The role of cultural background in diagnosing psychotic disorders: Misclassification of psychiatric symptoms in Moroccan immigrants in the Netherlands

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Chapter 2

The need for culture sensitive diagnostic procedures: a study among psychotic patients in Morocco.

Abstract

Objective
We examine the procedural validity of a standardized instrument for the diagnosis of psychotic disorders in Morocco.

Method
Twenty nine patients from Casablanca, Morocco, with a psychotic or mood disorder were examined using the Comprehensive Assessment of Symptoms and History (CASH) an adapted version using cultural formulation to make the instrument more culturally sensitive (CASH-CS). Chance corrected agreement was calculated between diagnoses based on these two versions of CASH and independent clinical diagnoses according to local psychiatrists.

Results
Agreement for traditional CASH versus clinical diagnosis and for CASH versus CASH-CS was low (kappa = -0.19; sd 0.16 and kappa = 0.21; sd 0.16 respectively). De CASH-CS, showed good agreement with clinical diagnosis (kappa = 0.79; sd 0.11).

Conclusion
Standardized instruments for the assessment of psychosis such as the CASH may be liable to cultural misinterpretations. This may be relevant to the interpretation of the high incidence rates of schizophrenia among immigrants.

Significant outcomes
Agreement between a culturally naïve version of a standardized diagnostic instrument for the assessment of psychosis and clinical diagnosis by Moroccan psychiatrists is poor. Adding additional probes and decision rules based on cultural formulation improves agreement with clinical diagnosis significantly.

Limitations
The study was conducted in a small sample. Both versions of CASH were administered by the same interviewer in a single interview session.
The need for culture sensitive diagnostic procedures: a study among psychotic patients in Morocco.

**Keywords**: standardized diagnosis, schizophrenia, psychosis, cultural formulation, Morocco.
1. Introduction

The repeated findings of an increased incidence of schizophrenia and other psychotic disorders among immigrants have challenged the common belief that schizophrenia is a disorder with a roughly equal incidence across countries and ethnic groups (Saha et al., 2005). Especially, the higher incidence rates among Afro-Caribbean immigrants in the UK (Murray & Hutchinson, 1999; Sharpley et al., 2001; Bhugra & Cochrane, 2001) and immigrants from Morocco to the Netherlands (Selten et al., 2001) have raised the interest in the role of social and cultural factors in the aetiology of this disorder. As yet the underlying mechanisms to explain these findings have remained elusive. A number of authors have criticized the methodology of these studies and challenged the validity of the increased incidence of schizophrenia among immigrant populations. Several authors have demonstrated that the ethnicity, language preference and related cross-cultural factors may influence mental health service utilization (Stuart et al., 1996; Folsom et al., 2007). Differences in admission rates and diagnostic evaluations between ethnic groups may have led to an overestimation of the treated incidence among these immigrants (Mortensen et al., 1997; Mckenzie, 1999; Littlewood & Lipsedge, 1981; Sashidharan, 1993; Hickling et al., 1999; Haassen et al., 2000). Others have questioned the effectiveness of standardized diagnostic procedures for the comparison of psychopathological phenomena in cross-cultural psychiatry (Wing et al., 1974). A number of these studies has demonstrated that factors such as race, gender and ethnicity are associated with considerable diagnostic bias, even when standardized diagnostic criteria and assessment procedures are being used, particularly when patients and psychiatrists differ from each other on these variables (Neighbors et al., 2003; Reeves et al., 2003; Arnold et al., 2004). E.g., Littlewood and Lipsedge showed that West Indian patients were much more often diagnosed as schizophrenic by the medical staff, even in the absence of Schneider’s First Rank Symptoms (Littlewood & Lipsedge, 1981a; Littlewood & Lipsedge, 1981b). The fact that such biases occur even when standardized diagnostic criteria and assessment procedures are being used, has serious consequences for the validity cross-national studies and for incidence studies comparing the rates of psychiatric disorders between ethnic groups within a population. Since the original introduction of standardized diagnostic instruments for the assessment of schizophrenia a number of studies has demonstrated the reliability of such instruments in various countries and cultural settings (Karno et al., 1983; Pakaslahti, 1987; Vazquero -Barquero et al., 1998; Strakowski et al., 2003). However, most of these studies have used diagnostic raters from the same cultural background as the patients. Only a few studies have
examined the procedural validity of these instruments when applied by diagnostic raters with a cultural background different from the patients (Hickling et al., 1999; Haassen et al., 2000). Kleinman (1980) questioned the validity of applying diagnostic concepts to different ethnic groups in Western societies and has introduced the term “categorical phalacy” to describe the misclassification which may result when culturally sanctioned idioms of expressing distress are interpreted as diagnosable pathological phenomena (Kleinman, 1987).

Two areas of pathology are particularly relevant in this respect, i.e. hallucinations and dissociative symptoms. In some cultures hearing voices and seeing images or faces of relatives is quite common and not necessarily pathological. Hearing voices may actually be a key presenting symptom of emotional problems which sometimes is perceived to be related to supernatural events (Alsughayir 1996; Al-Issa, 2000). Hearing voices, especially if experienced as originating from inside the head, can be a normal experience of thought. The differentiation between traditional, non-pathological idioms of distress and religious experiences, and true positive symptoms of psychosis can be very crucial in diagnostic procedures (Zarrouk, 1975; Rack, 1982; Al-Jadiri, 1996).

The second area of possible misinterpretation is that of dissociative experiences. In Morocco, as in some other areas in Africa, the Middle East, and Asia, people can enter a state of trance or dissociation during religious ceremonies. Many people have either had such an experience themselves or have observed other people in such states. In these regions sensations of floating above or outside of the body are not necessarily a medical condition, but a religious phenomenon or a culturally appropriate idiom of distress (van Duijl et al., 2005). In such a state a person experiences that his or her mind and body is taken over by an external force such as a spirit. In many parts of the world witchcraft and possession are idioms of distress and are culturally sanctioned ways of accounting for misfortune and are socially accepted. A “possessed” person may perform actions that are totally out of character. They are sometimes misdiagnosed as schizophrenia and treated as such (Dein, 1997).

These two areas of possible false positive symptoms can be the source of misclassification in epidemiological studies. Therefore, the American Psychiatric Association recommends using a “cultural formulation” as an aid to assist the proper interpretation of symptoms against their cultural background (APA, 1994). Unfortunately, very few studies have been conducted to assess the potential impact of a cultural formulation on diagnostic decisions. As yet, to our knowledge, no attempts have been made to incorporate cultural formulation into standardized diagnostic instruments.
In this paper we describe the results of a study using a standardized diagnostic instrument in a sample of treatment seeking psychiatric patients in Morocco with and without the application of additional probes and decision rules based on a cultural formulation. Diagnoses based on the original version of the CASH (CASH: Comprehensive Assessment of Symptoms and History) (Andreasen et al., 1992, and on the culture sensitive version of the CASH-CS (CASH-Cultural Supplement) specially developed for use among Moroccan patients were compared with each other and with independent clinical diagnoses made by local psychiatrists.

2. Material and methods

2.1. Subjects

Patients were recruited in a period of five weeks (April and May 2003) from the Ibn Rochd hospital in Casablanca (Morocco). This hospital is the main psychiatric facility of Morocco. It is affiliated with the University of Casablanca with 200 beds in a city with almost 4,000,000 inhabitants. During this period, we included newly referred patients who agreed to participate in our study, inpatients as well as outpatients (response rate 90%). The only inclusion criterion was to have a schizophrenia spectrum disorder or a mood spectrum condition. Exclusion criteria were the probable presence of organic cerebral disorders or disorders related to substance abuse. Because we were primarily interested in the validity of the instrument in cases of recent onset psychoses, all patients with a onset longer than two years ago were excluded. All subjects gave verbal informed consent, as many of them were analphabetic.

2.2. Instruments

The CASH is a semi-structured standardized diagnostic interview, specifically designed for making the diagnosis of schizophrenia spectrum disorders and affective spectrum condition according to different classification systems including DSM-IV. The CASH has been used primarily in studies on the neurobiology of schizophrenia and major affective disorders in clinical settings, and has more recently been used in a first contact incidence study of schizophrenia in the Hague, the Netherlands (Selten et al., 2001).
2.2.1. Adapting the CASH to Moroccan culture

For the purpose of a planned study to re-evaluate the high first contact incidence rates among Moroccan immigrants in the Netherlands, a modified version of the CASH was developed. The purpose of this modification was to arrive at a culturally sensitive, unbiased interpretation of psychotic symptoms, taking into account the cultural background of these immigrants which can determine the content of illness and the way that it is expressed.

The adapted culture sensitive instrument, which we call CASH-Cultural Supplement (CASH-CS), was developed to differentiate between true positive symptoms of psychosis and other, culturally appropriate idioms of distress among Moroccan patients.

As a first step in the development of CASH-CS a number of focus group sessions were held in which each of the CASH-items was reviewed for comprehensibility and appropriateness of formulation for use among patients of Moroccan descent. The members of these groups were trained psychiatrists, psychologists and a translator, all with extensive experience in working with Moroccan patients. Some of them were themselves of Moroccan origin.

One focus of attention was how to differentiate between non-pathological idioms of distress, described in the introduction, and true positive symptoms of psychosis. As one participant pointed out, Moroccan parents often ask their children when they are ill whether they hear voices. This is based on the fear that sick children are particularly prone to become possessed by demons. Based on such expectations, some Moroccan adults still hear voices whenever they have a fever.

A second important area was the assessment of affective symptoms. The Moroccan language does not have a specific word for depression (Tijdink & van Es, 2003), so our patients may not immediately know the meaning of this word. A third area was that of dissociative phenomena which is also discussed in our introduction. For each of these areas we formulated ways to introduce the item, words that could be used to describe the item, and appropriate translations to make sure all items were easy to understand. In addition guidelines were formulated to make sure the patient would feel fully at ease to freely discuss his or her experiences, without breach of taboos of feeling shame.

Appendix 1 gives an overview of the general and specific instructions for conducting the adapted version of the instrument and items which were adapted in the CASH-CS on the basis of the procedure described above.
2.3. Procedure

During a period of five weeks the recruited patients in Casablanca, Morocco were interviewed by a Dutch resident psychiatrist (TZ) of Iranian descent and a Dutch translator of Moroccan descent who was an experienced social worker. The translator translated the questions from the interviewer into Arabic or Berber language and used the Dutch language to convey the patient's responses to TZ. Both interviewer and translator worked in a mental health institute in Utrecht, the Netherlands. Before starting the study in Morocco both the interviewer and the translator were extensively trained in the use of the CASH. Positive symptoms were scored on the basis of the CASH interview, and were rated before and after applying the additional cross-cultural probes and decision rules described above. As is standard procedure in using the CASH, diagnoses are only made after taking all available clinical records into account. However, for these patients only limited documentation of prior medical history was available. Whenever possible information was gathered about the history of the illness from the family of the patients, either directly or through local residents or employees of the hospital who had contacts with the family. The interviewers remained blind for clinical diagnosis. A case history based on the CASH, family information (if available) was compiled. For CASH-CS a cultural formulation of the positive symptoms was added where appropriate. Diagnoses based on CASH and CASH-CS were formulated during consensus meetings in the Netherlands in which four Dutch psychiatrists participated (JMH, AL, SS and HE). These raters, who were also blind to the clinical diagnosis of patients and their names, discussed and decided on the DSM-IV diagnostic classification (Diagnostic and Statistical Manual of Mental Disorders, 4th edition, 1994) on basis of CASH and CASH-CS information at two separate consensus meetings.

Clinical diagnoses were established routinely using un-structured clinical interviews and clinical observation by experienced Moroccan hospital psychiatrists who were blind to the data collected with the CASH and the CASH-CS. The Moroccan psychiatrists interviewed the patients in their native tongue. They applied DSM IV as diagnostic criteria. These diagnoses were kept separately in a list.

2.4. Statistical analysis

In order to establish cross-cultural validity of the CASH and the CASH-CS, DSM-IV consensus diagnoses based on these instrument were compared with the independent clinical
diagnosis of the local psychiatrist using the overall percentage of agreement and a chance corrected measure of agreement: Cohen’s Kappa for dichotomous data (Cohen, 1960).

3. Results

The sample consisted of 29 patients (16 men, 13 women, mean age 32 years) with a clinical diagnosis of a psychotic or affective disorder. Table 1 shows the socio-demographic characteristics of the patients: 56% males, 38% married, 31% employed. Fourteen patients had a clinical diagnosis of schizophrenia and 15 patients a mood disorder. One patient had no clinical diagnosis at intake, but later when we finished inclusion she was clinically diagnosed with a factitious disorder.

Rates of employment were rather low in both clinically psychotic and mood disorder patients (21% versus 40%), but previous occupational status was somewhat higher: 57% in clinically psychotic patients and 71% in clinically mood disorder patients.

Tables 2a, b, c provide an overview of diagnoses based on CASH, CASH-CS and clinical diagnoses and pair wise of chance corrected agreement between the different diagnostic approaches. A psychotic disorder was present in 73%, 41% and 48% of the patients according to the CASH, the CASH-CS and the local psychiatrist respectively. Table 2a shows that 11 out of 15 patients (73%) with a clinical diagnosis of mood disorder were diagnosed as psychotic, but according to table (2b) none of these were classified as such by the CASH-CS. The agreement between CASH-CS and the clinician’s diagnosis of a mood disorder was perfect. This difference between the CASH and CASH-CS in their correspondence to the clinicians diagnosis was mainly attributable to the different interpretation of voices and trance states, which were rated as psychotic phenomena according to the CASH. In addition to over classification of positive symptoms we also observed considerable underestimation of the presence of mood disorders by the CASH in comparison to both the CASH-CS and the clinical rater. 4 out of 14 patients with a clinical diagnosis of psychosis (28%) were classified as having a mood disorder by the CASH, whereas this was the case in only 2 cases (14%) on the basis of the CASH-CS.

Also we found some indication that using the standard CASH interview some psychotic symptoms were missed. Interestingly, 50% of patients with a mood disorder according to CASH was clinically diagnosed as psychotic. For CASH-CS this was only 12%.

Chance corrected agreement between the different diagnostic approaches were Kappa=

63
-0.03 (sd 0.16) for clinical diagnosis versus CASH, Kappa = 0.79 (sd 0.11) for clinical diagnosis versus CASH-CS, and Kappa = 0.18 (sd 0.14) for CASH versus CASH-CS.

**Table 1:** Sociodemographic characteristic of patients

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Psychosis</th>
<th>Mood Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>29</td>
<td>14</td>
</tr>
<tr>
<td>Male/ Female</td>
<td>31%</td>
<td>21%</td>
</tr>
<tr>
<td>In-patient(%)</td>
<td>41%</td>
<td>50%</td>
</tr>
<tr>
<td>Married</td>
<td>38%</td>
<td>14%</td>
</tr>
<tr>
<td>Occupation</td>
<td>35%</td>
<td>21%</td>
</tr>
</tbody>
</table>

**Table 2:** Agreement between the various diagnostic approaches

2a: Clinical diagnosis versus CASH

<table>
<thead>
<tr>
<th></th>
<th>Clinical Psychosis</th>
<th>Clinical Mood disorder</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASH Psychosis</td>
<td>10</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>CASH Mood disorder</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>15</td>
<td>29</td>
</tr>
</tbody>
</table>

Percentage agreement = 48%
Kappa = -0.19 (sd 0.16)

2b: Clinical diagnosis versus CASH-CS

<table>
<thead>
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<th></th>
<th>Clinical Psychosis</th>
<th>Clinical Mood disorder</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASH-CS Psychosis</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>CASH-CS Mood disorder</td>
<td>2</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>15</td>
<td>29</td>
</tr>
</tbody>
</table>

Percentage agreement = 93%
Kappa = 0.79 (sd 0.11)

2c: CASH versus CASH-CS

<table>
<thead>
<tr>
<th></th>
<th>CASH Psychosis</th>
<th>CASH Mood disorder</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASH-CS Psychosis</td>
<td>10</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>CASH-CS Mood disorder</td>
<td>11</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>8</td>
<td>29</td>
</tr>
</tbody>
</table>

Percentage agreement = 55%
Kappa = 0.15 (sd 1.32)
4. Discussion

The purpose of this study was to assess procedural validity of a standardized diagnostic instrument for the diagnosis of psychotic syndromes in Morocco and to examine the impact of adding cultural sensitive probes and decision rules to a standardised diagnostic interview. These were added to clarify the presence or absence of symptoms in the context of the local culture and language. To our knowledge, this is the first study to compare the procedural validity of a standardized diagnosis in cross-cultural research against a clinical diagnosis of a fully culturally informed local psychiatrist and to assess the impact of using the specific cultural formulation on standardized diagnosis. Hickling et al., (1999) re-evaluated Afro-Caribbean patients diagnosed with schizophrenia in the UK by a Jamaican psychiatrist using clinical assessment and the PSE CATEGO system. They found that the agreement about a diagnosis of schizophrenia between a Jamaican, British psychiatrist and the PSE CATEGO system was poor. Diagnostic disagreement was greatest when the British and Jamaican psychiatrist were compared with PSE CATEGO system, and particularly so among Afro-Caribbean and/or black patients. These authors conclude that the high reported rates of schizophrenia in African or African-Caribbean populations in UK cannot be explained on the basis of misdiagnosis by British psychiatrists. However, they state that the PSE CATEGO system may have overestimated the rates of schizophrenia in African-Caribbean and white populations. One of the study implications is that the PSE generates a diagnosis of schizophrenia among African-Caribbeans in the UK at a higher rate than clinical evaluations. This study suggest that the PSE-CATEGO is also liable to over-diagnose of psychotic disorders, despite the fact that this instrument is accompanied by glossary which aim to help to differentiate between psychotic symptoms and culturally specific beliefs of experiences.

In this study by interpreting the symptoms in the context of culture, we were able to arrive at diagnoses which showed far higher agreement with the independent clinical judgement of local psychiatrists, than the original standardized interview. The study shows the value of using additional contextual information along cultural formulation guidelines to achieve greater diagnostic agreement with culturally informed local psychiatrists. This finding suggest that excluding cues about the cultural background of the patient, as applied as a method to exclude cultural bias by some authors (Selten et al., 2001), may itself introduce a source of bias.

In the present study the observed differences in agreement are mainly attributable to different scores for positive symptoms and the hierarchy of affective symptoms. After comparing
the results it looks like additional information as discussed in appendix I by considering the cultural beliefs could appropriately guide the Netherlands psychiatrists to distinguish the typical idioms of distress among Moroccan patients from psychotic symptoms and to more correctly identify mood symptoms. We found also some indication that the CASH-CS interview may pick up some psychotic symptoms missed by the original. The better agreement of CASH-CS with clinical diagnosis may be due to the additional information collected as part of CASH-CS, which may overlap with the contextual information routinely collected by the clinician as part of his routine diagnostic evaluation.

The study has a number of limitations which should be taken into consideration. First, the number of patients is relatively small. Second, the CASH and CASH-CS were administered and scored by the same interviewer and during a single session. Therefore the comparison presented in this paper can not be regarded as a test of inter-rater reliability, but rather as a test of procedural validity accessing only the impact of adding additional cultural information.

It is important to note that diagnosis were made independently by a panel of psychiatrists, thereby limiting any possible bias from the interviewer.

Despite these limitations, the high agreement between clinical diagnosis and CASH-CS, in contrast with the regular CASH interview, cannot be ignored. Even though there is no gold standard against which a diagnostic psychiatric interview can be adequately calibrated, the results of our study seem to implicate that the CASH-CS is less likely to lead to false positive diagnosis of psychotic illness in a sample of Moroccan patients.

Future larger scale epidemiological studies should pay more attention to the interpretation of the emotional language of the patient in a specific cultural setting. This can be a crucial element in reaching a valid diagnosis in both clinical and research settings. Whether the findings presented in this paper can be generalized to other standardized instruments remains to be further investigated.

5. Conclusion

On the basis of the findings presented in this paper it seems advisable to use an adapted version of a standardized diagnostic instrument similar to the CASH-CS in future epidemiological studies about psychotic illness, involving patients of diverse cultural background. Particularly our study seems to imply that the traditional CASH interview may be sensitive, but not very specific to positive symptoms of psychosis and may therefore give rise to false positive
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Appendix:

General instructions for a diagnostic interview for psychosis among Moroccans

- Take enough time. If necessary have contact with the family (siblings) to get more information about the patient.
- Make sure to establish a good rapport. Mostly you get reliable answers only if the patient trusts you. Repeat several times that all reported information is confidential.
- Before you start with each section, explain to the patient the purpose of that section. Make it clear that if you ask different questions this is because it is a part of the questionnaire and not because you expect him or her to have these symptoms.
- In Moroccan culture shame for forbidden acts (sin) and respect to elders sometimes inhibits people to give a direct answer. This should be taken into account with most of questions related to drugs or alcohol use, sex, physical and mental health.
- Ask all questions in concrete words (e.g. sad, tired, happy). Avoid abstract words as much as possible (e.g. depression, shame, guilt) and use plain concrete language to explain these conditions. Double-check whether the patient has understood your question correctly.
- Be alert that some people may try to obtain social facilities with a factitious medical or psychiatric diagnosis.

Instructions for specific symptoms among Moroccans

Depression:
Always check for affective symptoms carefully; patient may not report these spontaneously after an initial, straight-forward question. For some sub-groups of Moroccans depression is not accepted as a disease. The Berber language, which is one of the major languages in Morocco, does not have a proper word to directly and simply express depression. Only if one has serious somatic disabilities or severe symptoms one is not obliged to fulfil his social obligations. Hearing voices or noises can actually express a distressed situation and is not necessarily a manifestation of psychosis.

Mania:
During special days, like in the month of Ramadan and during Offering Ceremony, some Muslims can appear irritable or excited. Do not confuse this with mania or hypomania.
Suicide:
Suicide is forbidden in Islam. Muslims will not readily talk about it directly. An alternative question is whether one hopes or prays that God will take him or her sooner to Himself.

Delusions:
Make it clear that you are talking about a situation which is out of the ordinary. Check through the translator if this is fully understood by the patient. Some young Moroccan immigrants feel they are being observed because of recent international events. Consider if the experience of the patient may be understood in terms of a specific Moroccan tradition or religious belief. Some Muslims who have been in Mecca have had a religious experience, which may be mistaken for a delusion. Some people have similar experiences before falling asleep. Ask if somebody believes in evil eye, djunun (spirits) or magical powers, and whether his sickness is related to supernatural powers. On their own such traditional beliefs should not be considered as delusional. Always check with the family whether they consider it abnormal.

Hallucinations:
For some Moroccans hearing sounds or noises inside their head is the expression of their thoughts. The sound does not come from outside the head. Some people spontaneously report that they hear their own thoughts. If this is an isolated phenomenon, it is usually not a hallucination. Other people sometimes hear somebody call their name. This is not necessarily hallucination. Feelings of ants under the skin (‘nemel’), as isolated sensations, should not be considered as tactile hallucinations. Feelings of being touched on the shoulder by somebody as an isolated sensation should not be considered as hallucinations. Ask if somebody received help from a religious or traditional healer for these symptoms. Ask if these sensations are happening because of a curse on the family. It is very important to distinguish these traditional or religious experiences from hallucinations. The family may help you if you have doubts.

Negative symptoms:
Compare the persons level of functioning with a previous period during which the persons considered himself healthy. In the case of Moroccan, it should be realised that among healthy immigrant youth the percentage of unemployment, and thus inactivity during most of the day, is rather common and occurs more frequently than in the native population.
Dissociation:
Dissociative experiences are relatively common and are mostly interpreted as being possessed by Djin. In this state of mind it is accepted to see figures and hear voices of people (e.g. a holy person) or animals. The feeling of being touched is very common in this situation. It is also quite common for people to enter into a state of trance during religious ceremonies. Many people had such an experiences themselves or have observed other people in such a state. In these states, sensations of floating above or outside of the body can occur. If short-lived and not limiting to a persons role functions these experiences are usually a religious phenomenon, rather than a medical condition. The family may help you if you have doubts.

Substance abuse:
Be alert that some Moroccans start the use of cannabis at a very young age.
In Islam alcohol is forbidden, but it does not mean that Muslim people do not drink. Take time and explain that the answer is important for a correct diagnosis.
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References


Dein S. ABC of mental health. Mental health in a multiethnic society. BMJ. 1997; volume 315, 473-476


Kleinman A. Anthropology and psychiatry: The role of culture in cross-culture research on illness. British Journal of Psychiatry. 1987; 151, 447-454.


Sashidharan SP. Afro-Caribbeans and schizophrenia: the ethnic vulnerability hypothesis re-examined. International Review of psychiatry. 1993;5,129-144.


Tijdink DWGM, Van Es J. Translation and communication problems in diagnosing a depressive mood among berber patients living in Holland.Tijdschrift voor psychiatrie. 2003;45(6): 327-332 (abstract in English).


