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

Incidence of schizophrenia among Moroccan immigrants to the Netherlands

To the Editors,

With interest we read the report of a psychosis incidence study in the Dutch town of Utrecht (Zandi et al., 2010). The authors hypothesized that previous reports of an increased incidence of schizophrenia among Moroccan–Dutch people in the Netherlands were due to cross-cultural bias. They examined first-onset cases using a “culturally sensitive” version of the Comprehensive Assessment of Symptoms and History (CASH; Andreasen et al., 1992) and arrived at the conclusion that the first-contact incidence of schizophrenia among the Moroccan–Dutch was no longer significantly increased when this culturally sensitive instrument was applied. The purpose of this letter is to examine whether the authors have made a strong case.

The study procedures were as follows. Patients suspected of a first psychotic episode during the period May 1st 2002–May 1st 2004 were reported to a central office and interviewed twice: (1) academic psychiatrists (or residents) administered the standard Dutch version of the CASH and made a DSM-IV diagnosis; (2) the authors applied the culturally sensitive version of this instrument (CASH-CS), discussed all findings during a diagnostic meeting and made another DSM-IV diagnosis. The Relative Risks (RRs; Moroccan–Dutch versus Dutch nationals) based on the standard CASH turned out to be much higher than those based on the CASH-CS. Using information from the CASH-CS the RR of schizophrenic disorders (DSM-IV: schizophrenia, schizophreniform disorder, schizo-affective disorder) dropped from 7.8 (95% CI 4.0–15.2) to 1.5 (0.5–4.3). The authors also observed that they could not replicate the high RR of 9.3 (95% CI 3.7–23.4) for second-generation Moroccans in The Hague (Selten et al., 2001), because not a single second-generation Moroccan was reported to the central office of the researchers. We wish to make the following comments.

Firstly, the previous epidemiological studies found an increased incidence or prevalence of schizophrenia among Moroccan–Dutch males, not among Moroccan–Dutch females (Brook & de Graaf, 1985; Selten and Sijben, 1994; Schrier et al., 2001; Selten et al., 2001; Veling et al., 2006). Since Zandi et al. reported a RR of schizophrenic disorders for Moroccan–Dutch males of 2.4 (95% CI 0.8–7.7), the 95% confidence interval of which includes the usually reported RR of about 4 to 5 for Moroccan–Dutch males, their finding is not significantly different from the results obtained previously. There is an interesting parallel with the sex difference in social achievement, because it is not uncommon that within the same Moroccan family the brothers are in prison and the sisters attend university (Selten et al., 2008).

Secondly, the claim of the authors “that every patient aged 15–54 who made contact with one of the mental health services in Utrecht for a suspected psychotic disorder was reported to a central office” is pretentious. This happens only in an ideal world. Since 1999 the Psychiatric Case Register—Mid Netherlands receives anonymized information on patients who attend any of the in- or out-patient facilities for mental health care in the town of Utrecht and its surroundings. During the 5-year period 2002–2006 fourteen second-generation Moroccan citizens of Utrecht (11 males and 3 females) were reported to the registry for a non-affective psychotic disorder (DSM-IV: schizophrenia, schizophreniform disorder, schizo-affective disorder, delusional disorder, brief psychotic disorder, psychotic disorder not otherwise specified). Since these patients were young and had received no psychiatric treatment during the period 1999–2001, they were likely to suffer from a first episode. Using this information and population denominators of Utrecht we arrived at an age-adjusted RR of 7.7 (95% CI 3.8–15.7) for second-generation Moroccan males and of 4.2 (1.1–15.5) for second-generation Moroccan females (details of analysis in Selten et al., submitted for publication). The possibility that the authors missed potential cases is further supported by the lower rate of psychotic disorders for Dutch nationals in Utrecht (1.4 per 10,000) than in The Hague (2.2 per 10,000; 95% CI 1.7–2.7 per 10,000; Selten et al., 2001).

We do not differ in opinion with the authors that knowledge of the cultural background is required for a proper interpretation of the patient’s complaints. The apparent over-diagnosis of psychotic symptoms and under-diagnosis of depressive symptoms on the part of academic psychiatrists (or residents) may be explained in part by their failure to interview relatives (clearly illustrated by vignette 1) and to discuss findings during a diagnostic meeting. Both the interview with relatives and the diagnostic meeting were standard elements of the incidence study in The Hague (Selten et al., 2001; Veling et al., 2006).

We conclude (i) that Zandi et al. have failed to undermine the validity of the findings of an increased incidence of schizophrenia among Moroccan–Dutch males, and (ii) that their non-replication of the increased risk for second-generation Moroccan–Dutch is due to a failure to include them in their study.
References


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Letter to the Editor

Incidence of schizophrenia among Moroccan immigrants to the Netherlands. Response to letter written by Selten et al.

Dear Editors,

In a recent paper in Schizophrenia Research we conclude that first contact incidence of schizophrenia among Moroccans in the Netherlands is no longer significantly different from native Dutch inhabitants when a validated cultural sensitive diagnostic procedure is applied (Zandi et al., 2010). This finding raises serious doubts about the validity of the frequently reported increased incidence of schizophrenia in non-Western immigrants in countries like the Netherlands and Great Britain (e.g. Harrison et al., 1997; Van Os et al., 1996; Selten et al., 2001, Veling et al., 2006). In their letter to the editor, Selten et al. (2010) claim that our conclusions are based on invalid data, inaccurate collection procedures and misinterpretations of the findings, and that we have failed to undermine the validity of the repeatedly reported increased incidence of schizophrenia in Moroccans in the Netherlands. In this rebuttal we will refute their arguments.

First, Selten et al. argue that the point estimate of the Relative Risk (RR) of schizophrenic disorders based on the cultural sensitive version of the diagnostic interview for Moroccan versus Dutch males (RR = 2.4) is indeed smaller than the generally reported RRs of about 4 to 5, but that the 95% Confidence Interval (CI: 0.8–7.7) includes these generally reported RRs. We do not agree with the authors that this proves that our results are not significantly different from the results obtained in previous studies. Undoubtedly, the wide and overlapping confidence intervals found in all of these epidemiological studies, including theirs and ours, are the result of the small number of incident cases of schizophrenia. We appreciate Selten et al.’s attempt to down-play the findings of our study in this way, but they missed the main point of our study, which is that the use of culturally sensitive diagnostic procedure reduced the RR for schizophrenia among Moroccans compared to native Dutch inhabitants from 7.8 (95% CI: 4.0–15.2) to 1.5 (0.5–4.3), and was no longer significantly different from the figure for native Dutch. Also, the authors fail to point out that the relative risk of 2.4 we found using this culturally sensitive method lies outside of the 95% CI of 3.2–8.4 for first generation Moroccan versus Dutch males reported by these authors (Veling et al. 2006).

Second, Selten et al. claim that the registration of “every patient aged 15–54 who made contact with one of the mental health services in Utrecht for a suspected psychotic disorder” by the central office of the study is pretentious and can “happen only in an ideal world”. We agree that detection of all new cases of psychosis in this type of study is practically impossible, but it is unlikely that this would affect Moroccan patients more than native Dutch. Also, this equally applies to the studies from the Selten group, which used a similar method. More importantly, our study produced even higher incidence rates for first generation Moroccans than their studies, as long as the same culturally insensitive diagnostic methods were used. (Selten et al., 2001; Veling et al., 2006). These authors try to strengthen this argument by stating that missing Moroccan first episode schizophrenic patients and especially second generation, is the reason for our “non-replication of the increased risk for second-generation Moroccans”. In order to prove this point, they obtained information from the Psychiatric Case Register (PCR) of Utrecht. During the 5-year period 2002–2006 they found 14 second-generation Moroccan citizens of Utrecht (11 males and 3 females) that were reported to the registry for a non-affective psychotic disorder. Without providing any additional information about in- and exclusion criteria for these patients they declare that “since these patients were young and had received no psychiatric treatment during the period 1999–2001, they were likely to suffer from a first episode of schizophrenia. We have scrutinized the data from the PCR for cases in the period of our study, i.e. May 1st 2002 to May 1st 2004. In this period, only one second-generation Moroccan patient suspected of a first psychotic episode was definitely registered in Utrecht and in two other cases it was undeterminable if they were really registered in the period of our study. Theoretically, it remains possible that we missed these patients. However, we did register two second-generation Moroccan patients at the central reporting office during this period, but we had to exclude them after the first screening. One had received psychiatric treatment for psychosis before in another province; the other patient was excluded because it was a case of substance induced psychosis. Assuming that these are overlapping groups of patients (two of the three), this shows again that PCR data are not a valid source for incidence studies of schizophrenia, because it uses unstandardised diagnostic methods, imperfect probability linkage of anonymised cases and crude in- and exclusion criteria. This argument should perhaps be extended to other incidence studies using PCRs (e.g. Selten and Sijben, 1994).

Finally and most importantly, we are happy to see that the authors underline the importance of knowledge of the cultural background for a proper interpretation of the patient’s complaints. However, in their studies so far they...
applied ambivalent strategies. For example in the first period of The Hague study (1997–1999) psychiatrists who made the diagnosis were blind to ethnicity of the patients (Selten et al., 2001), whereas in the second period of this study (2000–2002) the psychiatrists were aware of the ethnicity of the patients, but did not specifically probe for relevant cultural background information as we did (Veling et al., 2006). Thus, in both periods of The Hague study, cultural aspects were not seriously taken into account in the diagnostic process itself, and therefore it comes as no surprise that the incidence rates between the two periods of the study were almost identical. This probably explains why they repeatedly found an increased incidence of psychosis and schizophrenia among Moroccans, whereas we did not (Zandi et al., 2010).

In conclusion, Selten et al. have failed to invalidate our findings. We strongly hope that – based on the outcome of our study – researchers as well as clinicians will appreciate the importance of culturally sensitive diagnostic methods in diagnosis of psychosis and schizophrenia among Moroccans and other immigrants.

References


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