[3] This experience entails some personal suffering and interpersonal and social conflict, which is finally resolved through ritual. Through this ordeal the diviner gains a deep understanding of interpersonal and social relations (Hirst, 1993). *Thwasa* represents a calling to become an *igqirha* (diviner) (Schweitzer & Buhrmann, 1978). Dreams are seen to provide insight into the person's condition since they are regarded as messages from the ancestors (Buhrmann, 1977; Hirst, 1990 & 1993b).

[4] Perhaps it is significant that in the present study some patients expressed feeling relieved at having had the opportunity to talk about their problems during the interview.

is likely to be some correlation between local forms of distress, and indigenous methods of diagnosis and treatment (Kirmayer, 1989).

Schweitzer (1985, p. 35) notes that; "...the healer is responding to a fundamental human need, which is to live within a meaningful and coherent world." By situating the individual's suffering within the realm of meaningful experience, the diviner is able to define the individual's relationship with the community and with the spiritual world.

5.6.2 PRIMARY MENTAL HEALTH CARE IN THE EASTERN CAPE REGION

In the present study it was found that very few patients indicated feeling most comfortable consulting with a traditional healer (1.5%). Previous research has indicated that the use of traditional healers is under reported in general population samples (cf. Swartz, 1987). This tendency may be especially marked in the present study considering that the survey was carried out in a medical setting. At present the medical practice does not recognise traditional practices and patients may be reluctant to indicate use of them. While there exists some tension between the traditional and medical practices, it has been argued that both practices are widely used, often simultaneously (personal communication, Bitalo 1995) and not exclusively by blacks, but by coloureds and some whites as well (personal communication, Hirst 1995).

In recognition of the potential benefits of opening up the channels of communication between the two practices, the Department of National Health Care has introduced a programme intended to promote interaction between traditional healers and professional nurses in the Eastern Cape which is being piloted in Zwelitsha near King William's Town. It envisages a two-way interaction where traditional healers become instrumental in referring patients to the appropriate health facilities where necessary and nurses consult with traditional healers in deciding on case management (personal communication, Bitalo 1995). Such a model exists in Ghana where care for the mentally ill is shared between the traditional healers (including 'healing churches') and the medical services (Community Psychiatric Programme) (Osei, 1994).

This approach may be seen as an attempt to extend the arms of a PHC service that is already over-extended and under-resourced. Very few respondents reported being referred to the clinic by community health workers (4.4%). National statistics show that only 9% of people sampled

in a health poll conducted by the NPPHCN[5] had been visited by a community health worker and that this figure was somewhat lower for blacks living in the rural areas (Hirschowitz, Orkin, Morake et al., 1994). Traditional healers may be more effective in reaching a larger proportion of the population, yet remaining an integral part of the community and its processes.

The results of a recent study conducted in the Cape Town area, and arguably as applicable to the Eastern Cape Region, show that clinic nurses in the study only spend around 52% of their time in direct patient care due to the pressures of administrative tasks, and only a small portion of this time was spent in health education and patient counselling. This means that activities requiring expertise such as patient counselling, are delegated to less qualified staff (Dick & Pekeur, 1995).

Yet there remains an important need to extend both the reach of the PHC service as well as the range of services provided. In an HSRC[6] study conducted in the catchment area of Fort England Psychiatric Hospital in the Eastern Cape Region it was found that the need for psychological services in PHC clinics was recognised by 75% of clients of the Psychiatric Community Services and that a full 98% would like to have all services provided in a central place, even if it meant travelling further (Esterhuysen & Levin, 1995).

The ideal of accessible and acceptable primary mental health care has yet to be realised in the area described in the present study. Future research in this direction may consider the task of defining the characteristics of high risk individuals and groups to aid the design and institution of preventive strategies. Research in this area may also focus on developing simple screening methods suitable for cross-cultural assessment of psychiatric distress at PHC level. The starting point for such an undertaking would be a critical analysis of existing instruments.

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[5] National Progressive Primary Health Care Network

[6] Human Sciences Research Council

CHAPTER 6 - CRITICAL EVALUATION OF THE INSTRUMENTS

Factors relevant to the administration of the psychiatric screening instruments in a cross-cultural research context are explored in terms of both content and process. This is considered necessary in establishing the value of the study as well as the value of the instruments for cross-cultural research.

In the PHC clinic setting patient administration is executed by nursing assistants and clerks. Patients then consult with the professional nurses. This system of patient management appears to function efficiently. Consultation periods are, however, brief with most patients reporting spending no more than five minutes with the health care practitioner. In terms of the research process, this meant that the administration of questionnaires had to be kept brief and simple, which limited the size of the instruments that could be used.

One of the most important considerations in translating the instruments for use in this study was the wide variation in the versions of *Xhosa* spoken by the rural and urban people, and the young and the old. This distinction is referred to in local terminology as '*Xhosa A*', the traditional version spoken in the rural areas, and '*Xhosa B*', that spoken by the urban people and by the younger generation. It is widely recognised that *Xhosa B* is a much simpler dialect than *Xhosa A*, the latter being complicated with traditional idioms and metaphors as well as the use of terms of respect (*ukuhlonipha*).[7] This is the practice of avoiding certain phonemes which sound similar to those contained in the patriarchal clan names. Women are particularly bound by this custom and become extremely deft at articulating themselves around these sounds. To the untrained ear *Xhosa A* almost sounds like another language.

The Komgha, Qumrha, Kei-Road, Emthonjeni and Tyutyu clinics, draw their patients from the surrounding rural areas in a radius of 60km, while the clinics in the town service a predominantly urban clientele. Translation of instruments was thus effected by a group of community workers who are familiar with the people of the area. The fieldwork required a fieldworker who was able to communicate in both the dialects identified.

While overt refusal to participate in the research process was infrequent, some patients exhibited a passive resistance to co-operate and would leave the clinic after completing their

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[7] cf. Mayer, 1961. Townsmen or Tribesmen. London: Oxford University Press.

questionnaires, without waiting to be invited to participate in the interview. On three occasions, it become apparent after a few lines of questioning that the patient was resisting full participation in the interview by using a response set or failing to respond to questioning, in which case interviewing was terminated. Together these instances accounted for the non-consents and the number of interviews on which it was suspected that some answers may have been misleading.

6.1 EVALUATION OF THE SRQ

Positive and negative factors relating to the use of the SRQ (see appendix 3) and which have relevance to the results of the present study are dealt with in section 3.4.1.

Eighteen of the 57 patients tested on the PSE were false-positives according to the PSE-CATEGO criteria for diagnosis. It is, however, not possible to calculate the actual false positive rate of the SRQ in this setting using the PSE as a criterion measure due to the high rate of non-consents in the second stage screening and no control group of PSE interviews for patients scoring below threshold on the SRQ.

Ratings on items 21-25, which are supposed to detect psychotic symptoms and epilepsy, may be culturally biased and were found to be over-rated in the present study. These items are therefore not considered reliable indications of psychiatric distress in the present context.

Interference with thinking (item 23), auditory hallucinations (item 24) and convulsions and fits (item 25) have correlates in traditional symptoms (see 5.4). Persecutory delusions (item 21) may be explained in terms of traditional beliefs in witchcraft and ancestral wrath (see 5.4.3). Item 22 is the most frequently endorsed of the psychotic items. A positive response to the question, "Are you a much more important person than most people think?" appears to run counter to the norms of respect that constitute traditional custom. However a closer look at the context of this response may reveal the position of unempowerment occupied by women and especially by people who have nothing of material worth by which to measure their status in the community (see 5.2).

Item 13, using the term 'daily work' which was frequently interpreted as referring to occupational functioning, may have caused some confusion since most of the respondents were unemployed. However, examination of the response pattern does not reveal anything out of the ordinary, since

there is a 100% response rate to this item.

These comments also apply to the use of a translated version of the PSE in the same setting, which contains some similarly worded items (cf. Gillis, Elk. Ben-Arie et al., 1982).

6.2 THE PSE IN A CROSS-CULTURAL CONTEXT

The use of the PSE in this study is discussed and compared with previous studies conducted in South Africa which have investigated the suitability of the PSE for use as a diagnostic tool in a cross-cultural context (Gillis et al., 1982; Swartz, Ben-Arie & Tegin; 1985; Buntting & Wessels, 1991).

All make the point that language, culture and the real life experiences of respondents are important in the translation of the PSE. Gillis et al. (1982) examined a *Xhosa* version of the PSE and Buntting and Wessels considered a *Zulu* translated version. While English and Afrikaans share similar roots, translation into a black language is a much more difficult task (Swartz et al., 1985). The points raised in these studies are generally applicable to both *Xhosa* and *Zulu* translations because of their similarity and shared derivation (Nguni). Further culturally relevant factors relate to the process by which the instrument is supposed to be administered.

6.2.1 LANGUAGE FACTORS

A comparison of the language and conceptual difficulties identified by Gillis et al. (1982) and Buntting and Wessels (1991) with those identified in this study paints a very similar picture. Although the psychotic states were not rated very often due to the non-clinical nature of the sample, with the exception of those questions relating to delusions of persecution and hallucinatory experiences, it was confirmed that items relating to emotional states were more difficult to translate and score. (See appendix 11 for PSE items referred to in the text.)

Certain words such as 'anxiety' and 'worry' (item 4) and depression (item 23) have no *Xhosa* equivalent. In these cases alternatives were used '*ukukhathazeka*' (heart sore) and '*umoya phantsi*' (meaning low spirits) which were considered to convey the meaning adequately. Buntting and Wessels (1991) note that, while worry or anxiety is more of a cognitive function in English, in *Xhosa* and *Zulu* it is related more to the heart. 'Yet when asked, "what is it like when you

worry?" patients would frequently respond, "I am thinking too much." 'Thinking' would appear to refer to the problems identified as causing the worry. Frequently patients would report thinking too much in relation to states such as *umbilini* (nerves) which had autonomic correlates like butterflies in the stomach, choking and palpitations.

Patients frequently affirmed feeling particularly cheerful without any reason (item 41), further investigation would reveal, however, that the cause was something like cleaning the home (a response frequently encountered) or being with friends.

Items relating to obsessional states (items 44, 45 & 46) were always answered affirmatively and had to be assessed using hypothetical prompts, e.g. item 44: "How many times do you go back and check that the stove is turned off or that your front door is locked?" Similarly, items 47, 48 and 49, relating to derealization, depersonalisation and delusional mood, would be consistently affirmed. Further questioning would reveal a very literal interpretation "the world is changing too quickly", "the young no longer have respect for the older generation", "when I am thinking too much", "when I am lonely."

6.2.2 FACTORS RELATING TO LIFE EXPERIENCE

The PSE makes reference to certain experiences and objects which are assumed to constitute part of the lifestyle of all respondents. This, however, is an assumption that does not hold true for many of the patients visiting PHC clinics, especially those from the rural areas not familiar with lifts, tubes (item 14), television, newspapers (items 20 and 73) and robots (item 71). In these instances, another analogy would have to be found. For example, in assessing concentration one would have to ask illiterate patients to what extent they are able to stay with a conversation or how easily they are able to follow a story being related by someone.

Similarly, rating weight-loss due to poor appetite (item 34) requires an estimate in kilograms or pounds. Not only do most respondents not have scales, but most seemed not to be concerned about their weight according to Western standards. The question was, therefore, rephrased; "Have your friends commented about your weight? Are your clothes getting looser on you?"

6.2.3 CULTURAL FACTORS

Even the notion of 'time' is subject to a different conception than that which assumes a linear progression. The findings of this study are consistent with those of Gillis et al. (1982) who found time to be judged in terms of events, which problematises PSE questioning into the onset and duration of symptoms. For an illustration of such a conception, when asked her age an old rural woman replied that she was born in "the year of the thunderstorm." When the fieldworker enquired from the clinic staff as to the age of the patient the nurse on duty produced a chart which listed a number of events, with their corresponding dates, to which patients frequently refer when relating time periods.

This conception of time also problematised ratings of hopelessness (item 24); "How do you see the future?" Often patients did not appear to have a clear conception of their future. This item then had to be reworded to take on a more literal meaning; "If you look at the years ahead do they look bright or dark to you? Why?"

Beliefs which constitute part of the witchcraft or ancestor complex (central to traditional *Xhosa* cosmology) are very much a part of the real life experiences of many of the patients interviewed. Patients would almost always provide an affirmative answer to item 12 rating anxious foreboding and consistently report a stereotyped set of autonomic accompaniments consisting of palpitations, choking, butterflies, difficulty breathing, etc. Forebodings are sent from the ancestors in the form of dreams and visions (personal communication, Hirst 1995).

Within this cosmological system it is not uncommon to hear the voices of ancestors calling to the individual. These experiences normally occur in dreams and this was used as a means of distinguishing culturally determined experiences from hallucinatory ones as assessed by items 60-70. This is, however, not a hard rule and many experiences were difficult to identify as either culturally related or psychotic, e.g. tactile and olfactory hallucinations, pseudo hallucinations (where it was difficult to determine if the sound was heard through the ears or in the head), and sounds like knocking or buzzing. While item 64 provides the opportunity of identifying the experience as sanctioned within a sub-cultural group, Swartz et al. (1985) make the point that this does not influence the diagnosis in terms of the PSE-CATEGO system and, further, that *Xhosa* culture may not be considered a sub-culture according to the definition.

Dhadphale et al. (1983), in a survey of general out-patients in Kenya had attempted to address these problems by adding 'bewitchment' as a symptom to the Standard Psychiatric Interview (SPI), which they used as a second-stage screening instrument.

In a culture centered around the principle of '*uBuntu*' suggestions of grandiose delusional states (items 43, 75, 76 & 77) following questioning into expansive mood and ideation (items 41 & 42) were denied consistently. There is no direct English translation of the term *uBuntu*. It refers to humanity with all its moral and ethical trappings, and embodies notions of community, sharing, co-operation and respect. The ancestors are seen as giving people special talents (cf. Hirst, 1990). Talents and powers do not appear to be considered implicit to any individual.

Consistent with this interpretation is the tendency for patients to become confused when presented with item 29 ("What is your opinion of yourself compared to other people?"). Gillis et al. (1982, p.146) note that such comparisons are problematic because "there is a strict and complex hierarchy of age, life development and status among the *Xhosa*" and to put oneself above others, "lays oneself open to envy and possible malevolent action."

Among the older generation and married persons from the rural areas there exists a strong inhibition to discussing personal sexuality and family problems with strangers. These issues are discussed in veiled terms because of the norms of respect. Caution had to be exercised when tackling this line of questioning, where a direct translation of items 38 and 39 relating to pre-menstrual exacerbation and loss of libido would have caused offense and possible non-co-operation.

6.2.4 PROCESS FACTORS

In terms of the process according to which the PSE is to be administered, problems related to the interrogative style of administration, embarrassment about revealing traditional beliefs and confidential information in a medical setting and the length of the interview were identified during fieldwork.

Buntting and Wessels (1991) make the point that norms of respect preclude overt display of affect in the presence of strangers and lengthy eye contact. Patients' unempowerment in relation to the medical profession may have exacerbated this problem in some instances where patients

would sit very still and look at the ground during interviewing, answering questions posed in a monotonous voice. In this regard, caution had to be exercised when rating observed depression and blunted affect (items 121 and 128). Perhaps consistent with this finding was the observed reluctance of patients to openly refuse the interview. Patients not willing to participate would either leave without one of the fieldworkers noticing or refrain from answering questions posed to them. To overcome the possibility of defensive response to the style of questioning, interviews proceeded by first prompting the patient to construct a frame of reference within which to position the interview. In some instances, it became apparent that real emotional contact had been made with patients who would become tearful or cry when discussing sensitive issues. In such cases, fieldworkers would divert from the PSE format to some extent and reassure the patient.

While both the SRQ and PSE present certain problems when applied in the context of the present study, these are not insurmountable and on the whole they are considered adequate in eliciting psychiatric symptoms. Future research may engage itself in investigating options for modifying the instruments to make them more suitable for detecting psychiatric distress in the present context as well as gathering the normative data required before inferences of prevalence of psychiatric illness can be made on the basis of psychiatric screening.

CHAPTER 7 - CONCLUSIONS

The outcomes of the study may be summarised into the following set of findings and conclusions:

1. Research literature has shown that psychiatric problems are more widespread in general community and PHC populations than psychiatric clinical records would seem to indicate. It has also been shown in the literature that while psychoses are relatively rare, affective and anxiety disorders make up the bulk of psychiatric morbidity occurring among the PHC patient population. Also, psychiatric problems in PHC may present with fewer, minor and more non-specific symptoms than those occurring in clinical settings; therefore, not always reaching threshold for diagnosis as mental disorder. Most psychiatric screening instruments have, however, been developed using samples of clinical patients, which problematises the task of identification of psychiatric distress in the PHC setting.

   The mode of presentation and patient characteristics identified in the present study, as well as health practitioner characteristics described by previous research may all influence the likelihood of detection in PHC settings. The present study produced evidence that these symptoms cause significant distress to PHC patients and research literature shows that these may develop into more chronic conditions if not treated at an early stage.

2. PHC is arguably the most effective means of bringing a comprehensive and relevant health service to the greatest number of people. This is especially so in the study area where a large proportion of the patient load comes from the rural areas which are under-serviced and largely inaccessible. Specialist services are situated in the urban centres and private health care is available only to the privileged few. Some statistics cited (5.6), including the results of the survey of patient preferences for consultation in the present study and the impressions of primary care nurses interviewed, indicate that PHC services have wide acceptance by the local communities and are both geographically and functionally more accessible to these communities. On the other hand, it would appear that psychiatric services, which are administered separately to PHC and which function mainly as a referral service, are less accessible and stigmas attached to mental illness make them less acceptable to local communities, as has been found in research conducted in other parts of the world. The argument has been presented that integrating community psychiatric services into PHC provision would increase the relevance,

acceptability, accessibility and effectiveness of the health care service as a whole.

3. It has been shown that psychiatric problems occurring in PHC settings in the study area have identifiable socio-demographic correlates (see 5.2). The population under study experience many of the socio-economic stressors that have been shown to be related to increased levels of psychiatric distress, including low employment and educational levels, family breakup and marital disharmony. These risk factors, together with rapid social change, evidenced in high rates of urbanisation, changes in traditional family and economic systems, and political change, increase the vulnerability of the population to psychiatric distress.

4. Psychiatric problems in the study area have identifiable modes of presentation. Consistent with research literature from general health care and PHC settings in both Western and developing countries, the distress was commonly presented in the present study in a somatic mode. The most common somatic complaints presented include decreased energy levels, headache (and various other tension pains) and stomach discomfort (see 5.3.1). Psychiatric symptomatology was shown to be significantly correlated with digestive problems, possibly a psychosomatic manifestation. These symptoms show some similarity with traditionally defined symptom complexes, including 'nerves', and some possession states resulting from bewitchment (see 5.4). It has been suggested in the present study that somatic presentation may reflect a more sophisticated mode of expressing psycho-social distress than was previously thought to be the case, which demands of researchers and PHC workers specific local ethnographic knowledge in interpreting complaints. Somatic presentation may also reflect the help seeking behaviour of the unempowered, who are most likely to be responded to in the PHC setting if the presenting complaint is one of a physical nature.

5. The observed relationship between psychiatric problems and certain aspects of health service utilisation suggests that undetected psychiatric symptomatology may constitute a drain on health service resources (see 5.5.1). PHC patients with psychiatric symptomatology appear to be more avid users of health resources, as reflected in time spent in consultation and the number of physical illnesses being treated. Further, the resources used may be less than effective in dealing with the real problem, since psychiatric patients report more sick bed days. These observations hold important

implications for health systems planning in that part of the problem lies in failure to detect psychiatric problems. Staff not trained in psychiatric case detection and pressurised with a large patient load are not in a position to identify problems of a social or emotional nature, as reflected in the large number of patients indicating that they did not feel that clinic staff properly understood their personal problems. Planning for a stronger, more integrated referral structure would be a priority area in streamlining health service utilisation for patients with psychiatric symptomatology.

6. The facilitation of closer co-operation between traditional and medical practices may extend resources and address patient needs. An analysis of the traditional healing approach shows clear similarities with psychological approaches such as family therapy. (see 5.6.1). Patients may attend both traditional and medical practices in an attempt to increase the likelihood of recovery, or if medical treatment is found not to be having the desired effect. Traditional healers, from their position as members of the community and legitimated mediators of social and spiritual relationships, are arguably likely to have a more sophisticated understanding of the psycho-social dynamics within a particular community. Co-operation between the two practices in the study area is minimal and patients are reluctant to admit using traditional healing services in a medical setting because of the perceived tension which presently exists between the practices.

7. Psychiatric screening instruments developed in other parts of the world, while suitable for detecting psychiatric symptoms in the present context, may present some problems of interpretation in the *Xhosa* translations (see ch. 6). Although SRQ items are translated relatively easily, psychotic symptoms supposed to be measured by items 21-25 constitute features of local cultural experiences and therefore their validity in the context of the present study is considered questionable. Certain items constituting the translated version of the PSE were found to be problematic when applied in the context of the study area due to semantic, life experience, cultural and process features of the instrument. The effects of these factors were dealt with to some extent in the present study, but before researchers may consider prevalence data from results of psychiatric screening in this setting, more valid and reliable research is required in gathering normative data and possibly modifying the instruments accordingly. Research may also focus on developing new and simpler instruments of case detection which may be used by both PHC workers and researchers in identifying PHC patients in need of psychiatric treatment.

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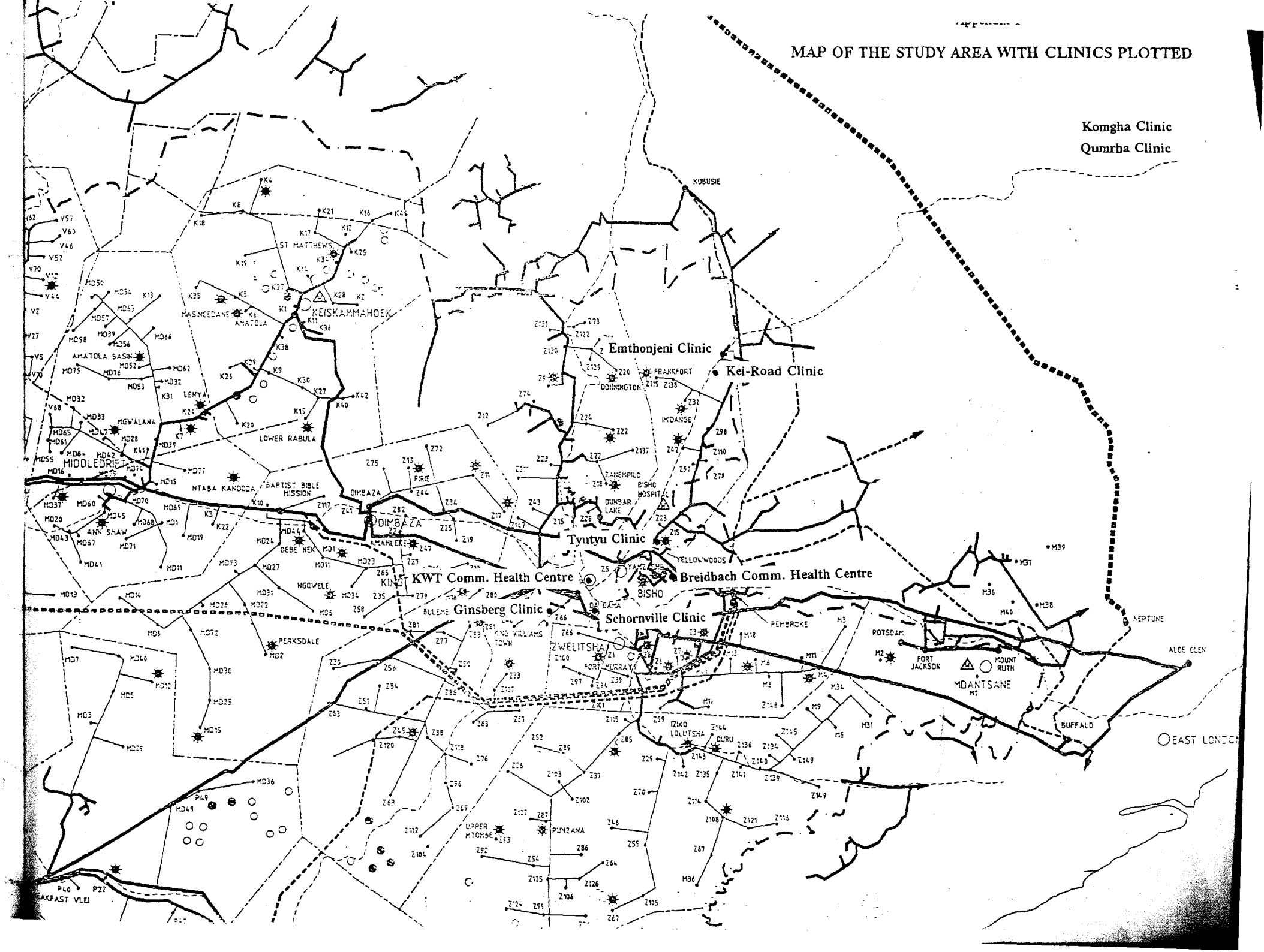
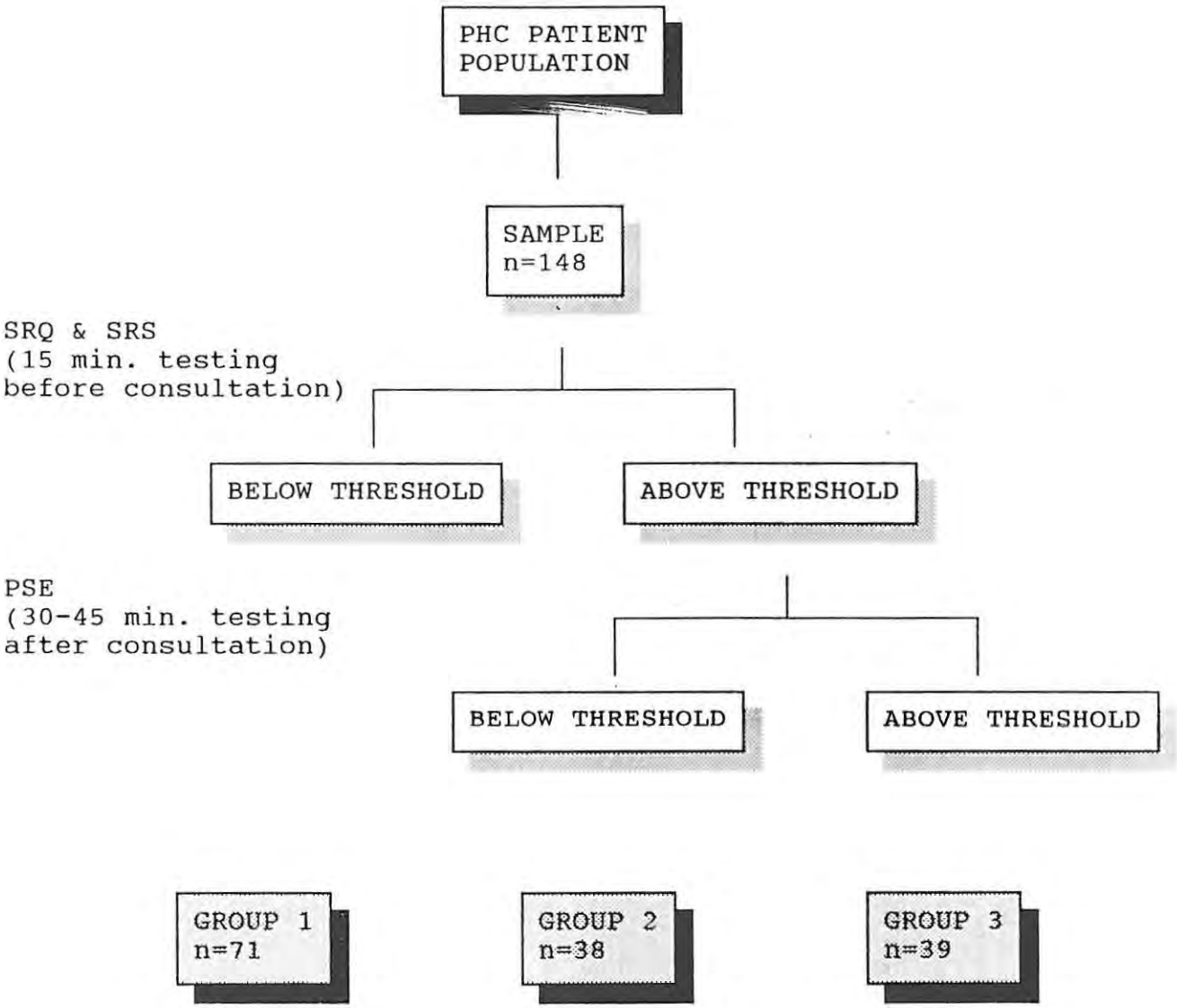
MAP OF THE STUDY AREA WITH CLINICS PLOTTED



Appendix 2

DIAGRAMMATIC REPRESENTATION OF THE RESEARCH DESIGN



Appendix 3

SELF - REPORTING QUESTIONNAIRE (English version)

Please answer each of the following questions by placing a X in the correct space. All of your responses will be kept confidential.

1. Do you often have headaches?

YES		NO	

2. Is your appetite poor?

YES		NO	

3. Do you sleep badly?

YES		NO	

4. Are you easily frightened?

YES		NO	

5. Do your hands shake?

YES		NO	

6. Do you feel nervous, tense or worried?

YES		NO	

7. Is your digestion poor?

YES		NO	

8. Do you have trouble thinking clearly?

YES		NO	

9. Do you feel unhappy?

YES		NO	

10. Do you cry more than usual?

YES		NO	

11. Do you find it difficult to enjoy your daily activities?

YES		NO	

12. Do you find it difficult to make decisions?

YES		NO	

13. Is your daily work suffering?

YES		NO	

14. Are you unable to play a useful part in life?

YES		NO	

15. Have you lost interest in things?

YES		NO	

16. Do you feel that you are a worthless person.

YES		NO	

17. Has the thought of ending your life been in your mind?

YES		NO	

18. Do you feel tired all the time?

YES		NO	

19. Do you have uncomfortable feelings in your stomach?

YES		NO	

20. Are you easily tired?

YES		NO	

21. Do you feel that somebody has been trying to harm you in some way?

YES		NO	

22. Are you a much more important person than most people think?

YES		NO	

23. Have you noticed any interference or anything else unusual with your thinking?

YES		NO	

24. Do you ever hear voices without knowing where they come from or which other people cannot hear?

YES		NO	

25. Have you ever had any fits, convulsions or falls to the ground, with movements of the arms and legs, biting of the tongue or loss of consciousness?

YES		NO	

Appendix 4

THE SELF-RESPONSE SCHEDULE (English version)

Please answer each of the following questions by placing a X in the correct space(s), for example:

1. Are you male or female?

male	
female	

All of your responses will be kept confidential.

PERSONAL PARTICULARS

2. How old are you? _____

3. How many dependent children do you have?

none	
one	
two	
three	
four	
five	
six	
more than six	

4. What is your marital status?

married	
divorced	
widowed	
unmarried	
separated	

5. Are you;

employed?	
unemployed?	
pensioned?	

6. What is your level of education?

none			
sub A			
sub B			
std 1		std 6	
std 2		std 7	
std 3		std 8	
std 4		std 9	
std 5		std 10	
		tertiary	

7. How many times did you fail at school?

none	
once	
twice	
more than twice	

HEALTH SERVICE UTILIZATION

8. What services do you receive from the clinic?

family planning	
pregnancy / mother care	
care of infants and children	
geriatric care	
psychiatric care	
minor ailments	
other (please state)	

9. Have you ever received treatment for any of the following conditions?

tuberculosis (TB)	
arthritis	
circulatory / heart problems	
diabetes	
digestive problems	
respiratory problems	
other (please state)	

10. How often do you visit the clinic?

less than once a month	
once a month	
more than once a month	

11. Do you keep your appointments?

yes	
sometimes	
never	

12. How long do you spend in consultation?

5 minutes	
more than 5 minutes	
more than 15 minutes	
more than 30 minutes	

13. Do you feel that your consultation periods are;

too long?	
too short?	
just right?	

14. Do you receive medication and/or injections?

yes	
no	

15. Do you take your medication as prescribed?

yes	
sometimes	
never	

16. Have you ever been hospitalized?

yes	
no	

17. If "yes"; how many times? _____ ____

18. For approximately how long? _____

19. Have you ever received treatment for an emotional or nerves problem?

yes	
no	

20. If "yes", where?

primary health care clinic	
psychiatric community clinic	
general hospital	
psychiatric hospital	
traditional healer	
herbalist	
church minister	
village health worker	
other (please state)	

21. How often do you feel sick enough to stay in bed?

never	
sometimes	
most of the time	

22. Who would you feel most comfortable consulting with?

nurse	
doctor	
social worker	
community health worker	
church minister	
traditional healer	
herbalist	
other (state)	

QUALITY OF THE SERVICE

23. Are you greeted by name at the clinic?

yes	
no	

24. Are you addressed in your own language at the clinic?

yes	
no	

25. Has your illness and medication been properly explained to you?

yes	
no	

26. Do the clinic staff ask you about your home and family life?

yes	
no	

27. Can you speak privately to any of the clinic staff if you want to?

yes	
no	

28. Do you think the clinic staff properly understand your personal problems?

yes	
no	

29. Would you like other members of the community to know if you or one of your family suffered from;

	yes	no
nerves?		
mental disease?		
alcohol?		

30. Who told you to come to the clinic?

community health worker	
nurse	
community member	
family member	
traditional healer	
church worker	
self	
other (please state)	

Appendix 5

SCHEDULE FOR SEMI-STRUCTURED INTERVIEW WITH CLINIC STAFF

1. What mental health training, if any, have clinic staff undergone?

2. What percentage of the patient load for this clinic are male/female?

3. What percentage of the patient load for this clinic are adults/children?

4. What percentage of the patient load for this clinic are blacks/coloureds/whites?

5. From which areas/communities does this clinic draw its patient load?

6. What services do you think are most required by the community serviced by this clinic?

7. What are the most pressing social problems experienced by the community serviced by this clinic?

8. Do you experience any problems in accessing the entire community? Explain.

9. Do you experience any difficulties in delivering primary health care services to the community? Explain.

10. If mental health services are provided, what is their nature?

11. Under what circumstances would you refer a patient presenting with suspected psychiatric symptomatology?

12. Where would you refer a patient presenting with suspected psychiatric symptomatology?

13. How are mental health care services administered in relation to primary health care services in the community?

14. Apart from their physical problems, do you ever discuss other problems of a social or emotional nature with patients?

15. Do you think there is a need for mental health services at a primary health care level?

Appendix 6

PSE-CATEGO OUTPUT TABLE FOR THE PILOT STUDY

PATIENT	PSE SCORES				TOT.	ID	CATEGO SUBCLASS(ES)		CATEGO CLASS(ES)		TENTATIVE DIAGNOSIS
1	2	7	13	21	43	8	NS+		S+		295.3
2	0	0	7	15	22	6	SD+		N+		300.4
3	0	7	9	24	40	8	UP?	RD+	O?	R+	296.2 OR 300.4
4	0	0	3	17	20	4	PN+		A+		
5	2	4	7	14	27	6	DS?		S?		295.3
6	0	0	8	16	24	7	RD+		R+		296.2 OR 300.4
7	0	0	4	12	16	5	ND+		N+		300.4
8	0	0	0	6	6	3	XN		X		
9	0	1	8	9	18	5	UP?	SD+	O?	N+	300.4
10	0	0	2	7	9	4	AN+		A+		
11	1	2	5	5	13	5	RS+	ND+	O?	N+	300.4

Appendix 7

PSE-CATEGO OUTPUT TABLE FOR THE MAIN STUDY

PATIENT	PSE SCORES	TOT.	ID	CATEGO SUBCLASS(ES)	CATEGO CLASS(ES)	TENTATIVE DIAGNOSIS
1 (2)	0 2 4 6	12	5	HM+	M+	296.1
2 (7)	0 8 7 18	33	7	MN?	M?	296.1
3 (10)	0 5 3 8	16	5	MN?	M?	296.1
4 (12)	3 4 8 24	39	7	NS+	S+	295.3
5 (15)	1 3 1 1	6	5	MN+	M+	296.1
6 (20)	0 2 6 19	27	6	SS RD+	O? R+	296.2 OR 300.4
7 (21)	0 1 6 11	18	7	RD+	R+	296.2 OR 300.4
8 (22)	0 0 9 15	24	6	ND+	N+	300.4
9 (26)	0 0 5 10	15	6	AN+	A+	300.0
10(33)	0 0 2 7	9	4	SD+	N+	
11(38)	0 2 3 9	14	5	RD+	R+	296.2 OR 300.4
12(43)	0 2 2 11	15	5	HM+	M+	296.1
13(45)	0 2 5 12	19	5	HM+	M+	296.1
14(47)	0 1 8 12	21	6	RS+ ND+	O? N+	300.4
15(48)	0 1 1 7	9	5	HM+	M+	296.1
16(49)	1 0 1 8	10	5	PD+	D+	296.2
17(51)	0 4 2 4	10	5	AN+	A+	300.0
18(52)	2 7 10 13	32	7	DP?/AP?	P?	297.9
19(53)	0 5 2 17	24	5	MN?	M?	296.1
20(59)	0 9 6 5	20	6	MN?	M?	296.1
21(60)	0 3 8 17	28	6	RS+ RD+	O? R+	296.2 OR 300.4
22(61)	0 0 0 8	8	3	XN	X	

23(62)	0	3	6	13	22	6	HM+	M+	296.1
24(65)	0	1	1	7	9	3	XP	O?	
25(67)	0	2	5	10	17	4	SS RD?	O? N?	
26(68)	0	2	1	9	12	5	HM+	M+	296.1
27(70)	0	3	5	12	20	5	UP? PN+	O? A+	300.2
28(73)	0	0	0	6	6	3	XN	X	
29(76)	4	8	21	28	61	8	NSMN/DSMN	S+	295.3
30(80)	1	6	12	23	42	8	DP?/AP?	P?	297.9
31(84)	0	2	3	12	17	5	RD?	N?	
32(86)	0	0	0	3	3	2	XN	X	
33(87)	1	2	7	13	23	6	DP?/AP?	P?	297.9
34(94)	0	3	1	10	14	4	UP? RD?	O? N?	
35(95)	0	2	0	0	2	2	XP	O?	
36(97)	0	2	8	18	28	7	UP? SD+	O? N+	300.4
37(98)	0	3	2	6	11	5	RS+ AN+	O? A+	300.0
38(102)	0	3	5	15	23	7	RD+	R+	296.2 OR 300.4
39(109)	1	7	16	24	48	7	PD+	D+	296.2
40(113)	0	3	6	17	26	7	RD+	R+	296.2 OR 300.4
41(115)	0	3	8	11	22	7	RD+	R+	296.2 OR 300.4
42(116)	0	3	1	1	5	3	SS RD?	O? N?	
43(118)	0	0	0	3	3	2	XN	X	
44(121)	0	0	0	2	2	2	XN	X	
45(122)	0	0	0	0	0	1	NO	NO	
46(123)	0	0	0	3	3	2	XN	X	
47(125)	0	6	2	2	10	4	RD?	N?	

48(126)	0	2	0	0	2	2	XP	O?	
49(127)	0	3	0	6	9	3	XP	O?	
50(130)	0	1	3	8	12	6	UP? AN+	O? A+	300.0
51(134)	0	0	10	7	17	6	ND+	N+	300.4
52(137)	0	0	1	0	1	2	SD?	N?	
53(139)	0	0	9	17	26	7	RD+	R+	296.2 OR 300.4
54(140)	0	3	2	6	11	4	RD?	N?	
55(141)	0	1	12	7	20	7	RD+	R+	296.2 OR 300.4
56(145)	0	0	7	26	33	7	SD+	N+	300.4
57(148)	0	1	3	8	12	5	RD+	R+	296.2 OR 300.4

Appendix 8

PSE-CATEGO DIAGNOSTIC CLASSES AND SUBSCORES

PSE-CATEGO CLASSES

SCHIZOPHRENIC PSYCHOSES (CLASS S+)

MANIC AND MIXED AFFECTIVE PSYCHOSES (CLASS M+)

DEPRESSIVE PSYCHOSES (CLASS D+)

PARANOID PSYCHOSES (CLASS P+)

OTHER PSYCHOSES (CLASS O+)

UNCERTAIN PSYCHOTIC CLASSES (S?, P?, M?, D?)

RETARDED DEPRESSION (CLASS R)

NEUROTIC DEPRESSIONS (CLASS N)

ANXIETY STATES (CLASS A)

RESIDUAL CLASS FOR NON-SPECIFIC SYMPTOMS (X)

PSE-CATEGO SUBSCORES

SUBSCORE 1 :	DELUSIONAL AND HALLUCINATORY SYNDROMES (DAH)
SYNDROMES :	NS, DD, AH, PE, RE, GR, SF, VH, OH, SC
POSSIBLE SCORE:	14, 8, 2, 2, 4, 6, 24, 2, 4, 3 = 69
SUBSCORE 2:	BAHAVIOUR, SPEECH AND OTHER SYDNROMES (BSO)
SYNDROMES:	CS, IS, RS, AF, HM, OV, SL, NP, AG, NG
POSSIBLE SCORE:	4, 4, 6, 2, 10, 6, 8, 26, 2, 2 = 70
SUBSCORE 3:	SPECIFIC NEUROTIC SYNDROMES (SNR)
SYNDROMES:	SD, ON, GA, SA, HT, ED
POSSIBLE SCORE:	10, 6, 6, 6, 8, 10 = 46
SUBSCORE 4:	NON-SPECIFIC NEUROTIC SYNDROMES (NSN)
SYNDROMES:	DE, IR, TE, LE, WO, IT, SU, IC, HY, OD
POSSIBLE SCORE:	4, 2, 6, 2, 10, 4, 6, 4, 2, 9 = 49

Appendix 9

PSE-CATEGO SYMPTOMS AND SYNDROMES

	SYNDROMES	SYMPTOMS
1.	(NS) Nuclear Syndrome	thought intrusion thought broadcast thought commentary thought withdrawal voices about patient delusions of control delusions of alien penetration
2.	(CS) Catatonic Syndrome	mannerisms and posturing catatonic movements
3.	(IS) Incoherent Speech	neologisms incoherence of speech
4.	(RS) Residual Syndrome	hears muttering, whispering behaves as if hallucinated non-social speech
5.	(DD) Depressive Delusions and Hallucinations	depressive hallucinations delusions of guilt hypochondriacal delusions delusions of catastrophe
6.	(SD) Simple Depression	inefficient thinking depressed mood hopelessness suicidal plans or acts depression on examination
7.	(ON) Obsessional Neurosis	checking and repeating cleanliness and rituals obsessional ideas and rumination
8.	(GA) General Anxiety	anxiety panic attacks anxiety on examination
9.	(SA) Situational Anxiety	situational anxiety specific phobias

		anxiety avoidance
10.	(HT) Hysteria	dissociative hallucinations (not sub-cultural) dissociative states conversion symptoms histrionic
11.	(AF) Flattening of Affect	blunted affect
12.	(HM) Hypomania	subjective euphoria ideomotor pressure grandiose ideas and actions hypomanic affect hypomanic content of speech
13.	(AH) Auditory Hallucinations	voices to patient (not depressive)
14.	(PE) Delusions of Persecution	delusions of persecution
15.	(RE) Delusions of Reference	delusions of reference delusions of mis-interpretation
16.	(GR) Grandiose and Religious Delusions	delusions of grandiose ability delusions of grandiose identity religious delusions
17.	(SF) Sexual and Fantastic Delusions	thoughts read delusional elaboration of hallucinations delusions of assistance delusional explanation morbid jealousy sexual delusions fantastic delusions delusions concerning appearance delusions concerning lack of organs primary delusions
18.	(VH) Visual Hallucinations	visual hallucinations
19.	(OH) Olfactory	

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		Hallucinations	olfactory hallucinations delusions that patient smells
20.	(OV)	Overactivity	gross excitement irreverent behaviour embarrassing behavior
21.	(SL)	Slowness	slowness and underactivity slow speech muteness restriction of quantity of speech
22.	(NP)	Non-specific Psychosis	unfamiliarity and delusional mood heightened perception changed perception changed perception of time hears music, tapping, etc. hears voice calling name minor visual hallucinations other minor hallucinations evasiveness concerning delusions clouding or stupor bizarre appearance stereotypies suspicion perplexity incongruous affect
23.	(DE)	Depersonalisation	derealisation depersonalisation
24.	(ED)	Special Features of Depression	self-depreciation guilty ideas of reference guilt dulled perception lost affect
25.	(AG)	Agitation	agitation on examination
26.	(NG)	Self-neglect	self-neglect
27.	(IR)	Ideas of Reference	Ideas of reference
28.	(TE)	Tension	tension pains muscular tension restlessness

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29.	(LE)	Lack of Energy	subjective anergia
30.	(WO)	Worrying, etc.	worrying tiredness nervous tension neglect through brooding delayed sleep
31.	(IT)	Irritability	irritability hostile irritability
32.	(SU)	Social Unease	anxiety on meeting people social withdrawal lack of self confidence
33.	(IC)	Loss of Interest and Concentration	poor concentration loss on interest
34.	(HY)	Hypochondriasis	hypochondriasis
35.	(OD)	Other Symptoms of Depression	morning depression loss of appetite early waking loss of libido premenstrual exacerbation
36.	(OR)	Organic Impairment	delirious visual hallucinations organic impairment of memory
37.	(SC)	"Sub-cultural" Delusions or Hallucinations	"sub-cultural" hallucinations "sub-cultural" delusions
38.	(DI)	Doubtful Interview	misleading answers

Appendix 10

PSE ITEMS REFERRED TO IN CHAPTER 7

4. Have you worried a lot during the past month?

12. Have you had the feeling that something terrible might happen?

14. Have you had times when you feel shaky, or your heart pounded, or you felt sweaty, and you simply had to do something about it?

20. What has your concentration been like recently?

23. Do you keep reasonably cheerful or have you been very depressed or low-spirited recently?

24. How do you see the future?

29. What is your opinion of yourself compared to other people?

34. What has your appetite been like recently?
Have you lost any weight during the past three months?

38. Has there been any change in your interest in sex?

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

41. Have you sometimes felt particularly cheerful and on top of the world, without any reason?

42. Have you felt particularly full of energy lately, or full of exciting ideas?

44. Do you find that you have to keep on checking things that you know you have already done?

45. 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?

46. Do you find it difficult to make decisions about trivial things?

47. Have you had the feeling that things around you were unreal?

48. Have you yourself felt unreal, that you were not a person, not in the living world?

49. Do you ever get the feeling that something odd is going on which you can't explain?

60. Do you hear noises like tapping or music?
Does it sound like muttering or whispering?

61. What does the voice say?

62. Do you hear several voices talking about you?
Do they refer to you as 'he' (she)?

63. Do they speak directly to you?

64. Can you carry on a two-way conversation with...?

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

66/7. Have you had visions, or seen things other people couldn't see?

68. Is there anything unusual about the way things feel, or taste or smell?
Does your body function normally?
Do you sometimes notice strange smells that other people don't notice?

69. Do you seem to think that you yourself give off a smell which is noticed?

70. Do you feel that there is someone touching you, but when you look there is nobody there?

71. Do you feel that you are under the control of some force or power other than yourself?

73. Do things seem to be especially arranged?

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

76. Is there anything special about you? Do you have special abilities or powers?

77. Are you a very prominent person or related to someone prominent, like Royalty?
Are you rich or famous?

121. Rate: observed depression (sad, mournful look, tears, gloomy tone of voice, deep sighing, voice chokes on distressing topic).

128. Rate: blunted affect (expressionless face and voice, uniform blunting whatever the topic of conversation, indifference to distressing topics, whether delusional or normal).