

VOLUME I

Black and White patients' experience of their first psychiatric admission: Is there a relationship between negative experiences of psychiatric care and 'poor insight' in schizophrenia?

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CONTENTS

ABSTRACT	4
PREFACE	6
ACKNOWLEDGEMENTS	7

CHAPTER ONE: INTRODUCTION

1.1 Background	8
1.2 Literature Review	
1.2.1 The aetiology and diagnosis of schizophrenia in Black people in Britain	15
1.2.2 Insight and schizophrenia	30
1.2.3 Institutional and personal factors in the psychiatric care of Black patients in Britain	42
1.3 Summary of Literature Review	
1.3.1 Main findings	55
1.3.2 Methodological weaknesses	58
1.4 Conclusions	62
1.5 The Current Study	63
1.6 Research Aims and Hypotheses	65

CHAPTER TWO: METHOD

2.1 Overview	68
2.2 Setting	68
2.3 Sampling	69
2.4 Participant Demographic	70
2.5 Ethical Approval and Procedure	71
2.6 Design	73
2.7 Measures	73

CHAPTER THREE: RESULTS

3.1	Overview	86
3.2	Data Preparation	87
3.3	Variables Concerning First Psychiatric Admission	88
3.4	Variables Concerning Current Psychiatric Admission	95

CHAPTER FOUR: DISCUSSION

4.1	Summary of Research Aims, Method and Main Findings	105
4.2	Interpretation of the Current Findings in the Context of Previous Findings	107
4.3	Limitations of the Current Investigation	124
4.4	Implications of the Current Investigation	131
4.5	Concluding Comments	135

REFERENCES	137
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APPENDICES

Appendix 1.	Ethical Approval	158
Appendix 2.	Consultant Letter	159
Appendix 3.	Patient Information Sheet	160
Appendix 4.	Patient Consent Form	161
Appendix 5.	Experiences of First Psychiatric Admission (EFPA)	162
Appendix 6.	Impact of Event Scale (IES)	163
Appendix 7.	The Client Satisfaction Questionnaire (CSQ)	164
Appendix 8.	Rating of Medication Influences (ROMI)	165
Appendix 9.	Schedule for the Assessment of Insight-Expanded (SAI-E)	166
Appendix 10.	Consultant Measure of Insight (SAI-hq)	167
Appendix 11.	Brief Psychiatric Rating Scale (BPRS)	168
Appendix 12.	National Adult Reading Test (NART)	169

ABSTRACT

Black patients with schizophrenia are currently over-represented in psychiatric and forensic mental health settings. It has been shown that psychiatrists view Black patients as having less insight than their White counterparts. No studies have yet explored the potential relationship between negative experiences of psychiatric care at first admission and insight, or have empirically investigated potential consultant bias in ratings of insight in Black patients.

22 Black and 22 White patients with paranoid schizophrenia were recruited from two medium secure units in London. Black and White groups were compared on their experiences and perception of their first psychiatric admission, and current views of psychiatric care. Participants were interviewed on measures of: psychiatric care at first admission, the impact of these experiences on symptoms of trauma, patient satisfaction, reasons for current medication compliance, and insight. Consultants were also asked to rate insight in their Black and White patients. Consultant ratings were compared between the groups and with standardised measures of insight.

There were no differences between the groups in negative experiences or feelings about the first admission, current trauma, reasons for current medication compliance, or insight. However, Black patients were less satisfied with the care they received at first admission, which was associated with being younger at first admission.

Consultants did not rate Black patients as having less insight than White patients. However, consultants' ratings for White patients were significantly correlated with the standardised measure of insight, but not for Black patients. The difference between these correlations between the groups was significant ($p < 0.05$). Insight across the sample was unaffected by negative experiences or perceptions of psychiatric care, trauma, satisfaction, IQ, psychological therapy, and depression. Only severity of psychosis predicted levels of insight.

Suggestions were made for future research and clinical practice in the areas of understanding of Black patients, improving their satisfaction with psychiatric care, and enhancing congruence between Black patients and clinicians, particularly in the area of assessment.

PREFACE

In the *Introduction* chapter of this thesis, review of the previous literature shows that studies do not often make the distinction between Black people born abroad and Black people born in Britain, unless when referring to research on second and third generation African and African-Caribbeans in Britain, and to research done in the Caribbean. Generally, though, when the term 'Black' is used in the introduction, it refers to both Africans and African-Caribbeans born in the Caribbean and the UK. However, in the *Methods, Results and Discussion* chapters of this thesis, use of the term 'Black' refers specifically to Black people who were born in Britain, and are therefore British, and of either African or African-Caribbean decent. They do not include Black people who were born in Africa or the Caribbean and later came to live in Britain. The term 'White' refers to White people who were born in Britain, and are therefore British, and of either British or European decent. They do not include White people who were born in Europe and later came to live in Britain. People of mixed-race parentage were not included in the current investigation.

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CHAPTER ONE: INTRODUCTION

1.1 Background

The provision of appropriate mental health services for ethnic minority groups in Britain, both native-born and immigrant, has become an area of considerable concern within the NHS. Indeed, ethnicity and mental health has been identified as one of six areas prioritized for research in London by the NHS. This is important, firstly because of the degree of ethnic diversity in London, secondly because of an overrepresentation of African and African Caribbean populations in psychiatric and forensic mental health settings in relation to general population demography (Boast & Chesterman, 1995; Shaw *et al.*, 1999; Sharpley *et al.*, 2001), and thirdly because of evidence they are more likely to be admitted and detained in hospital under the Mental Health Act (1983) (McGovern & Cope, 1987, 1991), and dissatisfied with the psychiatric services (Browne, 1997; Butt, 2001).

Problems with institutional psychiatric practices, in relation to ethnic minority groups in Britain, first received attention in the literature in the 1980s (e.g., Littlewood & Lipsedge, 1981; Fernando, 1988), and research into understanding ethnicity and mental health in Britain has been advancing considerably over the last ten years (reviewed in section 1.2). The findings on both a local and national scale suggest that the experience of psychiatric services is different for different ethnic groups, and in particular for African and African-

Caribbean people. Significant themes in this research include differences between Black and White people in: (1) the pathway to specialist mental health care, for example via police Section versus GP referral (McGovern & Cope, 1987), (2) the mode of inception into hospital, for example hospital Section versus voluntarily (Owen *et al.*, 1991), (3) the diagnosis of severe mental illness (Sharpley *et al.*, 2001), (4) the greater use of physical over psychological treatments (Browne, 1997), and (5) the frequency of transfer to more secure facilities such as intensive care wards in psychiatric hospitals, medium secure units and special hospitals (McGovern & Cope, 1991; Boast & Chesterman, 1995). There is also increasing evidence that attests to the differential quality of after care provisions and follow-up for ethnic minority groups compared to Whites (Cochrane & Sashidharan, 1996; Butt 2001). However, some researchers have proposed that some ethnic minority groups make themselves less available to follow-up, and suggest the need for further research in this phase of psychiatric care (e.g., Butt, 2001).

In 1994 the Research and Development department of the NHS Executive, West Midlands, commissioned the University of Birmingham to investigate differences in the nature and quality of psychiatric care received by people with severe mental illness from different ethnic backgrounds in Birmingham. Patients from three ethnic groups, White, Black and Asian, were followed through the process of admission to hospital, in-patient stay, and for three months after discharge from hospital (Butt, 2001). The main findings were as follows:

- (1) Black patients were more likely to be living alone before admission than White or Asian patients, and were significantly less likely to be living with a family member.
- (2) Black patients, and to a lesser extent Asian patients, had more complex pathways to hospital than White patients and these pathways were significantly harsher (e.g., police involvement).
- (3) Twice as many Black than White or Asian patients were admitted because of medication non-compliance.
- (4) Only a small minority of Black patients said they knew why they were in hospital or agreed that they needed hospital treatment.
- (5) Three quarters of Black patients and over half of Asian patients were detained compulsorily compared to one quarter of White patients.
- (6) Black patients were significantly more likely to be seen as violent towards other patients and staff than were White or Asian patients.
- (7) Fewer Black and Asian than White patients received psychological therapy during their admission.
- (8) Only half of Black patients received any visits from family or friends whilst in hospital compared to many White and Asian patients.
- (9) Black and Asian patients reported being told less about their care, and were more dissatisfied with the care they received than White patients.
- (10) A quarter of all Black patients, and one in five of White patients, discontinued their medication against medical advice in the three months after discharge from hospital.

The most striking and consistent finding of the study was that Black people have a much more negative outlook towards services, are less likely to accept that they need psychiatric treatment, and are less likely to comply with medical advice regarding treatment regimes than White and Asian people. The study acknowledged the possibility that mental health professionals may be less able to exert indirect influence via a relative or friend to persuade an unwell person to accept treatment voluntarily if they are Black, than if they are White or Asian (Butt, 2001). It was suggested that this may mean doctors and others in the psychiatric services rely on coercion to ensure that people perceived to be both ill and potentially dangerous get the treatment believed necessary (Butt, 2001). It was also suggested that the sequence of non-compliance, coercion and hostility becomes a vicious cycle, which escalates antagonism between Black patients and the mental health services to the extent that many Black people remain unrelentingly opposed to the need for psychiatric care (Butt, 2001).

Psychiatrists often describe the difficulty with engaging Black patients with psychiatric care as 'poor insight', and believe that 'poor insight' is more prevalent in Black patients than in other groups (Johnson & Orrell, 1996; White & Sandor, 2000). In reviewing case note summaries of 357 in-patients comparing demographic variables with comments describing patients' level of insight, Johnson & Orrell (1996) found that those from African and African-Caribbean populations were more likely to be subjectively judged by psychiatrists as having little or no insight compared to their White counterparts (70% versus 47%). Furthermore, when entered into a regression analysis with other variables,

ethnicity emerged as the most significant independent factor influencing psychiatrists' perception of patients having poor insight.

Johnson & Orrell (1996) proposed four possible explanations for psychiatrists' views of African and African-Caribbean patients' insight. The first is 'opposing cultural explanations for mental illness' between doctor and patient. However, given that Asian communities also have illness beliefs at variance with prevailing medical opinions in Britain (Cinnirella & Loewenthal, 1999), it might be expected that psychiatrists would view them as having similar difficulties with insight as their African and African-Caribbean counterparts. Johnson & Orrell's study (1996) did not report this, and suggests that other explanations are needed to explain psychiatrists' view that more Black patients have less insight than other groups. The second explanation proposed that there is 'greater stigma' regarding mental illness in African and African-Caribbean groups than other groups, thereby leading to greater denial of being ill. However, added to the fact that Black people approach their GP at similar rates as other groups when first ill (Burnett *et al.*, 1999; Hutchinson & Sharpley, 1999), White *et al* (2000) found no significant difference between ethnic groups regarding the influence of stigma on insight. They did find, though, a strong relationship between greater insight and a larger size of primary social group, suggesting a normalising function of the primary group on mental illness, perhaps making it easier for patients to accept an illness model. However, this primary group was not interviewed, and therefore it cannot be known whether stigma was present and just being hidden, or whether greater numbers provide a better chance of coming into contact with someone who does not stigmatise the patient's illness. The third explanation

is the idea that 'symptom severity' might be worse in Africans and African-Caribbeans with schizophrenia. However, preliminary research has shown that degree of insight is not consistently related to symptom severity (McEvoy *et al.*, 1989). Later research shows inconsistent findings (e.g., Amador *et al.*, 1994), and indicates that this variable requires further research. The fourth suggestion is the possibility that 'language difficulties' might prevent accurate assessment of insight. However, Johnson & Orrell (1996) admit that this is unlikely to be factor among British-born Africans and African-Caribbeans. Further, the literature has not shown that other immigrant groups, with English as their second language, are viewed as having less insight (Johnson & Orrell, 1996). Finally, Johnson & Orrell (1996) also proposed that there might not be real differences existing between ethnic groups in degrees of insight, and that ratings of insight are influenced by 'psychiatrists' biases'. The literature awaits standardised measurement of insight in Black patients, and comparison to other groups, if psychiatrists' view of Black patients' insight is to be challenged. It might be that, based on Black people's experience of psychiatric care, standardised measures of insight in this cohort reflect their opposition to psychiatric care, rather than demonstrating an illness-related poor insight. The current investigation hopes to contribute to this line of enquiry.

The Research and Development department of the NHS Executive has not yet investigated the origin of Black people's negative feelings towards psychiatric care outlined in their 1994 study. The current investigation seeks to examine Black people's first experience of psychiatric care to see if features of this experience are negative, and to see if these experiences contribute to negative views and emergent service-use patterns

particular to African and African-Caribbean patients outlined in previous studies. It is also hoped that this investigation might go some way towards expanding upon Johnson & Orrell's (1996) study on psychiatrists' views of insight in Black patients.

In the following sections of this chapter, research on the aetiology and diagnosis of schizophrenia in Africans and African-Caribbeans in Britain over the last three decades is reviewed. This literature develops into exploring patterns of service use in this population, which is relevant for the current investigation. Literature on insight and schizophrenia is reviewed in the subsequent sections. This is followed by an overview of the research on the role of institutional and personal factors in the psychiatric care of Black patients. Research aims and hypotheses for the current investigation then follow. The measures and procedures chosen for the current study are discussed in chapter two. Results and discussion of the current findings follow in chapters three and four.

This investigation does not seek to explain the reported higher incidence of schizophrenia in the African and African-Caribbean population in Britain. Instead, it reviews the literature in this area in order to provide a context for the current study. The main focus of this study is to establish a better understanding of this cohort's experience of referral to, and treatment in, psychiatric care to see if this bears a relationship to levels of insight in this population.

1.2 Literature Review

1.2.1 The aetiology and diagnosis of schizophrenia in Black people in Britain

Amongst Africans and African-Caribbeans in Britain, of all mental illnesses, psychosis and schizophrenia have been the most concerning for psychiatrists (Littlewood & Lipsedge, 1997). This has mainly been due to consistent reporting of higher rates of schizophrenia in this population than in their White and Asian counterparts over the past three decades (e.g., Bagley, 1971; Cochrane, 1979; McGovern & Cope, 1987; Owens *et al.*, 1991; King *et al.*, 1994; Van Os *et al.*, 1996; Shaw *et al.*, 1999; Sharpley *et al.*, 2001). Estimates of this increased incidence have shown considerable variation, ranging from two-and-half times to twelve times that of the general population (e.g. Littlewood, 1988; Harrison *et al.*, 1988). Various theories for the reported high rates of psychosis in the African and African-Caribbean community in Britain have been put forward over the years. Those presented over the last two decades are briefly reviewed below.

1.2.1.1 Genetic Differences

The first theory for the inflated rate of schizophrenia in African and African-Caribbean populations in Britain argued that this was due to genetic differences between races, postulating a higher genetic predisposition to the development schizophrenia within Africans and African-Caribbeans than other groups (e.g., Wessely *et al.*, 1991).

Although schizophrenia is not inherited in a simple Mendelian fashion, numerous studies have shown that relatives of affected individuals have a substantially higher risk of developing the disorder. Support for this argument has been outlined in twin studies, where monozygotic twins are more likely to be concordant for schizophrenia than dizygotic twins (MZ/DZ – 42:9). Adoption studies have also shown that adopted-away offspring of parents with schizophrenia have an approximately 12% increased chance of developing schizophrenia. However, no gene has yet been identified. Further, the fact that concordant rates for monozygotic twins are no higher than 42% indicates the plausibility of additional, non-genetic, explanations for schizophrenia (Sugarman & Craufurd, 1994). More precisely, it suggests that genetic vulnerability is part, but not all of the explanation. Furthermore, it is not clear how the genetic argument relates to race, as no real evidence has been provided to show that Black people have a higher genetic vulnerability to schizophrenia than Whites.

As a result, few researchers support the theory that a genetic predisposition to schizophrenia is higher in Africans and African-Caribbeans than other groups. More recently it has been suggested that increased rates of the disorder in Africans and African-Caribbeans are due to the more frequent experience of difficult socio-economic conditions in Britain in this group, which are said to act as a catalyst for schizophrenia in those Black people genetically predisposed to it, thereby increasing prevalence in this group (Sugarman & Craufurd, 1994; Bhugra *et al.*, 1999 – reviewed in section 1.2.1.7).

Support for the powerful contribution of environmental over genetic factors in the aetiology of schizophrenia is provided by studies showing that schizophrenia is less prevalent in Black people in the Caribbean than in Black people in Britain (Hickling, 1991). McKenzie & Murray (1999) also found that rates of schizophrenia among Black people in the Caribbean were identical to the White population in Britain, and other studies have revealed a disparity between the numbers of schizophrenia in first and second generation African-Caribbeans in Britain, with incidence rates being higher in the latter (Thomas *et al.*, 1993). If the genetic argument were valid, there would be a discrepancy between the rates of schizophrenia in Black people in the Caribbean and White people in Britain, and *no* discrepancy between the rates of schizophrenia in Black people in the Caribbean and Black people in Britain, or between first and second generation British African-Caribbeans. As a result, it is acknowledged that there is a need for incorporating environmental factors into research into the aetiology of schizophrenia (Van Os, 1994, 1998).

1.2.1.2 Biological differences

Some medical practitioners believe that Africans and African-Caribbeans are biologically predisposed to schizophrenia. This view commonly comes in the form of obstetric evidence, where it is purported that there are associations between adult schizophrenia and gestational complications (e.g., Gottesman & Shields, 1982; Mednick *et al.*, 1988).

Mednick *et al* (1988) found an elevated frequency of adult schizophrenia diagnoses amongst individuals who were exposed to a severe type of influenza epidemic during

their second trimester of gestation. This suggests that disruption of fetal neural development may be involved in the development of schizophrenia in later life. What has been suggested is that Africans and African-Caribbeans may be living in poorer conditions than all other groups in Britain, making them more prone to contracting the more serious influenza strains, and affecting the normal neural development in fetuses in this population. However, it has been argued that this view is misplaced liberalism (Littlewood, 1992), as it has not been shown that Black people are living in poorer conditions than the millions of White working-class in Britain. Further, people from Pakistani and Bangladeshi communities are the lowest on the economic hierarchy in Britain (Littlewood & Lipsedge, 1997), and have a lower incidence of schizophrenia than Black people. More importantly, later research revealed that White patients with schizophrenia are more than twice as likely to have had complications during their pregnancy and birth than their African-Caribbean counterparts (Hutchinson *et al.*, 1997). Further, when McKenzie & Murray (1999) examined the backgrounds of Black patients, they were actually less likely to have suffered brain damage at birth, head injury or drug abuse than White patients. Further, 75% of White patients had some biological reason for their vulnerability to schizophrenia, compared to 25% in Black patients. In conclusion, biological arguments cannot stand up in the face of alternative evidence, and thus alternative explanations are explored.

1.2.1.3 Migration theories

Another theory inferred that migration from Africa and the West Indies is correlated with the high incidence of schizophrenia in this population in Britain (Harrison, 1990). If the

disease in question is mostly genetically determined, the disease frequency in migrant groups will closely resemble the frequency of that disease in the country of origin (Castle *et al.*, 1993). However, if the disease frequency in the migrant groups exceeds that in the country of origin, as is currently the case (Hickling, 1991), then this might be an indication that the risk of the disorder has increased due to specific factors associated with being a migrant in the host country (Castle *et al.*, 1993). Therefore, the genetic explanation for the rates of schizophrenia in Black immigrants was replaced by migration theories when it was found that immigrant African-Caribbeans have higher rates of schizophrenia than African-Caribbeans in the West Indies (Hickling, 1991). However, it was later found that second and third generation British-born African-Caribbeans have even higher rates of schizophrenia than their immigrant parents and grandparents (Harrison *et al.*, 1999). This, therefore, placed an emphasis on the accumulating evidence for the significant role of environmental factors in Britain to explain the high incidence of schizophrenia in its Black populations, both native-born and immigrant (Sashidharan, 1993).

1.2.1.4 Inconsistent Research Methodologies

Another theory for the inflated rates of psychosis in African and African-Caribbean populations in Britain proposed that differential research methodologies increased incidence figures. For example, Harrison *et al* (1988) found that definitions of schizophrenia were both unstandardised and based on retrospective data in many studies. This was thought to have falsely increased the incidence rates of schizophrenia within this group. However, when these authors examined new cases prospectively within a defined

population, making diagnoses based on the DSM-III (American Psychiatric Association, 1980), their findings continued to reveal the highest rates of schizophrenia in African and African-Caribbean populations. Harrison *et al* (1988) then found that, due to inaccuracies in record keeping, if a patient relapsed they were counted as a new patient on re-admission. As psychotic relapse and number of psychiatric admissions have been found to be greater in African and African-Caribbean patients (Bhugra & Bhui, 1999a; Sharpley *et al.*, 2001), this was thought to have falsely increased the incidence rates of schizophrenia within this group. However, despite correction for this, the figures have continued to reveal higher rates of psychosis in Africans and African-Caribbeans in Britain.

1.2.1.3 Misdiagnosis

It has been stated, and continues to be debated, that lack of cultural understanding, or 'race-thinking' and stereotyping is misinforming the diagnostic process for Africans and African-Caribbeans presenting in psychiatric settings, thereby falsely inflating rates of psychosis in this population (e.g., Adebimpe, 1981; Lewis *et al.*, 1990; Littlewood & Lipsedge, 1997; Hickling *et al.*, 1999; McKenzie, 1999). This has also been argued to be the mediating factor in cases of 'psychiatric mismanagement' in this population (Bhugra & Bhui, 1999b).

Littlewood (1992) reported that paranoid schizophrenia was diagnosed twice as often among Blacks than Whites. One hypothesis is that a proportion of these diagnoses may be the result of misunderstanding due to a social and cultural distance between patient and

clinician (Adebimpe, 1981). That is, cultural differences between patient and psychiatrist may be leading to a misinterpretation of thought processes as disordered or delusional, when in fact they are not necessarily pathological if viewed in their appropriate cultural and experiential context. Indeed, within each culture there are acceptable, subtle variations in beliefs that may be regarded as eccentric rather than psychotic (Fuller & Boon, 1988). For example, in West Indian societies it is generally believed that some individuals can influence others through personal power, or can act as agents of higher powers. Thus in the absence of other psychiatric symptoms, people of West Indian and African origin who believe in the presence of ghosts or 'obeah' (men believed to be agents of the devil, or fortune-tellers, with the power to kill and cure), may not be exhibiting delusions or symptoms of psychosis.

The same can be said for 'paranoid' thinking, where certain thoughts may be considered as psychologically healthy in the appropriate context. For example, Black British individuals who experience overt racism such as verbal abuse, as well as covert institutionally racist practices, such as being denied promotion on the basis of being Black, may exhibit a healthy suspicion about the reoccurrence of such events. It has been argued that this indicates the presence of an adaptive response to the experience of racism (Adebimpe, 1981). This suggests that if a psychiatrist is not alert to these social, environmental and personal experiences during assessment, then they might be more likely to misdiagnose suspicion as a symptom of psychosis, rather than a coping strategy (Fernando, 1991). This is pertinent in light of Carpenter & Brockington's (1980) finding that the apparent excess of schizophrenia in their Black participants, compared to their

matched White participants, was almost entirely accounted for by Black patients presenting with 'delusions of persecution'. Thus, a failure to acknowledge racism as a real threat to Black people's psychological health may be resulting in the labelling of valid anger and fear as evidence of psychotic symptomatology (Fernando, 1991).

Additionally, one might ask why there are so few diagnoses of the more commonly encountered, stress-induced conditions of depression, suicide, and alcoholism in African-Caribbean patients (Fernando, 1988; McKenzie *et al.*, 1995). This may be a true reflection of differences in mental illness between groups, but requires replication and explanation.

Finally, in a study by Hickling *et al* (1999), the diagnoses made by a Black Jamaican psychiatrist were compared with those of White British psychiatrists. They found that the British and Jamaican psychiatrists agreed in 55% of the cases, but disagreed in 45% of the cases. Hence, inter-rater reliability was poor. Although this study was criticised on methodological grounds (King, 1999), it highlighted the influence of subjective opinion on the diagnostic process. However, the findings may also be explained by differences in training.

Despite the difficulty of arguing against incidents of misdiagnosis of schizophrenia in African and African-Caribbean groups presenting to services, some have argued that misdiagnosis is not frequent enough to account for the alarmingly high recorded incidence of schizophrenia in this population in Britain (Bhugra *et al.*, 1999; Sharpley *et*

al., 2001). As a result, environmental explanations are given greater weight by most researchers in the area (e.g., Bhugra *et al.*, 1997, 1999; Van Os *et al.*, 1999). These explanations are reviewed in sections 1.2.1.7 and 1.2.1.8 below. It must be added, though, that the extent of misdiagnosis in clinical practice has not yet been established, and consequently firm conclusions cannot be drawn as to its influence on rates of schizophrenia in both Black and White patients (McKenzie, 1999).

1.2.1.6 Cannabis induced psychosis

It is known that smoking cannabis can induce both brief psychotic states for a minority of its users, as well as act as a catalyst for the onset of psychosis and schizophrenia in those with a vulnerability to developing these illnesses (Onyango, 1986). It has been found that some psychiatrists believe that African-Caribbeans use an excessive amount of cannabis (Littlewood, 1988; Lewis *et al.*, (1990), and that this may explain the inflated the rates of psychosis and schizophrenia in this population. However there is, as yet, no published evidence that cannabis use is higher in Black patients with schizophrenia than other groups, and such beliefs might reflect 'race thinking' and misdiagnosis in clinical practice (Littlewood, 1988; McKenzie & Murray, 1999).

In a study by Littlewood (1988), of 104 psychiatrists questioned, 59 believed that cannabis induced psychosis is more common in British African-Caribbeans than Whites; versus 23 who did not, and 22 who were undecided. Therefore, over 50% of the psychiatrists in this study believed that cannabis use is greater in the British African-Caribbean community than in any other. The presence of this view amongst psychiatrists

was supported by findings from Lewis *et al* (1990), where psychiatrists more often diagnosed a hypothetical Black patient than the hypothetical White patient as having Cannabis Induced Psychosis. However, this research is vignette based, and it cannot be directly concluded that diagnosis of a hypothetical case directly reflects clinical practice. That said, despite a study by Browne (1997) showing that hospital records indicate that White patients are more likely to have a history of cannabis use than other ethnic groups (21% versus 7%), and McKenzie & Murray (1999) finding Black patients are less likely to have suffered from drug abuse, Black patients are still more likely to be drug screened (Browne, 1997). It could be suggested, though, that White people admit to drug-use more readily than other ethnic groups.

It is significant to reiterate here that it is medically accepted that cannabis plays at least a contributory role in the aetiology of psychotic disorders such as schizophrenia (e.g., Onyango, 1986). Littlewood's (1988) and Lewis *et al's* (1990) findings suggest that a perceived excessive use of cannabis by African-Caribbeans may lead to the more frequent application of a 'cannabis induced psychosis' diagnosis to explain the presentation of psychotic symptoms in African-Caribbeans. What these studies do not show, however, is the more frequent use of a schizophrenia diagnosis to explain such a presentation in this population. Therefore, there is not enough evidence to suggest that large numbers of Africans and African-Caribbeans are being misdiagnosed with schizophrenia. Instead, socio-environmental factors, rather than misdiagnosis, continue to be highlighted in the current literature to explain the reported incidence of schizophrenia in Black people in Britain.

1.2.1.7 Socio-economic disadvantage

As cited earlier, Bhugra *et al* (1999) have argued that social adversity may be a powerful factor for explaining the inflated rates of psychosis in Africans and African-Caribbeans in Britain. One example is institutional racism hindering employment rates, as well as hindering promotional and career prospects once in employment. It has been argued that such conditions play at least a contributory role in precipitating and maintaining mental illness in those people who may be biologically or genetically vulnerable to schizophrenia (Van Os, 1994; Bhugra *et al.*, 1999; Hutchinson *et al.*, 1999). Thornicroft *et al* (1999) have proposed that their finding that age onset of schizophrenia is lower in Black people supports the social adversity theory. The social adversity theory also accords with vulnerability-stress models of psychosis, which argues that schizophrenia occurs in individuals who have a biological or genetic predisposition to the illness, with onset being triggered by the experience of repeated stressors.

Some researchers have gone on to highlight the role of more specific negative social conditions in Britain as a cause of schizophrenia. Indeed, in an earlier study, Bhugra *et al* (1997) found that of 38 patients of African-Caribbean origin, 34% had been separated from their mothers for more than four years, and 19% had been separated from their fathers. These differences were significant when compared with White participants of whom 17% and 12% had been separated from their mothers and fathers, respectively. In addition, of the African-Caribbean sample, 48% had been living alone, 80% were unemployed, and only 10% had regular contact with their partner. Bhugra *et al* (1997) argue that the impact of racism on the psychology of Black people in Britain, combined

with these factors, has together resulted in a greater vulnerability to schizophrenia in this population than other groups. These researchers also identified 'expectations of socioeconomic success' as an important factor in the aetiology of mental illness. To expand, it has been found that members of Bangladeshi and Pakistani communities in Britain have lower expectations of economic and social success than Blacks and Whites, which have been viewed as more realistic in the context of racial inequality in British society (Bhugra *et al.*, 1997). Conversely, its findings showed that Black and White people in Britain have similar expectations, but that Black people are less likely to have these expectations met due to the presence of racial inequality (Bhugra *et al.*, 1997). Thus Bangladeshi, Pakistani and White communities are more likely to have their socio-economic expectations met. Therefore, it has been suggested that the stressor of being denied the appropriate socio-economic conditions for Black people's ambitions to be realised has a bearing on the incidence of psychotic disorders in this population in Britain (Bhugra *et al.*, 1997).

1.2.1.8 Social stigma and service use

Finally, in an attempt to explain psychiatrists' view that insight is poorer in Black patients than other ethnic groups, some researchers have suggested that 'social stigma' about mental illness in the Black community might be causing this population to present to services later on in the course of their illness (e.g., Johnson & Orrell, 1996). From this it could be hypothesised that mild psychosis that might otherwise be treated in the community develops into more acute and chronic schizophrenia that then requires treatment in in-patient settings, thereby inflating figures on the prevalence of

schizophrenia in this population. Across all non-White groups, one qualitative study found a fear of being misunderstood by out-group health professionals, and evidence of community-stigma about mental illness. It was found that this led to a preference for private coping strategies for mental illness, particularly among African-Caribbean and Pakistani groups (Cinnirella & Loewenthal, 1999). However, other studies have not replicated this. Firstly, White *et al* (2000) did not find a significantly different influence of stigma between different groups in Britain. This may have been due to different research methodologies. However, they did find a strong relationship between greater insight and a larger size of primary social group, suggesting a normalising function of the primary group on mental illness, making it easier for patients to accept an illness model. However, this primary group was not interviewed, and therefore it cannot be known whether stigma was present and just being hidden, or whether greater numbers provide a better chance of coming into contact with someone who does not stigmatise the patient's illness. Secondly, Burnett *et al* (1999) and Hutchinson & Sharples (1999) did not find more negative attitudes to seeking help from mental health services at first onset, which was indicated by the lack of difference in time and place of presentation to services between groups, with most presenting to their GP when they first became ill. These studies suggest that social stigma about mental illness may be greater in certain groups (e.g., Cinnirella & Loewenthal, 1999), but that this cannot predict whether or not they will approach their GP to get help, and therefore does not suggest that rates of schizophrenia are being inflated by reluctance to approach services at first admission.

What the research has found, though, is differences in service-use emerging *after* first admission, when patients are relapsing (Burnett *et al.*, 1999; Hutchinson & Sharpley, 1999). Indeed, Black people wait longer before re-presenting to services, are more florid when readmitted (Browne, 1997), and are often readmitted under Sections of the Mental Health Act (1983) without giving consent (McGovern & Cope, 1987). This might be one explanation for the inflated figures for use of the Mental Health Act (1983) to engage Africans and African-Caribbeans with psychiatric services. Although this is not definitive evidence for the higher rates of in-patient treatment for schizophrenia in this population, studies of service use patterns in Black people have been highlighted for further investigation. Hutchinson & Gilvarry (1998) have outlined the need to distinguish between the experience and perception of services in Black patients at different stages of their illness course, as this might indicate at which point difficulties arise in terms of their interaction with health services. As the literature has shown that difficulties emerge after the first admission (e.g., Burnett *et al.*, 1999), it might be pertinent to examine Black patients' experience and perception of the psychiatric care they receive at first admission, and to see if these factors, rather than social stigma, have a relationship to the reluctance to re-engage with services and, further, if this reluctance can explain why psychiatrists' view Black patients as having less insight than other groups.

Summary

Literature on the aetiology and diagnosis of schizophrenia in Africans and African-Caribbeans in Britain, with researchers attempting to explain the higher recorded

incidence of schizophrenia in this population, has been reviewed. This has shown that genetic, biological, and migration theories cannot explain the higher rates of schizophrenia in Black people in Britain. Although it has been recognised that inconsistent research methodologies have inflated incidence rates, and misdiagnosis and stereotypes informing diagnoses are present in clinical practice, current researchers generally propose that the frequency of these practices does not sufficiently explain the higher rates of schizophrenia in this population. These researchers have gone on to hypothesise that the noxious socio-economic conditions experienced by Black people in Britain is causing a more frequent onset of schizophrenia in those who are biologically and genetically vulnerable to the illness. Finally, stigma about mental illness in the Black community leading to them being more reluctant about getting help when first ill, perhaps causing higher rates of in-patient versus community care, has not been supported by the literature. This literature did find, though, that Black people are more reluctant to return to psychiatric services after first admission. This has led to questions being asked about Black patients' experience and perception of psychiatric care, and whether a reluctance to return to services when relapsing can explain psychiatrists' assumptions about insight in this cohort. This is the focus of the current investigation. Literature on insight and schizophrenia will therefore be reviewed. Black patients' experience and perception of psychiatric care will be reviewed in the subsequent section.

1.2.2 Insight and Schizophrenia

1.2.2.1 The rationale for investigating insight

Understanding insight is important in the care of psychiatric patients, as whether or not a patient is deemed as having insight has implications for: (1) the type of psychotropic interventions they receive, (2) whether or not they are compulsorily sectioned, and (3) the type of section they are detained under if sectioned, which itself has implications for: (a) whether the patient can consent to treatment, (b) how long the patient will have to remain in hospital and (c) whether they are allowed to have 'leave' from hospital. The literature shows that psychiatrists' perception of 'lack of insight' in patients is cited as the main reason for compulsory admission in 70% of Section papers in London (White & Sandor, 2000). Compulsory admission to hospital in this way entails significant deprivation of liberty for the patient. Such issues are magnified in forensic mental health settings, such as medium secure units, where all patients are compulsorily detained, and where leave, discharge, or transfer to places of lesser security are permitted only by the Home Office, Court or Mental Health Review Tribunal (e.g., Sections 37, 38, 37/41 and 48/49). Indeed, 'to what extent does the patient have insight into their illness and the need for medication?' is one of six questions asked by the Home Office. They stipulate that evidence of insight needs to be clearly demonstrated by the patient, and relayed by the psychiatric team before leave, transfer or discharge can be granted to an offender patient. However, standardised measures of insight are rarely utilised in the assessment of patient insight in such circumstances. Given these assessments play a primary role in the quality of life for the patient, it is important to evaluate what factors may be affecting patient

insight. Indeed, if insight is not better understood, the implications for human rights are clear, particularly for a population that is over-represented in mental health and forensic settings. Also apparent is the cost to the NHS for the continued detention of those with 'poor insight' in medium security and special hospitals, as well as in general psychiatric wards.

1.2.2.2 Theories of poor insight

Insight is notoriously hard to define (David, 1990). In ordinary usage, poor insight refers to impairments in comprehension, judgement, knowledge or understanding. However, in psychopathologies such as schizophrenia, poor insight refers to patients' lack of recognition that they are suffering from an illness, and that the illness is mental. For example, if an individual reports that they have an implausible perceptual experience, but are unaware that such an experience is a hallucination, they would be described as having poor insight. Research shows that this kind of insight is often poorer among people suffering from psychotic disorders than in those with other mental illnesses, and even poorer still in those with a diagnosis of schizophrenia (Amador, 1994). Further, many psychiatrists have thought insight to be particularly poor in Africans and African-Caribbeans with schizophrenia (Johnson & Orrell, 1996).

The theoretical understanding of poor insight is varied. At one end of the spectrum, poor insight is understood as a psychological defense mechanism, while at the other extreme it is argued that poor insight is caused by cognitive deficits as a result of neurological damage. In between lies a quagmire of related constructs that vary with the orientation of

the author (Amador & Kronengold, 1998). Added to this, some patients may recognise signs of illness, but attribute their presence to other reasons such as “stress” or “a curse”. Some patients may recognise certain symptoms while remaining unaware of others, indicating that insight might exist on a continuum (Amador *et al.*, 1991). Markova & Berrios (1992) introduce further complexity by conceptualising awareness of illness as a subcategory of self-knowledge rather than an independent feature of psychotic disorders. Finally, any discussion of insight raises epistemological presumptions about the nature of reality (David, 1990). Philosophical considerations aside, the phenomenon of insight relevant to mental health professionals is one in which ‘an individual’s perception of him or herself is grossly at odds with that of his or her community and culture’ (pg 16, Amador & Kronengold, 1998). At the most fundamental level, then, poor insight in schizophrenia can be described as a seeming lack of awareness of the deficits and consequences of the disorder, and the need for treatment (Amador & Kronengold, 1998).

Regardless of the theory espoused to explain the origins of poor insight, David (1990) proposed a model of insight composed of three overlapping dimensions: (1) recognition that one has a mental illness, (2) compliance with treatment, and (3) ability to ‘correctly’ re-label unusual mental events (delusions and hallucinations) as psychotic experiences. Some have argued that this model has poor construct validity, as insight is defined differently across studies; that the inter-correlations between the components of the model are weak; and that the model oversimplifies a complicated and multi-dimensional construct (e.g., Beck-Sander, 1998). However, a comparative study of five insight scales showed a high degree of inter-correlation between them (Sanz *et al.*, 1998); and research

has shown that David's (1990) construct of insight has predictive validity, and is associated with medication compliance after discharge (Bartko *et al.*, 1988; Sanz *et al.*, 1998), treatment outcome (McEvoy *et al.*, 1989), and suicide risk (Amador *et al.*, 1996).

While a variety of theories exist to explain poor insight in schizophrenia, three approaches tend to predominate. The first considers the role of neurological abnormality, or neuropsychological deficit, the second suggests a psychological defense or adaptive coping mechanism, and the third considers poor insight to be a symptom of psychosis.

1.2.2.3 Deficit theories of poor insight

Deficit theories of insight assume that psychological motivation is irrelevant because people with schizophrenia are unable to recognise their illness due to frontal lobe, cognitive deficits, such as problem solving or integrating information (Amador *et al.*, 1991; Liddle & Morris, 1991), yet studies had yet to directly measure the relationship between poor insight and neurological deficit. However, in a study of 31 patients with chronic schizophrenia, Young *et al* (1993) found a significant correlation between unawareness of illness, as measured by the Scale to assess Unawareness of Mental Disorder (SUMD), and two variables on the Wisconsin Card Sorting Task (WCST) – a neuropsychological test sensitive to frontal lobe damage and dysfunction. The percentage of perseverative responses and number of categories completed on the WCST were found to significantly correlate with total symptom awareness, and total symptom attribution scores as measured by the SUMD. This study offered the first empirical support for Amador *et al*'s (1991), and Liddle & Morris's (1991) hypothesised relationship between

poor insight and frontal lobe damage. Further support came from Lysaker & Bell (1995), who reported that patients with schizophrenia and neuropsychological dysfunction of the frontal lobes do not show improvements in insight following psychosocial interventions, compared to patients with schizophrenia without frontal lobe deficits who did. Kirkpatrick *et al* (2000) also found a correlation between neurological deficits and poor insight in patients with schizophrenia, compared to patients with schizophrenia and no such deficit. However, Cuesta & Peralta (1994) did not replicate these findings, and a study by David *et al* (1995) found no relationship between cerebral ventricular enlargement of the frontal lobes and insight. It has been suggested that the variability in sample composition and choice of insight measures in these studies makes comparing and interpreting the various findings problematic (Kemp & David, 1996; Beck-Sander, 1998).

Given that IQ tests measure global cognitive function, it is relevant to add here that some studies found only a modest correlation between insight and verbal IQ (David *et al.*, 1992, 1995), and others (e.g., Sanz *et al.*, 1998) found that pre-morbid IQ was not associated with insight. However, given the modest correlation between IQ and insight, it would be necessary to remove any potential bias by attempting to match levels of IQ across groups, before comparing levels of insight.

What is of interest to the current investigation, though, is the nature of insight in those without frontal lobe damage. This is pertinent given McKenzie & Murray's (1999) finding that Black patients are less likely to have suffered from brain damage at birth, or head injury (see section 1.2.1.2). Non-deficit explanations for poor insight, such as those

provided by psychological (or defense mechanism) and illness models therefore require exploration. This is also pertinent in light of the finding that defense-mechanism-driven poor insight is more commonly associated with persecutory delusions (Bentall *et al.*, 1994), and the finding that delusions of persecution are more commonly cited as a reason for diagnosis of schizophrenia in African-Caribbeans (Carpenter & Brockington, 1980).

1.2.2.4 Psychological theories of poor insight

Psychoanalytical and psychological theories of insight assume that individuals are at some level aware of their illness, but are motivated to keep this knowledge unconscious by attributing causality for internal psychotic experiences externally, in order to preserve self-esteem and maintain an optimistic outlook (Zigler & Glick, 1988; Startup, 1996).

Evidence to support the protective function of poor insight originally came from a study by McGlashan & Carpenter (1981), in which they identified a relationship between post-psychotic depression (PPD) and reduced denial in schizophrenia. The authors considered PPD a stage of recovery from psychosis that stems from a lessening of defensive denial, resulting in patients' awareness of the circumstances of their illness. This view states that patients who accept rather than deny the reality of their psychotic experiences are prone to *depression*. This implies a defensive or protective function for denial, or 'poor insight' in schizophrenia, where self-esteem is in some way protected from the knowledge that the individual has developed a serious mental illness. Zigler & Glick (1988) have argued that a presentation of poor insight represents a form of "camouflaged depression".

In earlier studies, McGlashan *et al* (1976) suggested a continuum of recovery styles from psychotic episodes where on one end lies “integration”, and on the other “sealing over”. Fourteen non-medicated, symptom-free patients with schizophrenia were interviewed 12 months after an acute psychotic episode. Responses from each participant were evaluated, and the authors concluded that ‘integrators’ displayed an awareness of their presentation before, during and after their psychotic episode, took responsibility for their psychotic symptoms, and were flexible in their thoughts about them. Meanwhile, patients who ‘sealed over’ were either unaware of their psychotic experience, or viewed their psychotic experiences as alien and caused by some force outside themselves. Garety (1993) argued that both McGlashan *et al*’s (1976) and McGlashan & Carpenter (1981) studies demonstrate the role of psychological variables in insight, and emphasised the role of denial in adaptation to the trauma of being psychotically ill.

Later studies support McGlashan & Carpenter’s (1981) findings of increased depression following improvement in insight (e.g., Amador *et al.*, 1996; Dixon *et al.*, 1998; Moore *et al.*, 1999). Further, attributing one’s problems to a mental illness rather than a physical, medical or biological problem was found to be associated with reduced subjective quality of life (Mechanic *et al.*, 1994). However, at later stages of recovery, it has been argued that denial may impede rehabilitation (Prigatano & Schacter, 1991).

Cognitive theories of delusions have also contributed to research on the function of poor insight, and why patients might be reluctant to ‘give up’ their delusions. Drawing on attribution theory, Bentall *et al* (1991) and Bentall (1993) found an externalizing

attributional bias in people with persecutory delusions. For example, they had a tendency to blame others for negative outcomes and to credit themselves for positive outcomes, showing an exaggerated 'self-serving bias'. They argued that the self-serving bias is a mechanism for maintaining *self-esteem* in non-patients, which becomes exaggerated in patients with persecutory delusions (Bentall *et al.*, 1991), perhaps explaining the function of continued psychological investment in delusions.

Others have argued that some delusions develop because of pre-existing low self-esteem, and do not develop in order to protect self-esteem. Research by Chadwick *et al* (1996) on two types of delusion (persecution or 'poor me' paranoia, and punishment or 'bad me' paranoia) suggests that poor self-esteem plays a crucial role in the type of delusions formed. These authors argue that 'poor me' persecution paranoia, characterised by a tendency to blame others and to see the self as a victim, originates from experiences of perceived injustice, such as being ignored and rejected (as in the experience of racism). This is pertinent given that persecutory delusions have been found to be more common in African and African-Caribbean patients (Carpenter & Brockington, 1980; Bhugra *et al.*, 2000). Alternatively, Chadwick *et al* (1996) argue that 'bad me' punishment paranoia, associated with a tendency to blame self and the belief that others are justifiably punishing the sufferer, originates from humiliating and intrusive experiences, which could also be associated with the experience of racism. This is an interesting line of inquiry, but does not indicate why a person would be unable to develop insight into the presence of these persecutory beliefs.

In one of the largest studies in this area of investigation, Freeman *et al.*, (1998) conducted a controlled trial of cognitive therapy for psychosis to see if levels of self-esteem increased with improvements in insight. However, in their sample of drug-resistant psychotic patients, almost three-quarters of participants with persecutory delusions reported having low self-esteem. This appeared to indicate that persecutory delusions are not likely to be serving as a defense against low self-esteem. Birchwood, (1999) also found no evidence of self-esteem increasing following the remission of persecutory thinking. Instead, some have argued that reduced self-esteem in florid patients is a reaction to the experience of psychosis as an uncontrollable traumatic life event (e.g., Birchwood & Iqbal, 1998). It is also possible that self-esteem is related to the content of delusions, with persecutory delusions being more likely to have reductive effect on self-esteem than grandiose delusions. It is pertinent, then, that Freeman & Garety (2000) have highlighted the importance of measuring the dimensional content of delusions, such as conviction, preoccupation and distress, as well as severity of threat, imminency of threat, and the intentions of persecutors. These are all likely to have an effect on both self-esteem and depression. Until the definition of delusions is further refined in the research, it may be difficult to refine the understanding of psychological processes in the formation and maintenance of delusional beliefs, and their relationship to insight.

These insight studies have attempted to explain the function of poor insight in schizophrenia. However, the results are mixed. Originally it was thought denial of mental illness might serve to protect self-esteem, by aiding maintenance of an optimistic outlook in the face of experiencing a mental illness, thereby protecting against the depression so

commonly experienced following acceptance of having a mental illness. Although there is convincing evidence that denial in schizophrenia protects against depression, there is no strong evidence that delusions protect self-esteem. Others have gone on to suggest that persecutory delusions might originate from perceived intrusive, humiliating and abusive experiences. This is an interesting line of inquiry, but does not indicate why a person would be unable to develop insight into the presence of these persecutory beliefs. Until the definition of delusions is further refined, it may be difficult to elicit the psychological processes involved in the formation and maintenance of delusional beliefs, and their relationship to insight.

In the literature on insight and schizophrenia, psychological features of poor insight are distinguished from symptom features of poor insight. This is a difficult conceptual leap, as illness-related poor insight is also likely to be affected by denial-related poor insight, and vice versa. However, attempts at this distinction are reviewed.

1.2.2.5 Symptom theories of poor insight

Psychoanalytical and cognitive accounts attempt to explain poor insight from an emotional or motivational perspective. However, perceptual accounts view delusions, or continued investment in delusions, from an intellectual perspective, and as a function of a normal attempt to account for abnormal perceptual experiences, to the exclusion of emotion or motivation (Maher, 1974; 1988). Maher (1988) cites evidence for this view from a study of a normal cohort exposed to abnormal experiences, where irrational beliefs to explain these experiences were “readily provoked”. Maher (1988) concluded that

abnormal perceptual experiences almost demand a delusional belief to explain them. From this premise, researchers went on to hypothesise that more severe symptoms of psychosis would result in poor insight, and found a relationship between poor insight and more severe scores of general psychopathology (Markova & Berrios, 1992; Young *et al.*, 1993). Later, though, a large-scale study by Amador *et al* (1994) failed to completely clarify this relationship, finding only a modest correlation between insight and symptom severity, and concluded that they were generally unrelated. Other authors, too, have gone on to consider insight as an independent phenomenological feature of illness (e.g., Amador & Kronengold, 1998), unless, as outlined in the deficit research, patients have schizophrenia and frontal lobe dysfunction. However, Amador *et al's* (1994) used patients with a mix of psychotic illnesses. This factor is likely to confound matters, particularly when schizophrenia is related to the highest levels of poor insight across the psychotic disorders (Amador, 1994). Until types of psychosis are controlled for, firm conclusions cannot be drawn regarding the relationship between symptom severity and insight. Further, it has been shown that medication reduces delusions in many cases (e.g., Tran *et al.*, 1997), and given the complicated relationship between delusions and insight, and the fact that medication may increase insight, this further complicates matters.

Given the inconclusive findings on the relationship between insight and symptom severity, psychological defense theories of poor insight might be better placed to explain assumed differences in insight between Black and White groups with schizophrenia, without a history of frontal lobe damage. However, given the modest correlation between symptom severity and insight, it would be necessary to remove this potential bias by

matching levels of psychosis between the groups before comparing levels of insight, and exploring psychological reasons for poor insight.

Summary

Three theories of insight in psychosis have been reviewed. It has been suggested that poor insight may have at least three different aetiologies – neuropsychological, psychological and symptomatic. The research has demonstrated some significant relationships between poor insight and frontal lobe dysfunction and protection against depression. Only modest correlations have been found between poor insight, low verbal IQ and symptom severity; and there are conflicting findings on the relationship between poor insight and protection of self-esteem. What remains to be clarified is why psychiatrists view Black patients with schizophrenia to have less insight than White patients with schizophrenia. If their view is correct, the cause of poor insight in this population requires investigation. In such an investigation, IQ and symptom severity can be controlled for by matching these factors between groups. As head injuries, biological and neurological difficulties are three times more likely to be the cause of vulnerability to schizophrenia in White than Black patients, cognitive deficits caused by frontal lobe damage can be eliminated as the reason for poor insight in many cases for Black patients. However, if psychological mechanisms are highlighted for exploring the view that this population has less insight than any other, patients with a history of head injury need to be excluded from such an investigation.

Psychological theories of insight provide a useful platform from which to explore Black patients' apparent reluctance to return to psychiatric care after first admission. It is possible that Black patients' experiences of psychiatric care might be creating feelings of antagonism, guardedness and suspicion that, when challenged and not 'given up', might be misdiagnosed as delusions of persecution and poor insight. Alternatively, these experiences may be having a negative effect on insight that is unrelated to illness, and more closely related to negative experiences of psychiatric care. To investigate this hypothesis, the origins of Black patients' personal feelings about psychiatric care, and the experiences that lead to these feelings, need to be identified. The next section reviews the work done in this area so far.

1.2.3 Institutional and personal factors in the psychiatric care of Black patients in Britain

1.2.3.1 Background

As outlined in previous sections, Burnett *et al* (1999) found that differences in figures for compulsory and forensic admission into psychiatric services between groups do not apply to first admission, but emerge after first admission. A reduction in the use of GPs after the first point of contact might point to bad experiences of psychiatric care for African and African-Caribbean people, that leads to an unwillingness to re-engage with services later on. Studies attest to this population receiving harsher forms of treatment in psychiatric care than other groups. For example, Black patients regularly receive higher doses of medication than their White counterparts (Bhugra & Bhui, 1999a), and are more regularly

detained under sections of the Mental Health Act (1983) in locked wards, and in medium security as 'offender' patients (White 32%, Asian 39%, African-Caribbean 68% - McGovern & Cope, 1987). A reluctance to return to services when relapsing may lead to a more chronic presentation of psychosis and increased risk of violence when the psychosis is left untreated. Further, if an illness seems more chronic it is more likely to attract more severe interventions. This might explain the higher rates of sectioning and medium security admissions in this population, and resulting negative views of psychiatric care in this population. Therefore literature outlining *institutional factors* in the psychiatric care of Black patients needs reviewing.

Also in need of review is literature related to Black patients' *personal experience* of psychiatric care. Studies done by Mallett *et al* (1998) and comments from 'The Commission for Racial Equality' have provided evidence to show that the personal experience of racism impacts on the mental health of Black and minority ethnic people. Although there has been a long and honorable tradition of social psychiatric research on social factors associated with major mental illness, only very recently has this perspective begun to counter the view that pathology and problems are located within Black people in Britain, and highlighted the neglect of socio-political factors such as racism and material deprivation in the aetiology of schizophrenia in this group. Further, only very recently has it been argued that the experience of racism may be precipitating mental illness outside the mental health system, and maintaining it once inside this system (Bhugra *et al.*, 1999; Hutchinson & Sharpley, 1999). It is therefore relevant to review literature that highlights

accounts of personal experiences of racism, both inside and outside of the mental health system.

1.2.3.2 The Browne study – institutional factors in the treatment of Black patients

Browne (1997) examined interviews with Police Officers, Approved Social Workers (ASWs), GPs and psychiatrists about their views of Black patients, to see if their views were influencing their use of Sections of the Mental Health Act and amount of medication prescribed. This was carried out over a two-year period, interviewing 50% (N=83) of professionals within a chosen catchment area of an inner city hospital. The focus was on gathering qualitative data from these interviews, but some quantitative data were also collected to reinforce the study.

Staff attitudes

Police Officers saw Black people as “excitable” and 50% of officers said they would use police shields, automatically request back up assistance, and “err on the side of caution” when dealing with Black patients. 50% also perceived Black people’s behaviour as necessitating extreme action. Thus by merely being Black when mentally ill appeared to require some form of restraint in the opinion of these police officers. **ASWs** gave examples of it being standard police practice to send not one or two officers, but an instant response van with several officers to “assist” if they knew that the patient was Black, or housed in a Black area or estate. It was the predominant view of ASWs that their own profession tended to take greater precautions when dealing with Black clients than they would in dealing with White clients, and were more likely to call on the police

for help in the case of sectioning the former. Browne also interviewed one GP whose patient list is 55% African and African-Caribbean, who said:

“it seems there is something in the physical make-up of Black people which predetermines the presence of schizophrenia. They require higher doses of sedative drugs than White people as they don’t respond to normal measures”. (Browne, 1997, p 19)

Over 75% of all these professionals concurred that Black patients were more likely than White patients to be perceived as “dangerous”. Upon examination of hospital records, Browne (1997) showed that Black people were more likely than White to have “required” physical restraint prior to or on admission (16% versus 2%), and more likely to have medication used as a sedative (24% versus 14%).

Browne (1997) suggests that race has an impact on the process of sectioning, and that there is an association in the minds of professionals between Black people and dangerousness. However the statistical significance of the relationship between these factors was not reported.

Use of sections

Browne (1997) went on to find that Black men are nine times more likely to be on a Section 3 than White men (18% versus 2%). Further, once they are sectioned, they are twice as likely to be detained in hospital for long periods than White patients (14% versus

7%). Several hospital doctors spoke of an abuse of Section 136 by police, which gives police the power to remove floridly psychotic patients from a public place, but not from their homes. Many times it transpires that a patient has been taken from their home. As Black men are more likely to come into hospital on a Section 136 by the police, it would seem that this group suffers more frequent infringement of their human rights in the process of coming to hospital. However, it is possible that Black patients stay in hospital for longer because they are more unwell, and that the inequality in Section use between groups may be indicative of the difficulties of getting Black patients to re-engage with services when relapsing. Again, Browne (1997) made no statement about the statistical significance of these findings, nor was the study explicit about how much longer Black patients were kept in hospital, and whether this difference was significant. However, inequalities in Section use have been well established in previous studies (e.g., McGovern & Cope, 1987).

Stereotypes informing treatment

Browne (1997) investigated doctors' practice of treating Black patients. One junior doctor gave examples of colleagues over medicating young Black men because they had an increased fear of "danger" and "risk", for no apparent reason other than the patient's race. Another doctor admitted "some colleagues have difficulty in assessing people who live 'idiosyncratic' lives". One of the central questions for this doctor was "are we understanding Black people?" It was also admitted that Black patients are more likely to be drug screened, despite hospital records indicating that White patients were more likely to have a history of cannabis use than other ethnic groups (21% versus 7%), which has

also been shown by McKenzie & Murray (1999). As cited in section 1.2.1.6, Lewis *et al*'s (1990) study provides empirical evidence for the use of stereotypes of drug use to inform diagnoses, and therefore treatment plans. Vignettes were matched on all variables but race (one explicitly African-Caribbean, the other – no race specified), and the African-Caribbean vignette was more frequently diagnosed with 'cannabis induced psychosis' than the 'unknown' race vignette. Browne's (1997) study does not empirically replicate this study, as only one hospital's practices are examined, and individual examples of stereotype use are given to demonstrate general practice without evidence to show that this is the case. However, this study highlights concerns about stereotyping in the process of treating of Black people in psychiatric care.

Drug treatments

When examining records on drug treatments, Browne (1997) found that 85% of the total Black sample was in receipt of medication, versus 72% of the White group. Sixty-one percent of the Black group was being administered two types of medication as opposed to 39% of the White group. Thirty-five percent of the Black group was in receipt of three types of medication, whilst this was the case for 22% of the White group. Both doctors and nurses confirmed that Black patients were given more medication than Whites, with nurses expressing concern about dosage. More than half of the junior doctors interviewed believed that Black patients were treated differently in hospital. One of them gave the following justification:

“Yes, I think there are higher doses of medication for Black people. The typical Black admission is young, in his twenties, loud, paranoid, resisting strongly. You need to get him sedated to restrain him. The police usually bring him in; therefore the doctor hasn’t got a clue as to his history, and as with men generally, they’re more aggressive and you’re more frightened of them, so you put them on more medication”.

(Browne, 1997, p 35)

One of the nurses who expressed concern about the doses of medication used on Black patients made the following point:

“most of the White patients are on medication three times a day; all of the Black patients are on medication four times a day. Black patients are more often receiving PRN and restraint. There was this one White patient who had been ‘acting up’ on the ward, and was getting such a low dose he may as well have been given smarties. I’m sure if he was Black he would have got a much higher dose”.

(Browne, 1997, p 36)

These views express valid concerns about the treatment of Black patients, but the study fails to strengthen the findings by failing to report the statistical significance of its results.

Talking therapies

A study by Wilson & Francis (1997) found that of 100 Black service-users they interviewed, only 45% (compared to 75% of White service-users) had experienced talking treatments. Wilson & Francis (1997) acknowledge that different types of treatment can be helpful at different times and to different people, but make the point that the general experience of treatment for African and African-Caribbean patients indicates a bias towards the use of medication, and a neglect of additional treatments such as psychotherapy. The percentages reported here appear to be significantly different between Black and White service-users, but this was not reported in the study.

Length of stay

When Black people are detained in hospital, Browne (1997) found that the staff felt that they were likely to be compulsorily detained in hospital for longer periods than White patients. Medical staff tended to explain this in terms of Black deviance rather than any difference in treatment application based on psychiatric presentation. A senior registrar gave the following reason for his discharge practice with Black patients:

“In people of West Indian origin there’s a lot of drug taking, there is in all cultures, but especially among young West Indian males. This is probably one of the reasons why more of them are presenting to services. It’s also a reason why Black patients are kept on section, because they go on leave, take drugs and go back to square one. You would discharge many people when they’re 75% but the patient who would go back on dope, you wait until they’re 100%”. (p36)

Such views of drug-use in Black patients is concerning given Browne's finding that hospital records show White patients are more likely to have a history of cannabis use than other ethnic groups. The frequency of negative results from drug screening in Black patients supports these hospital records (Browne, 1997).

1.2.3.3 The Wilson & Francis study – personal experiences in the treatment of Black patients

The above Browne (1997) study is essentially an audit of institutional factors in the treatment of Black patients, which provides some evidence for the presence of negative attitudes affecting the type of treatment received by these patients. One researcher (Strauss, 1994) argued that such objective measures are limited in their ability to discover people's subjective experiences, and that research is more reliable when combining objective and subjective measures. Kitwood (1997), in researching dementia in elderly patients, has also argued that a person's environment and their view of how they are treated can contribute to their level of functioning and well-being. From this perspective, it is pertinent to ask people directly about their experiences.

In the first study of its kind, Wilson & Francis (1997) circulated one thousand questionnaires to 220 Mind associations throughout England and Wales over a three-month period, addressed specifically to Black service-users. The questionnaires were a mix of open and closed questions. One hundred responses were received and analysed in the areas of: diagnosis, the nature of services received, experiences of social exclusion or discrimination in general life, and views on mental health services received. The response

rate (10%) was too low to demonstrate that the experiences analysed are as prevalent as implied. However, the following important themes were highlighted.

There was a predominant feeling in Black patients that they had experienced racial stereotypes in psychiatry. The following two statements typify many of the respondents' experience: One respondent felt "a lot of White people seem to be threatened by my presence...why?" (42-year-old man with schizophrenia). Another said "I wonder if they expect me to attack them sometimes." (34 year-old man with manic depression). Wilson & Francis (1997) concluded that Black people who use the mental health services regularly face stereotypes of aggression. It was the opinion of Black service-users that this had its origins in distorted media coverage of the Black community in Britain, which tends to highlight incidents of crime, aggression and violence, to the exclusion of more positive representations, creating the impression that most Black people behave in this way. Much less frequent were reports of verbal racial abuse. One patient gave the following example: "there was this one nurse who called me a monkey...I couldn't believe it...I got that in school, and expect it from kids, but it really surprised me to get it from adults working in the 'caring' profession."

User's perceptions of how being Black had affected their care and treatment were mixed. The most common response (36%) concerned being sectioned under the Mental Health Act because of their ethnic origin, followed by 32% feeling that being Black was the main reason why medication was prescribed. 30% felt that they were more likely to be placed in a locked or secure unit because they were Black. One respondent said "I felt that

talking would have helped me more than medication, and the way it was administered without consent took away my dignity and choice. I was confused about something, but I felt medication was not the answer and that talking would have helped.” (38-year-old with schizophrenia). Another “felt humiliated, without any rights to think for myself, especially where taking medication was concerned.” (48-year-old woman with schizophrenia). However, 24% also felt that their own views had been considered, and 16% felt their ethnic origin and culture had been recognised in the process of treatment.

Studies in previous sections of this paper substantiate the presence of stereotyping informing clinical practice, more regular use of Sections of the Mental Health Act (1983) to admit Black people to hospital, greater numbers of anti-psychotic medication to treat Black patients, and less psychological therapy being given to Black patients compared to other groups. However, due to the low response rate, and the lack of statistical analysis to demonstrate the significance of responses they received, Wilson & Francis’s study does not empirically replicate these findings. Importantly, though, the study is the first of its kind to begin to explore Black patients’ personal experience of psychiatric care, and provides some evidence as to why there is a greater reluctance in this group to return to psychiatric services when relapsing.

Covert and overt racism, both within the mental health system and in wider society, has adverse affects on the mental health of Black service users (Mallett *et al.*, 1998). A significant proportion of the Black service-users interviewed in Wilson & Francis’s (1997) study felt largely misunderstood within the mental health system - either because

they are feared, stereotyped or ignored. This can reduce people's trust in the services on offer. Wilson and Francis's (1997) findings suggest that the 'colour-blind' approach of pretending ethnic differences do not exist is not satisfactory either. However, more positively, the study provides evidence that some Black patients are willing to acknowledge the positives they find within the mental health system, and are concerned to carry on a meaningful dialogue with mental health professionals, expressing their views in order to help bring about a system of care and treatment more responsive to their particular needs. More specifically, they feel a need for greater awareness of racism and its impact on them pre- and post admission. Many users have experienced social exclusion, racial exclusion, racial abuse, and other forms of discrimination that have contributed to and exacerbated their original mental health problems. The respondents of the Wilson & Francis (1997) study felt that it was crucial for mental health workers to recognise this reality for Black people, and to more closely scrutinise the relationship between ethnicity, psychiatric diagnosis and treatment.

Summary

In Browne's (1997) study, interviews with a range of personnel in one catchment area suggested that race has an impact on the admission and treatment process within the mental health system. Indeed, there appears to be an association in the minds of many practitioners between race and dangerousness, which is borne out by police over-reaction when dealing with Black people requiring hospital admission. Images of Black people as dangerous could possibly be encouraging a greater degree of police involvement in these

cases. ASWs are critical of this police tendency for over-reaction, but despite this are more inclined to request the assistance of the police when their clients needing admission are Black. It is also the perception of the staff interviewed that Black people are more likely to be held in seclusion and given higher doses of medication due to an inherent “dangerousness”. Finally, Black people spend longer in hospital. This was seen by some medical staff as a reaction to an alleged tendency to return to cannabis use. However, any assumption that Black people are more likely to use cannabis compared to Whites is not supported by the research.

The data collected in the Wilson & Francis (1997) study does not provide definitive evidence that all African and African-Caribbean patients experience institutionally racist psychiatric care, but indicates that a proportion believe that their race seems to have an impact on the treatment they receive. Indeed, it is the perception among some Black service-users that there is an association in the minds of practitioners between race and dangerousness. The accounts cited in the Browne (1997) study provide evidence in this direction.

Both of these studies generate important themes for further exploration. However, on their own, they are essentially clinical audits of service providers’ and service-users’ views, with some examples taken as evidence for general practice and experience. More scientifically rigorous studies are required to expand upon and quantify the results that have been outlined so far. For example, other factors that might contribute to service

providers' and Black service-users' views need to be highlighted and controlled for, and this is difficult to do without comparison to other cohorts.

What needs establishing is the degree to which these perceptions of dangerousness are due to dealing with a population that has less insight when ill, or institutionally racist practices in psychiatric care. As outlined in previous sections, many Africans and African-Caribbeans in Britain present voluntarily to primary care services at first onset. It is only when relapsing that this pattern changes. This suggests that institutionally racist practices might be causing Black people to be reluctant about returning to psychiatric care when relapsing, which might be perceived as poor insight by practitioners. This may contribute to mental health practitioners resorting to even more aggressive means of readmitting relapsing patients into the mental health system, further contributing to a vicious cycle of self-fulfilling prophecies. Clearly, experiences of psychiatric care and their possible link to insight require investigation.

1.3 Summary of Literature Review

1.3.1 Main findings

Literature on the aetiology and diagnosis of schizophrenia in Africans and African-Caribbeans in Britain has shown that genetic, biological, and migration theories cannot explain the higher recorded incidence of schizophrenia in this population. Although it has been recognised that inconsistent research methodologies have inflated incidence rates, and misdiagnosis and stereotypes informing diagnoses are present in psychiatric practice,

some more recent researchers are of the opinion that the frequency of these practices does not sufficiently explain the higher rates of schizophrenia in this population. These researchers have gone on to hypothesise that the noxious socio-economic conditions experienced by Black people in Britain are causing a more frequent onset of schizophrenia in those who are biologically and genetically vulnerable to the illness. Stigma about mental illness in the Black community, leading to them being more reluctant about getting help when first ill, and perhaps causing higher rates of in-patient versus community care, has not been supported by the literature. Studies have found, though, that Black people are more reluctant to return to psychiatric services after first admission. This has led to questions being asked about Black patients' experience and perception of psychiatric care, and whether a reluctance to return to services when relapsing can explain psychiatrists' assumptions about insight in this cohort.

The research on insight and schizophrenia has suggested that poor insight may have at least three different aetiologies – neuropsychological, psychological and symptomatic. A significant relationship between poor insight and frontal lobe dysfunction, as well as poor insight and protection against depression has been demonstrated. Only modest correlations have been found between poor insight, verbal IQ and symptom severity; and there are conflicting findings on the relationship between poor insight and the protection of self-esteem. Given that head injuries and neurological difficulties are three times more likely to be the cause of a vulnerability to schizophrenia in White than Black patients, cognitive deficits due to frontal lobe damage can be eliminated as the reason for poor insight in many cases for Black patients. However, the significant relationship between

frontal lobe dysfunction and poor insight indicates that those with a history of head injury need exclusion from any investigation into the effect of psychological factors on insight. Further, the potential confounding effect of IQ and symptom severity would need to be controlled for by matching these factors between groups.

Psychological theories of insight provide a useful platform from which to explore Black patients' apparent reluctance to return to psychiatric care after first admission. It is suggested that Black patients' experiences of psychiatric care might be creating feelings of antagonism, guardedness and suspicion that, when challenged and not 'given up' by patients, might be being misdiagnosed as delusions of persecution and poor insight. Alternatively, these experiences might have a reductive effect on insight that is unrelated to illness.

Studies of institutional and personal factors in the psychiatric care of Black patients in Britain suggest that race has an impact on the admission and treatment process within the mental health system. It has been suggested that there is an association in the minds of many practitioners between race and dangerousness, which is borne out by police over-reaction when dealing with Black people requiring hospital admission. It is also the perception of the staff interviewed that Black people are more likely to be held in seclusion and given higher doses of medication due to an inherent "dangerousness". Black people also spend longer in hospital, and this was seen by some medical staff as a reaction to an alleged tendency to return to cannabis use, despite the lack of research showing that Black patients with schizophrenia are more likely to use cannabis compared

to other groups. The research also indicates that a proportion of Black patients believe that their race has an impact on the treatment they receive. It is also their experience that there is an association in the minds of practitioners between race and dangerousness. What needs establishing is to what degree these perceptions of dangerousness are a result of dealing with a population that has less insight when ill, or institutionally racist practices in psychiatric care. It has been suggested that institutionally racist practices might be causing Black people to be reluctant about returning to psychiatric care when relapsing, which might be perceived as poor insight by practitioners. This may then contribute to mental health practitioners resorting to even more aggressive means of readmitting relapsing patients into the mental health system, further contributing to a vicious cycle of self-fulfilling prophecies.

1.3.2 Methodological weaknesses

Research on the aetiology of schizophrenia in Africans and African-Caribbeans in Britain has provided rigorous findings that genetic, biological and migration factors cannot explain the inflated rates of this illness in this population. These studies clearly show that rates of schizophrenia in second and third generations of Black people in Britain are higher than in first generation immigrants from the Caribbean, and in Black people who have not emigrated from the Caribbean. Therefore socio-economic factors in Britain have been highlighted to explain these rates. However, these findings are confounded by the fact that the 'jury is still out' on the issue of misdiagnosis of schizophrenia. One study has shown that a British psychiatrist more frequently diagnosed Black patients with schizophrenia than a Jamaican psychiatrist, but the literature has not demonstrated the

prevalence of such disagreements. Research also demonstrates the overuse of a diagnosis of 'cannabis induced psychosis' to explain the presentation of psychotic symptoms in Black patients. However, this research is vignette based, and it is difficult to conclude that diagnosis of a hypothetical case directly reflects clinical practice. Until these methodological weaknesses are addressed, researchers cannot safely conclude that rates are genuinely higher in this population. If misdiagnosis is greater than first thought, this further validates Black people's view of psychiatric practice as flawed, and indicates that more research needs to be directed to investigating the 'social distance' between Black patients and psychiatrists, and its impact on the diagnostic process. If, however, misdiagnosis is less frequent than has been suggested, Black patients' experience of psychiatric care continues to demand attention, with perhaps socio-cultural influences on illness beliefs in this population requiring additional attention. There are clearly overlapping influences on the rates of schizophrenia that are difficult to separate and control for. It is important for studies to highlight these difficulties when drawing conclusions from its findings. Finally, the diagnosis of schizophrenia also has an influence on assumptions about insight, as the research has shown that insight is poorer in people with schizophrenia than other psychotic disorders.

A broad view of the methodological weaknesses in insight research is highlighted here, which addresses many aspects of the research done in this area so far: The meaning of insight in mental illness, and more specifically schizophrenia, have been debated in the literature for over thirty years. However, the more rigorous investigations, guided by academic models and operationalised, structured measures, are a much more recent

contribution, and have shown that insight is a more complicated construct than the earlier literature suggested. Not only has it been demonstrated that insight has at least three different aetiologies – neuropsychological, psychological and symptomatic, which can overlap in non-linear ways, it has at least three dimensions – recognition that one has a mental illness, complying with treatment, and the ability to re-label unusual mental events as symptoms of psychosis, which can also overlap in non-linear ways. The authors have acknowledged the complicated nature of investigating insight, and are often torn between taking a broad perspective, thereby underestimating the complex details, or carrying out a precise examination of only a small part of the concept, thereby missing the many influences on insight (Strauss, 1998). Added to this, insight itself varies according to the cultural context, situation, psychological method at which it is assessed (e.g., overt self-report, observed behaviour), psychological level at which it is assessed (e.g., neuropsychological, psychological), stage of illness, and the definition of insight espoused - of which there is no general agreement (Strauss, 1998). As insight has been viewed as a key factor in mental illness, it cannot be concluded that insight is so complex that it cannot be researched, and thus continues demands further investigation that is both necessary and unavoidable. However, in any attempt to further advance the understanding of insight, researchers need to remain aware that the findings are limited by these complexities.

The research on institutional and factors in the psychiatric care of Black patients in Britain can be criticised on more basic methodological grounds. The studies reviewed generate important themes for further exploration. However, on their own, they are

essentially clinical audits of service providers' and service-users' views, with individual examples of malpractice and bad experiences taken as evidence of the norm. More scientifically rigorous studies are required to quantify and expand upon the results outlined so far. For example, studies need to highlight and control for other factors that might contribute to service providers' and Black service-users' views, with comparison to other cohorts or a control group.

A further neglected area in the above research of personal accounts of psychiatric care is factors affecting the measurement of autobiographical memories. For example, it is well known that depression affects the validity of, or biases, recall for past events. In studies based on Brown & Harris's (1978) investigation into life events and depression in women, it was found that subjects diagnosed with major depression reported an elevated rate of emotion-related, negative memories in daily incidents, and Smith (1997) found a substantially elevated rate of emotional memories of the more distant past. Williams & Scott (1988) also found that depressed people have difficulties in being specific in autobiographical memory, reporting generic memories with omissions. These findings suggest that if patients interviewed about their experience of their first psychiatric admission are depressed at the time of the interview, their accounts might be biased. For this reason, patients' level of depression at the time of interview requires measurement. As depression is likely to bias both Black and White patients' accounts, so that as long as one group is not more depressed than the other, findings related to first admission experiences should be less vulnerable to this bias.

It is also known that persecutory delusions affect the validity of autobiographical memories. For example, Kaney *et al* (1997; 1999) found that people with persecutory delusions recalled significantly more general memories and fewer specific memories than normal control subjects. This suggests that if patients interviewed about their experience of their first psychiatric admission have persecutory delusions at the time of the interview, their accounts might be biased. For this reason, patients' severity of psychosis at the time of interview requires measurement. As psychosis is likely to bias both Black and White patients' accounts, so that as long as one group is not more psychotic than the other, findings related to first admission experiences should also be less vulnerable to this bias.

1.4 Conclusions

In the context of inflated rates of schizophrenia in the African and African-Caribbean communities in Britain, the NHS Executive has identified ethnicity and mental health as a priority for research, and continues to investigate the nature and quality of psychiatric care received by this population. In the exploration of the aetiology of schizophrenia in this cohort, institutional, personal and social factors have been identified as playing a role in the onset and maintenance of this illness, and may also contribute to explanations of patterns of service use in this population. So far, patterns of service use in this population have been seen as evidence of poor insight by many psychiatrists. To date, though, there has been very little research on how institutional and personal factors might affect patterns of service use and insight - insight of a psychological, rather than neuropsychological or symptomatic kind.

Personal accounts of experiences and perceptions of psychiatric care by Black patients with schizophrenia is an under-researched area in the psychological and psychiatric literature. This continues to be the case despite the amount of NHS resources utilised for treating a population that is over-represented in psychiatric and forensic admissions. Indeed, the studies by Browne (1997) and Wilson & Francis (1997) are the only published investigations of African and African-Caribbean patients' views of psychiatric care. Not only is the current investigation keen to further explore the views of service providers and Black service-users, but to use a more scientifically rigorous research design to do so. Further, findings on personal accounts of psychiatric care in this population do not specifically refer to first admission experiences, but an overall experience of treatment. The current investigation was designed to explore experiences at first admission, to see if these experiences lead to more negative views of psychiatric care by Black service-users that may explain the reluctance to return to services when relapsing - which has been perceived as poor insight, or whether these experiences actually have a reductive effect on insight.

1.5 The Current Study

As well as confirming or disconfirming previous findings related to service use by and provision for Black patients with schizophrenia, the main aim of the current study is to investigate first admission experiences of British-born Black and White patients, and consider the effect of these experiences on views of psychiatric care, trauma, reasons for compliance, and insight. In order to investigate first admission experiences, Black and

White patients will be interviewed about their process of admission, the amount of coercion experienced during their admission, and the sense of affiliation and support they experienced whilst in hospital. The level of trauma experienced as a consequence of these experiences, and the level of satisfaction with the care received will be measured. Current levels of insight and reasons for current compliance with medication will also be measured. All results will be compared between Black and White patients. The current investigation also aims go some way towards expanding on Johnson & Orrell's (1996) study into psychiatrists' view of insight in Black patients, by using standardized measures to assess patients' insight, and comparing these measure to psychiatrists' views of their insight.

The investigation seeks to further explore the psychological theory of insight, and introduce the idea that insight might change according to positive or negative experiences of psychiatric treatment, or that negative experiences create a reluctance to return to services, which is perceived as poor insight. As the subject of 'insight' has considerable implications for forensic cohorts in the assessment of risk, and therefore personal freedoms, service provision and costs, exploring the links between insight, schizophrenia, and ethnicity is deemed important.

1.6 Research Aims, Questions and Hypotheses

1.6.1 Research Aims

The first aim of the current study is to compare experiences of and feelings about the first admission between Black and White patients. The second aim is to see if these experiences and feelings are reflected in current levels of trauma, levels of satisfaction with the first admission, and current reasons for compliance between Black and White patients. The third aim is to investigate consultants' view of their Black and White patients' current insight, and compare these views with measured levels of current insight. The fourth aim is to examine the effect of negative experiences and feelings of the first admission, trauma and satisfaction on current insight, and the effect of IQ, psychological therapy and severity of psychosis and depression on current insight. From these aims, the following experimental and exploratory hypotheses have been generated, and build upon previous research in the area. More explicitly, the first hypothesis addressing Black patients' possible dissatisfaction with psychiatric care, and negative experiences of and feelings about psychiatric care, draws on some of the audit findings outlined in the Browne (1997) and Wilson & Francis (1997) studies, as well as the many empirical findings outlined in the literature over the past 15 years related to the frequency of police involvement (e.g., McGovern & Cope, 1987), the frequency of Section use (e.g., Owen *et al.*, 1991), medical practitioners' assumptions about cannabis use (e.g., Lewis *et al.*, 1990), and dissatisfaction with psychiatric care (e.g., Butt 2001). The second hypothesis is an attempt to replicate Browne's (1997) findings on the differential prescription of medication to Black and White patients. The third hypothesis relates to

Johnson & Orrell's (1996) finding that psychiatrists consider Black patients to have the least insight of all patient groups, and their hypothesis that this may be due to bias. The exploratory hypotheses reflect the current study's pilot component of the investigation to examine the possible effect of negative experiences of and feelings about psychiatric care on insight, and attempt to replicate some of the previous findings on other psychological constructs affecting insight.

1.6.2 Research Hypotheses

The experimental hypotheses for investigating the above research aims are:

First Psychiatric Admission:

(1) It is predicted that Black patients with schizophrenia will remember having more **negative experiences** during their first psychiatric admission, will have more **negative feelings** about their first psychiatric admission, have **higher levels of current trauma** related to events experienced during their first admission, and will have lower levels of **satisfaction** with the psychiatric care received during their first admission, than their White counterparts.

Current Psychiatric Admission:

(2) It is predicted that more Black patients with schizophrenia will currently be on **more than one anti-psychotic**, and be **complying with medication** due to pressure and fear of re-hospitalisation in the future, than their White counterparts.

(3) It is predicted that **consultants** will rate their Black patients with schizophrenia as having **poorer insight** than their White patients with schizophrenia, that **consultants' rating of insight** in their Black patients with schizophrenia will *not* correlate with standardised measures of insight, and that consultants' rating of their White patients' insight *will* correlate with standardised measures of insight.

1.6.3 Exploratory hypotheses

The exploratory hypotheses for investigating the above research aims are:

(1) Are levels of (a) **first admission insight** and (b) **current admission insight** different between Black and White patients with schizophrenia?

(2) Is there a relationship between current **insight** and the variables of negative experiences of and negative feelings about the first admission, trauma related to the first admission, and satisfaction with the first admission?

(3) Is there a relationship between current **insight** and the variables of pre-morbid IQ, psychological therapy, and severity of psychosis and depression?

CHAPTER TWO: METHOD

2.1 Overview

A total of 44 male, British-born Black and White patients with paranoid schizophrenia detained in medium security were recruited to participate in an interview about their experiences of their first psychiatric admission. Questionnaires comparing Black and White patients' feelings and satisfaction with this first admission, the impact of this first admission, their current views of medication compliance, their current degree of illness and their current level of insight were also administered. Participants were recruited from two medium secure units (MSUs), one in inner London and one in outer London.

2.2 Setting

One MSU in North London and one in East London were involved in the study. These units specialise in treating mentally disordered offenders who exhibit behaviour that poses a danger to others, and less frequently to themselves. Patients arrive via four routes: from police cells, prisons, other less secure psychiatric facilities and special hospitals. However, the important distinguishing feature is that these routes depend on one factor - whether or not the patient's current offence was committed in the context of a mental illness. During their stay within medium security, all patients are detained under sections of the Mental Health Act (1983). Discharge is aimed towards the community in the end,

although some patients move to conditions of greater security (e.g., Rampton Hospital), or back to prison.

2.3 Sampling

The inclusion criteria for participants were as follows:

- male
- DSM-IV (1994) diagnosis of paranoid schizophrenia (category 295.30)
- detained in medium security
- Black British-born or White British-born
- a pre-morbid IQ above 70
- aged 18 - 64

Patients meeting the above criteria in November 2001 were invited to participate. In total 62 patients were identified as potentially suitable for the study and were approached for interview. Of the target sample, 44 (71%) agreed to participate, 16 (26%) refused to participate and 2 (3%) were not approached after discussion with ward nurses, as they had recently assaulted a member of staff and were floridly psychotic. There was no difference between Black and White patients in refusal rates (8 White patients, 8 Black patients).

2.4 Participant Demographic

As patients in medium security are predominantly male (approximately 93%), all participants in the current study were male. Further, due to the potential reduction in statistical significance created by introducing another variable such as gender, and because of the scarcity of female patients in medium security, female patients were not included in the study.

There were two groups of 22 men. The first group was made up of British born African and African-Caribbean patients, and the second group was made up of British born White patients. Having participants belonging to different cultural groups in the first group, that is African and African-Caribbean, would appear to introduce the problem of differences in illness beliefs. However, in an attempt to reduce this effect, only British born Black patients were recruited. Africans and African-Caribbeans were also not separated into different groups as it was hypothesised that being visibly Black was enough to elicit different forms of treatment as an in-patient than being White.

A total of ten consultants across both MSUs were approached for their opinion of their patients' level of insight. All consultants were White.

2.5 Ethical Approval and Procedure

Ethical approval was gained from the Research Ethical Committees of East London and City Health Authority, and Barnet Enfield and Haringey Health Authority (Appendix 1). A letter was then sent to the Responsible Medical Officers (RMOs) in both MSUs (a total of 12 RMOs), outlining the purpose of and the procedures involved in the research (Appendix 2). In accordance with ethical procedures, patients' verbal consent to participate had to be obtained by their RMOs before they could be approached for interview. RMOs gave patients an information sheet outlining the purpose and format of the study (Appendix 3). This information sheet did not refer to the comparison of Black and White experiences of hospital admission, and therefore prospective participants were blind to the purpose of the study.

Once permission for interview was granted from patients in this way, the interviewer contacted their key-nurse to inform them of the procedures involved in the study and to arrange an appointment to meet with prospective participants. Issues of risk and the suitability of interviewing each patient were discussed before a meeting time was arranged. A room was requested so that meetings with participants could be conducted in privacy. Standard security measures for interviewing patients in medium security were used.

Once met by the interviewer, prospective participants were once again provided with the patient information sheet. Once it was clear they had understood the purpose and

procedures of the study, and had the opportunity to ask questions, they were asked if they were still willing to participate. Once it was established that they were still willing to be involved with the study, written consent was obtained to both interview and to allow access to case notes (Appendix 4). Each participant was told that whatever they disclosed in the interview would not affect their progress through medium security, and assurances of confidentiality were given. In all cases, interviews were only commenced when it was felt that the patient was well enough to give informed consent. Those who were willing to be interviewed but presented as too unwell were approached again at a later date. Those who were unwilling to be interviewed were asked for permission to be approached again at a later date. Those who refused this were not approached again. Where possible, appointments were made for the next day. In the interim, participants' case-notes were read for demographic data and to gain information on the nature of their schizophrenia.

At the beginning of the interview, participants were reminded that they could withdraw consent for their participation at any time, without it affecting their treatment or progress through medium security. If there was any evidence of distress during or by the end of the interview, the interviewer offered participants as much time as they needed to talk through how they were feeling. Key-nurses were also made aware of any distress resulting from the interview. If no distress was evident during or by the end of the interview, participants were reminded that this could occur later and encouraged to approach their key-nurse for support if this became the case.

Interviews lasted approximately 75 minutes. For those participants who were unable to complete the interview in one sitting, additional appointments were made.

All data was encoded anonymously so that there were no identifying features, and locked in a filing cabinet when not being analysed. Only the current investigator had access to this information.

2.6 Design

This was a between groups, independent samples experimental design. The independent variable was ethnicity. One group was made up of 22 British born Black patients, the other 22 British born White patients - forming the comparison group. To test the main hypotheses of this study, a power analysis indicated that two groups of 22 participants will have 80% power to detect an effect size of 0.87 or greater at $\alpha=0.05$ (Cohen, 1992).

2.7 Measures

All measures were administered via interview by one White female interviewer in her thirties. All measures were administered via interview in order that all respondents understood and completed all questions. To avoid the possible influence of diurnal variation on the presentation of psychotic symptoms, all interviews took place in the afternoon.

2.7.1 Socio-demographic data

The first part of the investigation involved collection of socio-demographic data considered relevant for the questions being addressed in the current investigation. This data was collected from patient case-notes, other than pre-morbid IQ, which was measured at the time of the interview, and religious affiliation which collected by simply asking “do you follow or believe in any religion?” These are reported in the results chapter.

2.7.1.1 *Pre-morbid IQ*

Previous literature has shown that the findings on the relationship between IQ and insight are inconsistent. Therefore, the possibility remains that intelligence may have some association with how well someone is able to understand and articulate their experience of having a mental illness. Therefore, the current investigation aimed to remove this potential bias by matching levels of pre-morbid intelligence between the groups using the National Adult Reading Test (NART).

2.7.1.2 *Medical History*

As frontal lobe damage has been shown to correlate with poor insight, and would therefore bias the investigation of psychological factors associated with insight, patients with a history of frontal lobe injury were not included in the study.

2.7.1.3 Pre-admission Variables

Socio-demographic information around the time of the first admission relating to age, familial contact, accommodation status, employment status, pre-morbid drug and alcohol abuse, marital status, whether or not they were registered with a GP, and prison history, was collected.

2.7.2 Psychiatric information

2.7.2.1 Diagnosis

As outlined in the introduction, the research suggests that poor insight is more severe and pervasive among individuals with schizophrenia than those with other psychotic disorders. So that the findings were not confounded by this difference, only those with a DSM-IV (1994) diagnosis of schizophrenia were included in the study. Further, due to the potential effect of delusions on levels of insight, and the potential bias that might be introduced by selecting patients for whom delusions are not a prominent part their presentation, only those with the sub-type of paranoid schizophrenia (category 295.30) were included in the study. When consultants provided names of patients with this diagnosis, reports of patients' symptoms in case-notes were checked against the criteria given in DSM-IV (1994). All those selected by consultants fulfilled the criteria for a DSM-IV (1994) diagnosis of paranoid schizophrenia.

2.7.2.2 Psychiatric History

Information on participants' number of psychiatric admissions, illness duration, and length of current admission was collected. Illness duration was calculated by counting the number of years from the time of the first admission. Although it was recognised that in many cases participants' illness began prior to their first admission, this time of onset was not available in case-notes.

2.7.2.3 Medication

As medication has been shown to reduce delusions in many cases (e.g., Tran *et al.*, 1997), and therefore possibly affect insight, medication dose had implications for potentially confounding insight scores in this study. For this reason, information on the name and dose of participants' medication at the time of interview was collected. However, the British National Formulary (BNF 43, 2002) does not provide equivalent doses for Amisulpiride, Olanzapine, or Quetiapine, which are commonly prescribed anti-psychotics in the two medium secure units approached for the current study. Patients having different body weights also confounded calculating equivalent doses. For example, some patients might be on higher doses of medication, not because they are more psychotic, or even Black, but because they have a greater body weight. For these reasons, strength of medication was not included in the analyses of the current investigation. However, the number of patients on more than one anti-psychotic medication was collected in order to explore the possibility of over-prescription of anti-psychotics for Black patients – as outlined in the hypotheses.

2.7.2.4 *Contact with psychology*

The Home Office requires that patients in medium security gain sufficient insight into the relationship between their mental illness and the index offence before consideration is given to their discharge. Therefore, psychological input in medium secure units is often geared towards gaining this insight. Given the potential improvement in patients' insight following this input, data was collected from case-notes on how many months of weekly one-hour psychological input each participant had received prior to interview, during the current admission. There was no record of the amount of psychological therapy received before the current admission.

2.7.3 Self-Report Measures

2.7.3.1 *Experience of First Psychiatric Admission (EFPA) (Appendix 5)*

The EPFA is a pilot measure designed to determine the number of negative experiences and feelings participants had during their first admission to hospital. As few scales exist examining admission processes and inpatient treatment, particularly for patients in medium security, this schedule was developed for the purpose of this study. The 'sense of support and affiliation' section of this questionnaire was adapted from the Verona Service Satisfaction Scale (Ruggeri & Dall'Agnola, 1993) - a questionnaire designed to measure satisfaction with community-based psychiatric services. The current investigator devised the other sections of the questionnaire. Additional input on the content and coding of the measure was received from other forensic psychologists and psychiatrists. The final draft version was piloted with forensic psychologists role-playing participants. This helped

with the order and wording of questions designed to interview a cohort that may be both psychotic and suspicious.

The EPFA has a total of 21 questions, separated into three sections, comprised of seven questions each. The first section relates to the process of admission into the hospital setting; the second section to the experience of coercion during the admission; and the third section relates to the experience of support and affiliation during the admission. A categorical scale of negative / neutral / positive was used to score the participant's view of each experience. The negative feelings about these experiences were totaled at the end of each section. Added to the beginning of the questionnaire, but not included in scoring of the EPFA, were seven questions related to participants' insight into the process of becoming unwell, and mode of inception into hospital.

Unfortunately, due to the time limits of the current study, and the reluctance of participants to be re-interviewed about their first admission experiences, test-retest reliability could not be assessed. However, this questionnaire has good content and face validity, and statistical analysis of the three sections of the measure revealed Cronbach Alphas of: Admission Process, $r=0.60$; Coercion During Admission, $r=0.54$; Support and Affiliation, $r=0.62$. Therefore this questionnaire has acceptable reliability.

2.7.3.2 *Impact of Event Scale (IES) (Appendix 6)*

The IES (Horowitz, Wilner & Alvarez, 1979) is one of the earliest and most widely used self-report measures of specific responses to trauma. This instrument specifically

evaluates trauma-related intrusion and avoidance in terms of Horowitz's (1976) theory of stress response syndromes. It consists of 15 questions and has two subscales, which look separately at intrusion and avoidance. The intrusion subscale (seven items) measures the extent to which memories of the traumatic event continue to impinge upon the mind. The avoidance subscale (eight items) measures the extent to which the individual tries to exclude unpleasant memories from consciousness, deliberately tries to avoid getting upset, and avoids reminders of the event. Together these scales give a Total Impact of Event score and serve as a useful indicator of the extent to which a traumatic event is still intruding in the mind of the respondent. In the current investigation, only the total score was used for statistical analysis.

Participants are asked to rate IES symptoms items on a four point scale according to how often each item has occurred in the last seven days, on a scale marked 0 (not at all), 1 (rarely), 3 (sometimes) and 5 (often). There are no cut-off points as it is a descriptive rather than a diagnostic tool. The time frame of the scale is designed to assess current symptoms, regardless of when the traumatic event(s) took place. In the current study, patients are asked to rate the items on the IES in relation to their memory of their experience of the whole first psychiatric admission. In all cases, this measure followed the administration of the EFPA, thereby attempting to solely measure trauma caused by the first admission, and not any other admission. To further anchor the measure, participants were reminded that the questionnaire only referred to their experiences of their first admission, and each question was preceded with the statement "regarding your experience of your first admission..."

Horowitz *et al* (1979) report good reliability for the IES: Split half reliability for the total score is $r=0.86$. Internal consistency of the subscales is high with Cronbach's alpha for intrusion = 0.78 and for avoidance = 0.82. Test re-test reliability is also good ($r= 0.89$ intrusion, $r=0.79$ for avoidance and $r=0.87$ for total score). Other research has confirmed these findings of high internal reliability (summarised by Weiss & Marmar, 1997).

The IES has also been shown to discriminate between varied traumatized groups and non-traumatized controls. These include combat veterans, emergency services personnel, natural disaster survivors, victims of crimes and adults sexually abused as children (e.g., Alexander, 1993; Arata *et al.*, 1991; Briere & Elliott, 1996; Bryant & Harvey, 1996; Hendrix *et al.*, 1994; Lundin & Bodegard, 1993; Runtz, 1990). Due to some of the participants' in the current study having their first admission many years ago, it is useful that the IES elicits trauma from events experienced many years ago, as outlined in the studies of adults abused as children. Again, to make sure that the IES was not measuring other admissions, participants were reminded that the questions related only to their first admission.

There are now several questionnaires designed to assess PTSD symptomatology. The IES has been selected, as it is a measure with which many are familiar and for which comparison data exist and this has advantages in the clinical setting. A good alternative is the revised IES (Weiss & Marmar, 1997). However, funds were not available for purchasing this measure.

2.7.3.3 *The Client Satisfaction Questionnaire (CSQ) (Appendix 7)*

A review of the literature on client satisfaction (Ruggeri, 1994) found that there was a low range of choices in the response items on many scales (e.g., reduced to satisfied/dissatisfied), and that most instruments considered only general aspects of consumer's interaction with a service rather than specific care elements. For this reason the Verona Service Satisfaction Scale (Ruggeri & Dall'Agnola, 1993) was designed. Unfortunately, this scale is not appropriate for forensic settings as many of its items refer to services in the community pre- and post-admission. However, the CSQ (Larsen *et al.*, 1979) is a standardised self-report questionnaire on overall satisfaction with services, designed for service users, that improves on the satisfied/dissatisfied scale by using a four-point scale on which to rate satisfaction with services, and addresses different aspects of care. There are no cut-off points as it is a descriptive rather than a diagnostic tool. As there are only eight questions, it is quick and easy to administer to a cohort that can be difficult to engage. Aspects of care that might be neglected in this measure are mostly addressed in the EFPA.

The CSQ has been shown to have construct validity, split-half reliability and good psychometric properties (Ruggeri, 1994). Indeed, it possesses a high degree of internal consistency and correlates with therapists' estimates of client satisfaction. The scale's coefficient alpha was $\alpha=0.90$ when used with clients after their first service contact, and $\alpha=0.94$ when used in a 90-day follow-up with the same clients (Cox *et al.*, 1978).

2.7.3.4 Rating of Medication Influences (ROMI) (Appendix 8)

The ROMI (Weiden *et al.*, 1994) is a standardized measure used to evaluate compliance with medication in psychiatric cohorts. It assesses the attitudinal and behavioural factors influencing patients' compliance with neuroleptic treatment. There are a total of 20 questions. Respondents are asked to rate the degree of influence for reasons for complying or not complying with medication over the past month. Seven items are related to compliance and 13 items related to non-compliance. However, given that participants in the current study were in medium security, and have to comply with medication, only those questions related to reasons for compliance were included in the current study (questions 1 – 7). Each item has a four-point scale marked 0 (not applicable), 1 (item is present but has no influence on compliance), 2 (item has a mild influence) and 3 (item has a strong influence). The items related to compliance address illness prevention, influence of others and liking medication. There are no cut-off points as it is a descriptive rather than a diagnostic tool.

The ROMI has moderate reliability and validity, with a Kappa coefficient of 0.60, and a Cronbach Alpha of 0.57 (Weiden *et al.*, 1994).

2.7.3.5 Schedule for the Assessment of Insight-Expanded (SAI-E) (Appendix 9)

The SAI-E (Kemp & David, 1996) is an expanded version of David's (1990) standardised insight measure, and is designed to assess participants' level of understanding about their condition, and the need for psychiatric care. There are a total of nine questions. These include items on awareness of change in mental functioning, awareness of need for

treatment, and awareness of the psychosocial consequences of illness; as well as the original measure's items assessing treatment compliance, recognition of illness and re-labeling of psychotic phenomena. It also includes a supplementary question on responses to a hypothetical question that contradicts the patient's view of their illness (question nine). Six of the questions have a three-point response scale (0 – 2), and the other three questions have a five-point Likert scale (0 – 4). All scores are summed to give an overall insight score. The SAI-E has good face and content validity, and has a Cronbach Alpha of $r=0.68$, indicating acceptable reliability (Kemp & David, 1996).

An additional scale was used to assess RMOs' opinion of their patients' level of insight. This replicated the supplementary question 9, scoring patients' response to a hypothetical question contradicting their view of their mental illness (SAI-hq - appendix 10). This was given to RMOs' on a piece of paper, asking them to give their opinion of what their patient would say in response to a contradictory view of their illness. Consultants completed this the day after the patient was interviewed. As consultants are very busy, and unlikely to be willing to complete the full insight measure for each of their patients, they were asked only to rate assumed responses to the hypothetical question.

2.7.4 Brief Psychiatric Rating Scale (BPRS) (Appendix 11)

The BPRS (Overall & Gorham, 1962) is a quantitative standardised scale consisting of 18 items that are constructed for detecting the presence of schizophrenic states (items 3, 4, 7, 8, 10, 11, 12, 14-18). It also includes questions for detecting symptoms of depression

(items 1, 2, 5, 6, 9 and 13). Scores on these items are summed to gain a total score for depression and psychotic symptomatology. Depression and psychosis have been found to bias retrospective recall (e.g., Brown & Harris, 1978). Level of psychosis has also shown to be modestly related to levels of insight (e.g., Amador *et al.*, 1994). Therefore it was necessary to measure levels of depression and psychosis in participants in the current investigation in order to take account of the effect of these variables on retrospective accounts and measures of insight. Each item has a five-point Likert scale marked 0 – 4, where 0 indicates normal functioning. The BPRS therefore also serves the purpose of identifying how ill patients are at the time of interview. This measure has good inter-observer reliability ($r=0.83$), and intra-observer reliability ($r=0.80$).

2.7.5 The National Adult Reading Test (NART) (Appendix 12)

The NART (Nelson & O'Connell, 1978) is designed to estimate pre-morbid IQ. It is comprised of a list of 50 words printed in order of increasing difficulty. The words are relatively short to avoid the possible adverse effects of stimulus complexity, and they are all 'irregular' with respect to the common rules of pronunciation in order to minimise the possibility of reading by phonemic decoding rather than word recognition.

The respondent reads aloud down the list of visually presented words and the number of pronunciation errors is recorded. WAIS-R Verbal, Performance and Full Scale IQs can be predicted from this reading error score by inserting it into the appropriate formulae. Within the range of the NART formulae, these predicted IQs approximate closely to the

respondent's pre-morbid IQ. This is a well-established standardised measure. The reliability of the NART was assessed by a split-half technique (Cronbach alpha), which gave a high reliability coefficient of $r=0.93$.

CHAPTER THREE: RESULTS

3.1 Overview

The study aimed to investigate a number of hypotheses that focus primarily on the effect of first admission experiences and feelings of Black patients with paranoid schizophrenia on current levels of trauma, their satisfaction with psychiatric care at first admission, and current reasons for complying with medication. Also under investigation was consultants' view of their Black patients' current insight, and comparison of these views with measured levels of current insight. Finally, the current study explored the effect of first admission experiences and feelings, trauma, satisfaction, IQ, psychological therapy, and severity of psychosis and depression on current insight. The findings were compared with White patients with paranoid schizophrenia. All interviews were fully completed; therefore there was no missing data.

3.2 Data preparation

All dependent variables in the current investigation were checked for normality and outliers. Z-tests revealed only two dependent variables where there were significant Skewness and Kurtosis ($p < 0.05$). These were (1) length of current admission, and (2) current admission psychology contact. On both these variables, it was found that non-normality was caused by the presence of outliers (cases with standard deviations greater than 3 from the mean). In order to improve the distribution of these variables, the outliers

were reduced by following procedures described by (Tabachnick & Fidell, 1996). Subsequently, the Skewness and Kurtosis for these variables were no longer significant.

Although the Impact of Event Scale variable was not significantly Skewed, visual inspection of the distribution indicated a non-normal distribution. This was due to a substantial proportion of the cases scoring zero. For this reason, a non-parametric test was used to analyse mean differences on this variable.

3.3 Variables Concerning First Psychiatric Admission

3.3.1 Comparison of socio-demographic and psychiatric variables at first admission between Black and White Patients

Socio-demographic variables related to the first psychiatric admission which were considered relevant for analysis, were collected. Analysis of these variables was carried out individually, and therefore controls for type one error (correction for multiple testing), were not conducted. This was done in order that potentially important confounds were not missed, and could be taken into account in later analyses. Mean scores and category membership were compared between Black and White patients. Tables of results are separated into independent sample t-tests (Table 1.), and Pearson's Chi-Square analyses (Table 2.).

Table 1. Comparison of socio-demographic and psychiatric variables at first admission between Black and White patients (independent samples t-tests)

	Black (n=22)		White (n=22)		<i>t</i>	<i>p</i> ^a
	M	SD	M	SD		
Age 1 st Admission	24.0	4.58	28.0	9.58	1.727	0.094*
No. of Family Contacts	3.0	2.13	3.3	2.61	0.507	0.614

note: ^aall *p*-values are two-tailed; df=42

*approaching significance at $p < 0.05$

Mean differences were analysed using independent samples t-tests. This showed there was a significant difference between Black and White patients in age at first admission. However, there was no significant difference between Black and White patients in the number of family members they were in contact with around the time of their first admission.

Table 2. Comparison of socio-demographic and psychiatric variables at first admission between Black and White patients (Pearsons' Chi-Square tests)

Yes	Black (n=22) %	White (n=22) %	χ^2	p^a
Living Alone	31.8	31.8	na	na
Unemployed	68.2	50.0	1.504	0.220
Religion (Christian only)	54.5	54.5	na	na
Neg. view of Mental Illness by Church	0.0	0.0	na	na
Pre-morbid Drug Abuse	77.3	86.4	0.611	0.434
Self Noticed When 1 st Ill	27.3	22.7	0.121	0.728
Understood it was an Illness	54.5	36.4	1.467	0.226
Understood Why Admitted	59.1	50.0	0.367	0.546
Agreed with Admission	45.5	40.9	0.093	0.762
1 st Ad. from Prison	31.8	27.3	0.109	0.740
If not in Prison, Got GP	73.3	75.0	0.011	0.916
If got GP → Approached	45.5	45.5	na	na
GP Helped	60.0	80.0	0.476	0.490

note: ^aall p -values are two-tailed; df=42; na=not applicable

Categorical differences were tested using Pearson's Chi-Square analysis. This showed there were no differences between Black and White patients on the variables of living alone at the time of first becoming unwell, observing a religion - all of which were Christian (i.e. Catholic and Church of England; none were Pentecostal), and their church holding a negative view of mental illness. More Black than White patients were

unemployed pre-admission, more White than Black patients abused drugs before their first admission, and more Black than White patients were the first to notice they were becoming unwell, (rather than others noticing first), but none of these were significant. More Black patients understood they had an illness, understood why they were being admitted, and agreed with their admission, but none of these differences reached significance. More Black patients were first admitted to hospital from prison, but this did not reach significance. Of those patients not in prison, the amount of patients with a GP was nearly equal between the groups, and exactly the same percentage in each group approached their GP for help. More White patients felt their GP helped, but this was not significant.

3.3.2 Levels of insight in Black and White patients at first admission (*Exploratory Hypothesis 1, part A*).

From the first admission variables analysed, patients (1) first noticing that they were becoming unwell (rather than others), (2) understanding that they had an illness, (3) understanding why they were admitted, and (4) agreeing with their first admission, can be seen as an indication of the presence of insight at the time of first admission. Individual analysis of these variables indicated that there were no significant differences between Black and White patients, as shown in section 3.3.1. Summing of these variables into one score, and analysing mean differences between Black and White patients using an Independent Samples t-test, confirmed this finding ($t=0.785$, $df=42$, $p=0.438$, two-tailed).

3.3.3 Do Black patients remember having more negative *experiences* during their psychiatric admission than White patients? (Hypothesis 1, part(i).)

In order to analyse differences between Black and White patients regarding negative experiences they had during their first psychiatric admission, the percentage of patients who were (1) removed from a public place (Section 136) (2) not given an explanation as to why they were admitted, (3) not shown around on admission, (4) given depot (intra-muscular injection) anti-psychotic medication, (5) forced to take medication, (6) experienced restraint, sedation or seclusion, (7) drug-screened, (8) had their room searched, (9) did not feel they could talk to other patients or a member of staff, (10) not offered psychological therapy, and (11) were not visited, was collected. All of these variables were categorised into yes or no groups. The number of yes responses on these variables was then summed to give an overall number of negative experiences for each patient. Mean scores were compared between the Black and White groups, as shown in Table 3.

Table 3. Comparison of negative *experiences* between Black and White patients

	Black (n=22)		White (n=22)		<i>t</i>	<i>p</i> ^a
	M	SD	M	SD		
Neg. Experiences	6.73	2.51	6.50	2.35	0.310	0.379

note: ^a*p*-value is one-tailed; df=42

Independent samples t-test analysis showed there was no significant difference between Black and White patients in the number of negative experiences they had encountered at first admission.

3.3.4 Do Black patients have more negative *feelings* about their first psychiatric admission than White patients? (Hypothesis 1, part (ii).)

The previous section analysed differences between Black and White patients' negative *experiences* during their first psychiatric admission. This section analyses whether Black patients had more negative *feelings* about their first psychiatric admission. The number of counts of negative feelings (from an interval scale of negative, neutral, positive), on each of the three subscales of the Experience of First Psychiatric Admission (EFPA): (1) admission process, (2) coercion, and (3) support and affiliation, was collected. Mean scores were compared between Black and White patients, as shown in Table 4.

Table 4. Comparison of negative *feelings* between Black and White patients

	Black (n=22)		White (n=22)		<i>t</i>	<i>p</i> ^a
	M	SD	M	SD		
Neg. Ad. Process	1.7	1.52	1.0	0.98	1.891	0.034
Neg. Coercion	2.3	2.19	2.0	2.08	0.353	0.363
Neg. Support/Aff.	2.3	1.49	2.4	1.43	0.103	0.460

note: ^aall *p*-values are one-tailed; df=42

As three tests were carried out, a Bonferroni correction was applied ($\alpha = 0.05$ divided by 3). Therefore, tests will only be declared significant when $p < 0.017$. Mean differences were analysed using independent samples t-tests. This showed that there were no significant differences between the groups regarding negative feelings about the admission process, the coercion used, and support and affiliation. Further analysis of the percentage of patients who were reluctant to return to psychiatric care after their first admission was carried out to see if reluctance was more elevated in Black patients. Categorical differences were tested using Pearson Chi-square analysis. This showed that there was no difference between the groups on this variable ($\chi = 0.834$, $df = 1$, $p = 0.181$, one-tailed).

3.3.5 Do Black patients have higher levels of current trauma related to events experienced during their first admission than White patients? (Hypothesis 1, part (iii).)

Total scores on the Impact of Event Scale (IES) were collected. Mean scores were compared between the Black and White groups, as shown in Table 5.

Table 5. Scores on the IES for Black and White patients

	Black (n=22)		White (n=22)		<i>U</i>	<i>p</i> ^a
	M	SD	M	SD		
IES	12.1	13.75	12.5	16.46	0.211	0.459

note: ^a*p*-value is one-tail; $df = 42$

Black patients had a marginally lower score on the Impact of Event Scale than White patients. However, when mean differences were analysed using a Mann-Whitney U-test, this showed no significant difference between Black and White patients on this measure.

3.3.6 Do Black patients have lower levels of satisfaction with the psychiatric care received during their first admission? (Hypothesis 1, part (iv).)

Total scores on the Client Satisfaction Questionnaire (CSQ) were collected. Mean scores were compared between the Black and White groups, as shown in Table 6.

Table 6. Scores on the CSQ for Black and White patients

	Black (n=22)		White (n=22)		<i>t</i>	<i>p</i> ^a
	M	SD	M	SD		
CSQ	16.5	7.18	20.2	6.86	1.74	0.044*

note: ^a*p*-value is one-tail; df=42
lower scores indicate less satisfaction

**p*<0.05

Black patients had a lower score on the Client Satisfaction Questionnaire than White patients. Mean differences were analysed using an independent samples t-test. This showed that the difference was significant. Previous analysis showed a significant difference between the groups in age at first admission, but no significant differences

between the groups in negative experiences during the first admission, negative feelings about the first admission, or levels of trauma related to events experienced during the first admission. Analysis of Covariance (ANCOVA) analysis was used to see if the difference in satisfaction between the groups remained after controlling for age at first admission. This showed that the difference between Black and White patients in satisfaction was no longer significant ($F_{(1,41)}=1.558$, $p=0.110$, one-tailed). Therefore, it appears that difference in satisfaction can be explained by the difference between the two groups in age at first admission.

3.4 Variables Concerning Current Psychiatric Admission

3.4.1 Comparison of socio-demographic and psychiatric variables at current admission between Black and White patients

Socio-demographic and psychiatric variables related to the current admission which were considered relevant for analysis, were collected. Analysis of these variables was carried out individually, and therefore controls for type one error were not conducted. This was done in order that potentially important confounds were not missed, and could taken into account in later analyses. Mean scores were compared between Black and White patients, as shown in Table 7.

Table 7. Comparison of socio-demographic and psychiatric variables between Black and White patients

	Black (n=22)		White (n=22)		<i>t</i>	<i>p</i> ^a
	M	SD	M	SD		
Age	31.7	6.8	37.0	10.0	1.986	0.056*
IQ	96.3	12.14	92.3	12.18	1.079	0.288
No. of Admissions	3.5	2.76	4.5	4.00	0.922	0.362
Illness Duration (yrs)	8.0	5.70	9.0	7.87	0.508	0.614
Length Current Ad. (mths)	19.7	12.43	19.1	13.6	0.151	0.882
Current Ad. Ψ (mths)	8.8	10.01	5.8	7.09	1.121	0.268
Current Psychosis	6.6	5.00	6.2	5.32	0.292	0.772
Current Depression	1.7	1.52	3.1	2.85	1.977	0.058*

note: ^aall *p*-values are two-tailed; df=42

*approaching significance at $p < 0.05$

Mean differences were analysed using independent samples t-tests. This showed there were significant differences between Black and White patients in current age and current level of depression, with White patients being older and more depressed. Analysis of Covariance (ANCOVA) analysis was used to see if the difference in depression between the groups remained after controlling for current age. This showed that the difference in depression between the groups could not be explained by being older ($F_{(1,41)}=6.281$, $p=0.008$, one tailed). Therefore, it appears that difference in depression cannot be

explained by the difference in age between the two groups, and that other variables were at work.

There were no significant differences between Black and White patients in pre-morbid IQ, number of psychiatric admissions, years of illness duration, months of current admission, months of contact with psychological therapy during current admission, and current severity of psychosis. Further, categorical differences between the numbers of Black and White patients who committed their offence in the context of a mental illness were examined. Chi-square analysis did not need to be conducted as 17 patients in each group had committed their offence in the context of their mental illness.

3.4.2 Are more Black patients currently on more than one anti-psychotic medication than White patients? (Hypothesis 2, part (i).)

Patients were categorised into those who were, and those were not, on more than one neuroleptic. These categories were compared between Black and White patients, as shown in Table 8.

Table 8. The number of Black and White patients on more than one anti-psychotic medication

	Black (n=22) %	White (n=22) %
On more than one med.	13.6	18.2
Not on more than one med.	86.4	81.8

Categorical differences were tested using Pearson's Chi-square analysis. This showed there was no difference in the percentage of Black and White patients on more than one anti-psychotic medication ($\chi=0.170$, $df=1$, $p=0.34$, one-tailed).

3.4.3 Are more Black patients complying with current medication due to pressure and fear of re-hospitalisation in the future than White patients? (Hypothesis 2, part (ii).)

Scores were summed on four subscales of the Reasons for Compliance (ROMI) questionnaire: (1) influence of own experience of illness (questions 1, 5), (2) influence of professionals (questions 2, 3), (3) influence of family (question 4), and influence of pressure and not wanting to return to hospital (questions 6, 7). Mean scores were compared between Black and White patients, as shown in Table 9.

Table 9. Reasons for Medication Compliance in Black and White patients

Influence	Black (n=22)		White (n=22)		<i>t</i>	<i>p</i> ^a
	M	SD	M	SD		
Own Experience	4.1	2.11	3.6	2.24	0.762	0.225
Professionals	2.8	1.97	2.3	2.12	0.810	0.213
Family	1.5	1.5	1.1	1.36	1.036	0.153
Pressure and Re-hospitalisation	4.2	1.74	3.8	1.62	0.718	0.238

note: ^aall *p*-values are one-tail

As four tests were carried out, a Bonferroni correction was applied, which showed that results could only be significant when $p < 0.013$. Mean differences were analysed using independent samples t-tests. This showed no significant difference in the number of Black and White patients complying with current medication due to pressure and fear of re-hospitalisation in the future, and no significant difference between the groups on all other reasons for complying with medication. Patients' responses were also categorised into (1) those whose *strongest* reason for complying with medication was 'pressure and fear of re-hospitalisation', versus (2) all other reasons. Categorical differences were tested using Pearson's Chi-Square analysis, which showed there was also no significant difference between the groups on these variables ($\chi^2 = 0.091$, $df = 1$, $p = 0.381$, one-tailed).

3.4.4 Levels of insight in Black and White patients at current admission
(Exploratory Hypothesis 1, part B).

Total scores on the Schedule for the Assessment of Insight-Expanded (SAI-E) were collected. Mean scores were compared between the Black and White groups, as shown in Table 10.

Table 10. Insight scores (SAI-E) for Black and White patients

	Black (n=22)		White (n=22)		<i>t</i>	<i>p</i> ^a
	M	SD	M	SD		
SAI-E	16.5	7.65	15.0	7.72	0.657	0.516

note: ^a*p*-value is two-tail; df=42

Mean differences were analysed using independent samples t-tests. This showed there was no significant difference between Black and White patients on the Schedule for the Assessment of Insight-Expanded (SAI-E).

3.4.5 Do consultants rate their Black patients as having poorer insight than White patients? (Hypothesis 3, part (i).)

Scores were collected on consultants' ratings of their Black and White patients' insight, using the hypothetical question (SAI-hq) from the SAI-E. Mean scores for Black and White patients were compared, as shown in Table 11.

Table 11. Consultants' scores of insight (SAI-hq) for Black and White patients

	Black (n=22)		White (n=22)		<i>t</i>	<i>p</i> ^a
	M	SD	M	SD		
SAI-hq	2.3	1.24	2.3	1.55	na	na

It was not necessary to test mean differences, as mean consultant scores for Black and White patients' insight on the hypothetical question (SAI-hq) were the same.

3.4.7 Do consultants' ratings of Black patients' insight (SAI-hq) *not* correlate with the standardised measure of insight (SAI-E), and do consultants ratings of White patients' insight *correlate* with the standardised measure of insight? (Hypothesis 3, part (ii).)

When consultant ratings across the whole sample were compared to the standardised measure of insight across the whole sample, Pearson's Correlation Analysis showed that there was a highly significant correlation between the two ($r=0.535$, $p<0.0001$, two-tailed). However, the correlation between the standardised measure of insight and consultant ratings for Black patients was not significant ($r=0.314$, $p<0.077$, one-tailed), and for White patients the correlation was significant ($r=0.721$, $p=0.001$, one-tailed). Using Fisher's Z-test to analyse the difference between the two correlations derived from the separate groups showed that the difference between the two correlations was significant ($z=1.76$, $p=0.04$, one-tailed). Therefore, there was no difference in consultants' average rating of insight in Black and White patients, but the association between consultant ratings and the standardised measure of insight was higher for the White group than for the Black group.

3.4.8 Is there a relationship between current insight and the variables of negative experiences and feelings concerning the first admission, trauma related to the first admission, and satisfaction with the first psychiatric admission? (*Exploratory Hypothesis 2.*)

Although there was no evidence of differences between Black and White patients in insight, negative experiences and feelings concerning the first admission, and trauma related to first psychiatric admission, with the difference in satisfaction between the groups appearing to be related to a younger age at first admission, the current study explored the potential relationship between the above variables and current insight, independent of race. These variables were entered into a multiple regression analysis. A significant model did not emerge: (Adjusted R square=0.048, $F_{(6,37)}=1.361$, $p=0.256$). It therefore appears that none of the above dependent variables predicted current insight.

3.4.9 Is there a relationship between current insight and the variables of pre-morbid IQ, psychological therapy, and current severity of psychosis and depression? (*Exploratory Hypothesis 3.*)

Although there was no evidence of differences between Black and White patients in amount of current contact with psychological therapy, pre-morbid IQ, and current severity of psychosis, with the difference in depression between the groups appearing to be related to variables other than being older during the current admission, the current study explored the potential relationship between the above variables and current insight,

independent of race. These variables were entered into a multiple regression analysis. A highly significant model emerged: (Adjusted R square=0.610, $F_{(5,38)}=14.452$, $p=0.0001$). There was one independent effect, with lower severity of psychosis significantly predicting higher current insight in this model ($B=-1.007$, Beta=-0.674, $t=-6.284$, $p=0.0002$, two-tailed). Contact with psychological therapy, pre-morbid IQ, and depression were not significant predictors in this model. Therefore, only severity of psychosis had a relationship to current levels of insight.

It was surprising that psychological therapy did not have an effect on current insight, and it was thought that patients with higher insight might be offered, and remain in, psychological therapy for longer. However, when first admission insight was controlled for in the analysis, psychological therapy was not able to predict current insight.

CHAPTER FOUR: DISCUSSION

4.1 Summary of Research Aims, Method and Main findings

The aim of the current study was fourfold: (1) to investigate the first admission experiences feelings of Black patients with schizophrenia, in comparison to their White counterparts; (2) to see if first admission experiences and feelings have a relationship to current trauma, treatment satisfaction, and current medication compliance; (3) to investigate consultants' view of their Black and White patients' current insight, and compare these views with measured levels of current insight; and (4) to explore the effect of first admission experiences and feelings, IQ, psychological therapy, and severity of psychosis and depression on current insight. Twenty-two Black and twenty-two White patients with schizophrenia, all in medium security, were recruited. All participants completed a structured interview designed to measure the variables highlighted for investigation.

Regarding the first admission, it was found that Black patients were significantly younger on admission than White patients, and that levels of insight at first admission were not different between the groups. Black patients did not remember having more negative experiences than White patients, nor did they have more negative feelings about the first admission than White patients. There was no significant difference between the groups in levels of trauma related to events experienced during the first admission, however Black patients were less satisfied with the psychiatric care they had received during their first

admission. Further analysis showed that the difference in satisfaction between the groups could not be explained by the difference in age, whereby patients who were younger at first admission were less satisfied with the care they received.

Regarding the current admission, it was found that White patients were significantly older and more depressed than Black patients. Further analyses controlling for age revealed that the White patients being older could not explain the differences in depression between the groups, and that other variables were at work. There were not more Black patients on more than one anti-psychotic than White patients, nor were there more Black patients complying with current medication due to pressure and fear of re-hospitalisation in the future. Measurement of levels of current insight showed no difference between the groups. Consultants did not rate their Black patients as having poorer insight than their White patients, and consultants' ratings across the whole sample accorded with the standardised measure of insight across the whole sample. However, further analysis revealed that consultant ratings of insight in Black patients did *not* correlate with the standardised measure of insight, that consultant ratings of insight in White patients *correlated* with the standardised measure, and that the difference between these two correlations was significant. This suggested, then, that the association between consultant ratings and the standardised measure of insight was lower for the Black group. Exploration of the relationship between current insight and the variables of negative experiences and feelings concerning the first admission, trauma, and satisfaction revealed that none of these variables predicted current insight. Exploration of the relationship between current insight and the variables of pre-morbid IQ, psychological therapy, and

current severity of psychosis and depression revealed that only lower severity of psychosis predicted higher current insight.

4.2 Interpretation of the Current Findings in the Context of Previous Findings

4.2.1 First admission variables

4.2.1.1 *Socio-demographic variables*

Stigma and size of primary group

There were no significant differences between Black and White patients in the size of their primary group contact at the time of the first admission. Previous research has not indicated differences between ethnic groups in the size of primary group, but has found that size of primary group has a relationship to insight by reducing stigma (White *et al.*, 2000). They suggest that a larger size of primary group has a 'normalising function' for mental illness, with greater numbers perhaps providing a better chance of patients coming into contact with someone who does not stigmatise their illness, thereby making it easier for patients to accept an illness model (White *et al.*, 2000). As the basic measure of insight at first admission did not show a difference between Black and White patients on this variable, it can be speculated that this may have been a reflection of the groups being in contact with a similar size of primary group.

Age

The difference between Black and White patients' age at first admission was approaching significance, with Black patients being younger. This has been noted in the previous literature (Thornicroft *et al.*, 1999). This appears to accord with social adversity theories of schizophrenia in this cohort (Bhugra *et al.*, 1999). To expand, it might be expected that the conditions of less employment, living alone, and unmet socio-economic expectations, which have been found to make Black British people more vulnerable to schizophrenia (Bhugra *et al.*, 1997), would become most pronounced after leaving school and home. This might be one explanation for the younger age of first onset in the Black group. The effect of age on patient satisfaction is discussed later in this section.

Living alone

Previous literature has found that Black patients are more likely to be living alone before admission than White patients (Bhugra *et al.*, 1997; Butt, 2001). However, this was not found in the current study, with exactly the same number of Black and White patients living alone before their first admission. The literature has shown that this is one variable that contributes to a vulnerability to schizophrenia, and suggests that the Black and White patients in this study were equally vulnerable to its influence in the aetiology of their schizophrenia. Indeed, it is possible that White patients in medium security represent a minority of White patients in Britain that have been exposed to similar levels of social adversity as Black patients in Britain. However, this is speculation, and requires further investigation that was beyond the focus of the current study.

Unemployment

Although more Black patients were unemployed than White patients at pre-admission, this difference was not significant. This does not accord with previous literature, which has consistently found greater levels of unemployment in the Black cohorts they have researched (Bhugra *et al.*, 1997, 1999, 2000; Van Os *et al.*, 1994, 1999; Hutchinson *et al.*, 1999). However, as with the previous point on 'living alone', the literature has shown that unemployment is one variable that contributes to a vulnerability to schizophrenia, and suggests that the Black and White patients in this study were equally vulnerable to its influence in the aetiology of their schizophrenia. Indeed, it is possible that White patients in medium security may represent a minority of White patients in Britain that have been exposed to similar levels of social adversity as Black patients in Britain. Again, this is speculation, and requires further investigation that was beyond the focus of the current study.

Religion and insight

Previous researchers have suggested that cultural explanations for mental illness, perhaps linked to different religious beliefs, creates opposing explanations for mental illness that may affect insight (e.g., Johnson & Orrell, 1996; Cinnirella & Loewthal, 1999). The current study found that equal numbers of Black and White patients followed a religion, and that this was a Christian religion. None were Pentecostal, which is a Christian religion known to espouse beliefs of 'possession by evil spirits' to explain physical and mental affliction. Nor did any of these patients report that their Church or congregation had a negative view of mental illness. This suggests that the lack of basic differences in

religious beliefs across the two groups may have led to the lack of difference in levels of insight on the standardised and consultant measures. However, church membership is not the only factor in religiosity. Further, Black patients might have been reluctant to report religious beliefs at variance with dominant 'British' religions (Church of England, Roman Catholic), to a White interviewer. Both these factors may have confounded the findings.

Drug-abuse

Regarding the controversial issue of drug-abuse in ethnic minority groups, the current study found no significant difference between Black and White patients on this variable. This accords with Browne (1997) and McKenzie & Murray's (1999) findings. However, given that Black people are likely to be aware of the stereotype of drug-abuse attached to their community, they may be more reluctant to self-report such practices. This may be one plausible explanation for why rates of drug-abuse in psychiatric reports have been found to be consistently lower in Black patients (e.g., McKenzie & Murray, 1999). Currently, though, there is no explanation, other than stereotyping, for why psychiatrists have been shown to consider drug-use to be more prevalent in Black patients. This might have been useful to explore in the current study, but was not the focus of the investigation.

Use of GP and insight

In line with previous findings that Black people approach their GP at similar rates as other groups when first ill (Burnett *et al.*, 1999; Hutchinson & Sharpley, 1999), the current study found no difference between the groups in the number who approached

their GP, and suggests that the Black group demonstrated an equal awareness of their symptoms when they first became ill as the White group. This was further supported by the finding that there was no difference in the number of Black and White patients who ‘first noticed that they were ill’, ‘understood that they were ill’, ‘understood why they were admitted’, and ‘agreed with their admission’, all of which suggest good insight. The current findings on these last two variables are at variance with Butt’s (2001) findings, which found only a small minority of Black patients knowing why they were in hospital, and agreeing that they needed hospital treatment. However, Butt’s (2001) study did not interview patients about their first admission. This is important, as it continues to highlight the need to understand what aspects of the first admission would cause Black patients to be less ‘involved’ with subsequent admissions, to the degree that they do not understand or agree with an admission when relapsing. Alternatively, this lack of involvement in re-admission might not be related to experiences of first admission, but to the experience of after-care following discharge after first admission. This was not explored in the current investigation.

4.2.1.2 Negative experiences of and feelings about the first admission

The current study found no significant differences between Black and White patients in the number of negative experiences they had endured, or in the number of negative feelings they had about the first admission. This does not accord with previous studies, which have hypothesised that the experience of psychiatric care is significantly different between Black and White patients (e.g., Browne, 1997; Wilson & Francis, 1997). It is possible that the experiences themselves may not be significantly different, but that the

feelings about these experiences might be. However, the current study did not find a significant difference between the groups in the number of negative feelings they had about the first admission. The lack of difference in negative experiences and feelings could also be explained by the lack of difference between the groups on the variables of understanding and agreeing with the first admission, whereby those who have less understanding and agreement with their treatment might require higher levels of coercion during their admission.

There was also no difference between the numbers of Black and White patients who were reluctant to return to psychiatric care after discharge from the first admission. This does not accord with previous studies (e.g., Burnett *et al.*, 1999), which found that reluctance to return to hospital becomes elevated in Black patients after the first admission. However, the lack of difference in reluctance might be explained by the lack of difference between the groups in the amount of negative experiences and feelings related to their first admission. It might also be explained by the lack of difference in first admission insight between the groups, whereby it has been suggested that greater reluctance to return to services is a function of poor insight. A further explanation is that Burnett *et al.*'s (1999) findings might relate to the experience of after-care, which was not addressed in the current study. Finally, however, the measure of reluctance in the current study was a basic yes or no measure, and it is possible that if the measure had used a 0-10 scale, a difference between the groups might have emerged.

4.2.1.3 Trauma related to events experienced during the first admission

Previous studies have shown that Black patients are less satisfied with psychiatric care they receive (e.g., Butt, 2001), they have not, however, suggested that Black patients might be more traumatised by their experiences in hospital. However, research of this variable in the current investigation did not show any difference between Black and White patients. Again, this might be explained by the lack of difference between the groups on the variables of understanding and agreeing with the first admission, whereby those who have less understanding and agreement with their treatment might be more traumatized as a result. Further, as previously reported, there was no difference between the groups in the amount of negative experiences and feelings related to their first admission. If a difference had emerged on these variables, a difference in trauma may have also emerged.

4.2.1.4 Satisfaction with psychiatric care received at first admission

As cited above, previous research has shown that Black patients are less satisfied with the care they receive than White patients (Butt, 2001). This was confirmed in the current study, and further analysis showed that this lower satisfaction was related to being younger at first admission. This is the first empirically supported finding to begin to explain why some Black patients might be more dissatisfied with the care they receive. Further, given that there were no differences in insight between the groups at first admission, it might be suggested that being in the psychiatric system at a younger age, rather than poor insight, affects Black patients views of psychiatry. Life-span developmental theories (e.g., Baltes, 1987) could be useful for further exploration of why

these variables are related in the psychiatric population. Indeed, being younger is generally associated with having fewer responsibilities, and therefore greater freedoms. Being detained in or admitted to hospital at a younger age might trigger greater dissatisfaction that is more closely related to the admission, rather than the treatment received once admitted. Clearly this is an under-researched area in the literature, and requires replication to support the current findings, and more in-depth interviews to uncover other potential variables affecting patient satisfaction in Black patients.

4.2.2 Current Admission Variables

4.2.2.1 Socio-demographic and psychiatric variables

Age and depression

The current study found that, at the time of interview, the difference between White and Black patients' age and level of depression, with White patients being older and more depressed, was approaching significance. Higher rates of depression in White patients have been cited in previous literature (e.g., Fernando, 1988; McKenzie *et al.*, 1995). However, as outlined in the previous literature (see chapter one, 1.2.1), this continues to require explanation. Further analysis in the current study revealed that being older was not the reason for the White group being more depressed, and indicated that other variables were affecting the level of depression in this group. Again, life-span developmental theories (e.g., Baltes, 1987) could be useful for further exploration of why White patients are generally more depressed than Black patients. One idea to explain

these differences might be related to in-group comparison to other men at the same stage in the life cycle. To explain, due to Black people's greater experience of socially adversity in Britain, and therefore less socio-economic success (Bhugra, *et al.*, 1997, 1999), the loss of social-economic success and status on admission might be greater for White patients than Black patients. White patients may then unconsciously compare themselves to socially successful White males, who are not in hospital, further magnifying these losses. This might act as a catalyst for depressive thinking and depression. However, further exploration of this was beyond the scope of the current study, and is perhaps an area for further investigation in future studies.

Pre-morbid IQ

Levels of pre-morbid IQ were not found to be different between the groups, and the relationship of this variable to insight is outlined later.

Number of psychiatric admissions

Interestingly, there was no significant difference in the number of psychiatric admissions between the groups. This goes against the previous finding that psychotic relapse and numbers of admissions are greater for Black patients than other cohorts (Thornicroft *et al.*, 1999; Sharpley *et al.*, 2001). However, this might be explained by the current study addressing a very specific cohort, and the difficulty with generalising the current findings to all cohorts of Black patients with schizophrenia across settings. Indeed, a factor that was overlooked in the current study was the number of forensic mental health admissions for each patient. To expand, firstly, given that forensic hospital admissions are

significantly longer than non-forensic hospital admission, a greater number of forensic admissions would reduce the overall number of admissions. Secondly, Sharpley *et al* (2001) hypothesise that re-exposure to factors of social adversity specific to Black groups is one cause of the higher reported rates of relapse in their study. Given that forensic mental health admissions run into years, this suggests that Black forensic patients may, in some way, be protected from some of these factors whilst in hospital. This, in addition to sections of the Mental Health Act (1983) requiring some patients to stay on medication after discharge, with the possibility of 'recall' if they do not, may have reduced the relapse rate for the Black patients in the current study. However, more simply, the current findings might have been the result of the sample size. Either way, replication is necessary, but with an additional measure of the number of forensic admissions being included in the interpretation of the findings. It may be important to add here that, in any replication, the findings may yield greater reliability if the length of time since the first admission is limited to five years. In the current investigation, the mean number of years since the first admission was eight years for the Black group, and nine years for the White group. However, a prospective design would remove any vulnerability to retrospective memory bias.

Length of admission and contact with talking therapies

The current study found no difference between Black and White patients in the length of their current admission, and in the amount of contact with psychological therapy during their current admission. This also goes against the previous literature, which found that Black patients tend to be kept in hospital for longer (Browne, 1997; Butt, 2001), and are

less frequently offered talking therapies (Browne, 1997). Given the purported over reliance on the view that “Black patients are more dangerous” and “more likely to return to drug use” to justify the longer detainment of Black patients in general psychiatric care (Browne, 1997; Butt, 2001), it might be expected that such views would become magnified in medium secure settings, where issues of dangerousness and re-offending are a regular part of assessment. However, as all patients in medium security have a reported history of dangerousness or offending, this might have neutralized any potential biases against Black patients. Further, psychological therapy is accepted as a necessary part of rehabilitation in medium security settings, and perhaps differences would emerge in general psychiatric settings which have fewer resources, as has been reported in the previous literature (Browne, 1997; Butt, 2001).

Severity of psychosis

In an attempt to explain why psychiatrists view Black patients as having poor insight, previous researchers hypothesised that severity of psychotic symptoms might be worse in Black patients (Johnson & Orrell, 1996). However, the severity of psychosis between the groups in the current study was not found to be significantly different. It is possible, however, that patients being compulsorily medicated confounded the current findings, by masking potential differences in symptom severity. Replication of the current study, including non-forensic and community patient cohorts, is necessary for the thorough investigation of the role of symptom severity in both insight and service use.

4.2.2.2 Current number of prescribed anti-psychotic medications

Following on from the previous point, the current study did not, however, find any differences between Black and White patients in the number on more than one neuroleptic, which goes against Browne (1997) and Bhugra & Bhui's (1999a) findings. This suggests that the lack of difference between the groups in symptom severity was genuine. The fact that there was a lack of difference between the groups in length of current admission perhaps provides further evidence in this direction, if it can be assumed that a more severe presentation leads to a longer admission. This is not always the case, however, and severe symptoms in some patients may respond quickly to anti-psychotic medication.

4.2.2.3 Reasons for complying with current medication

In the current study, Black and White patients did not have significantly different reasons for complying with their current medication, and more specifically, there was no difference between the groups in the number complying mainly due to 'pressure and fear of re-hospitalisation in the future'. This does not accord with previous literature relating to this area, which found that a quarter of all Black patients, compared to a fifth of White patients, discontinued their medication against medical advice in the three months after discharge from hospital (Butt, 2001), and that twice as many Black than White or Asian patients were admitted because of non-compliance (Butt, 2001). However, as all participants in the current study were compulsorily medicated, non-compliance was not measured. Further, the current study did not interview patients in the community. Therefore, other outpatient factors, which were not measured or controlled for in the

current study, may explain Butt's (2001) findings. However, the lack of difference in reasons for compliance in the current study suggests that, despite the finding that Black patients are less satisfied with their first admission, this did not have an effect on their reasons for compliance. This more specifically suggests that this component of insight (accepting the need for treatment and complying with treatment) is unaffected by being less satisfied with the first admission.

4.2.2.4 Levels of insight and consultants' view of insight

In the current study, there were no differences in levels of insight between Black and White patients on the standardised measure of insight, and consultants did not rate their Black patients as having less insight than their White patients. Further, consultants' ratings of their patients' insight across the whole sample accorded with the standardised measure of insight across the whole sample. These findings do not replicate Johnson & Orrell's (1996) study, where consultants viewed Black patients as having the poorest insight of all patient groups. However, a possible explanation for the current findings may be due to setting. Indeed, it could be argued that consultants in forensic mental health settings are better practiced at assessing insight, given their awareness of the implication of poor insight on patient freedoms, and the implication of relapse and re-offending on consultants. Indeed, in light of the more recent history of official inquiries following allegations of consultant malpractice when patients in the community hurt members of the public, there is an enormous pressure placed on forensic consultants to 'get it right', for both Black and White patients. Clearly, it would be good to replicate the study in non-forensic settings to see if the view that Black patients have less insight re-emerged.

However, examining the correlation of consultants' rating with the standardised measure of insight between the groups, rather than across the whole sample, revealed some interesting findings. Consultants' rating of insight in Black patients did *not* correlate with the standardised measure, their ratings of White patients' insight *did* correlate with the formal measure, and the difference between these two correlations was significant. Therefore, there was no difference in consultants' average rating of insight in Black and White patients, but the association between consultant ratings and the standardised measure of insight was higher for White patients, and lower for Black patients. This suggests a possible effect of ethnicity on the process of consultants assessing insight, whereby consultants do not rate their Black patients as having lower insight, but more accurately assess insight in White patients. One hypothesis for this, as suggested in the introduction (see section 1.2.1.3), is the possibility that consultants might be misinterpreting 'healthy' suspicion of psychiatric interventions as paranoia, which may remain unchanged when challenged, and be taken as evidence of reduced insight. An alternative hypothesis is that, due to the experience of racism pre-admission, Black patients may be more wary of disclosing their views of mental illness to White practitioners, thus reducing the accuracy of consultants' assessment of insight in this group. Clearly, further investigation of these hypotheses is necessary in future studies. However, the number of consultants participating in the current study also needs to be taken into consideration here. Indeed, having ten consultants, rather than five for example, may mean the insight scores given to the Black group by the consultants reflect variability in opinion, rather than the effect of race on their assumptions about insight.

However, it could be argued that this variability would also be seen in the White group, which was not the case.

4.2.2.5 The relationship between insight and the variables of negative experiences and feelings concerning the first psychiatric admission, trauma related to the first psychiatric admission, and satisfaction with the first psychiatric admission.

Although there was no evidence of differences between Black and White patients in negative experiences and feelings concerning the first admission, and current insight, the current study investigated the relationship between these variables across the whole sample. However, none of these dependent variables were shown to predict current insight, which suggests that insight is unchanged by these negative aspects and effects of psychiatric care. This is the first empirically cited finding to exclude these variables in relationship to insight.

4.2.2.6 The relationship between current insight and the variables of pre-morbid IQ, psychological therapy, and severity of psychosis and depression

Although there was no evidence of differences between Black and White patients in pre-morbid IQ and current insight, the study investigated the relationship between these variables across the whole sample.

The current study did not find an effect of pre-morbid IQ on current insight. This does not accord with David *et al's* (1992, 1995) previous findings of a relationship between IQ and insight, but supports other studies (e.g., Sanz *et al.*, 1998). However, the continuing lack

of consistency in findings on the relationship between IQ and insight might be related to David *et al* (1992, 1995) and Sanz *et al* (1998) using participants with a range of psychotic illnesses. This factor is likely to confound findings, as schizophrenia is related to the highest levels of poor insight across the psychotic disorders (Amador, 1994), and the number of patients with a diagnosis of schizophrenia in these studies was not specified.

There was no evidence of differences between Black and White patients in the amount of contact with psychological therapy they received during the current admission. Investigating the relationship between psychological therapy and current insight across the whole sample showed that psychological therapy did not have an effect on current insight. This goes against Lysaker & Bells's (1995) finding that insight in non-frontal lobe damaged patients improves with psychological input. It is surprising that the current study found no relationship between psychological therapy and insight, given that psychological therapy is frequently insight-focused in forensic settings. These findings might be explained by the fact that those with higher insight, across the whole sample, might be offered and remain in psychological therapy for longer. However, when first admission insight was controlled for, psychological therapy was still not able to predict current insight. Alternatively, these findings might have been confounded by the amount of psychological therapy received during previous admissions, which was not measured in the current study.

There was no evidence of differences between Black and White patients' severity of psychosis in the current study. However, investigating the relationship between psychosis and current insight across the whole sample showed that severity of psychosis had an effect on current insight. This adds further controversy to previous studies finding only a modest correlation between symptom severity and insight (e.g., Amador *et al.*, 1994). Again, however, Amador *et al.*'s (1994) findings may have been confounded by the study using patients with a mix of psychotic illnesses. Until this is controlled for, firm conclusions cannot be drawn in either direction. Therefore, the current findings are just a further contribution to the ongoing debate.

Levels of depression in the current study differed between the groups, with White patients being more depressed. However, investigating the effect of depression on current insight across the whole sample showed that being more depressed had no relationship to current levels of insight. This goes against the many previously reported findings of a relationship between insight and depression (e.g., Moore *et al.*, 1999), whereby patients who accept rather than deny having schizophrenia are more prone to depression. However, it is likely that other psychological variables have a more powerful relationship to insight in forensic settings, such as self-esteem, which might be greatly reduced by the process of admission to, and the terms of detention in such settings. As previous studies have demonstrated a relationship between self-esteem and insight (e.g., Chadwick *et al.*, 1996), inclusion of this variable in future studies would be valuable. More simply though, these findings might have been a function of the small sample size in the current study.

4.3 Limitations of the Current Investigation

4.3.1 Generalisability

The two primary limitations to the generalisability of the study, which reduce its external validity, are the size of the sample and the specificity of the cohort investigated. The sample used in the study was relatively small, and the study only investigated patients in medium security.

The generally low numbers of patients in medium security reduced the sample size in the current study. As the sample size was small, in order to control for type 1 error, restrictions were placed on the analysis by reducing the number of variables in some of the measures, and reducing the level at which findings could be declared significant. Therefore, a larger sample size may have led to more significant findings on many of the variables investigated. This emphasizes the need for replication of the study with larger sample sizes, and fewer measures.

The current study only investigated patients in medium security. However, given the scarcity of research on Black patients in this setting, and the greater implications for patient freedoms in medium security, the current investigator was committed to investigating insight in this group. Unfortunately time limitations precluded comparison to other psychiatric cohorts. Although conclusions can be drawn from the study about Black patients' satisfaction, more subtle comparisons could have been made with

participants from non-forensic and community settings that might have revealed more relevant factors other than age affecting satisfaction. Conclusions can also be drawn about Black patients' insight, and consultants' view of insight in their Black patients. However, forensic psychiatrists may have greater expertise at assessing insight than psychiatrists in non-forensic and community settings. Psychiatrists in forensic settings are also likely to have more time to devote to each patient than in a fast moving acute psychiatric setting, perhaps increasing precision of assessment. Both these points highlight the difficulty of generalisability.

4.3.2 Measures employed

4.3.2.1 Experience of First Psychiatric Admission (EFPA)

Statistical analysis showed that this measure has moderate reliability. However, a primary criticism of this measure is its vulnerability to autobiographical memory bias. Further, if there were any general memory deficits in the current sample, this could have affected the validity of the findings. A measure of general memory could have been used to control for this, and should be employed in any replication of the current study. Secondly, regarding psychiatric presentation, patients having current or retrospective persecutory delusions might have distorted their memory of the first psychiatric admission. This is pertinent as the current study examined experiences of a persecutory nature, such as coercion and police involvement. However, this might have been controlled for, to a certain degree, by levels of psychosis not being significantly different between the groups. Further, the current study found that White patients were more depressed. This might

have inflated the number of negative memories of the first admission in this group, thus reducing the difference in negative experiences between the groups.

Some of the memory biases could have been reduced by comparing recall of events experienced during the first admission, with a case-notes review of the first admission. However first admission nursing notes were not available to the current study. If replication of the study relied upon retrospective accounts, it would be necessary to incorporate a case-notes review to validate verbal reports. Alternatively, a prospective design could be employed.

4.3.2.2 National Adult Reading Test (NART)

The efficacy of the NART in eliciting pre-morbid IQ can be criticised for its potential vulnerability for measuring level or quality of pre-morbid education. The WAIS-III comes the closest to measuring current IQ, taking into account level of education in the reporting of its findings, however it does not measure pre-morbid IQ. If the WAIS-III were used in a prospective design, this would remove the issue of measuring pre-morbid IQ. However, the WAIS-III is time-consuming to administer, and the WAIS-short form may be a better choice for a prospective design.

4.3.2.3 Cross-cultural validity of measures employed

The issue of cross-cultural validity applies to all the measures employed in the current study, and is a continual problem in all research investigating mental illness in ethnic minority groups. Indeed, empirical research is geared towards ensuring the validity of the

measures and constructs employed, but these do not lend themselves easily to cross-cultural comparisons.

4.3.2.4 *Self-report measures*

Self-reports generally have the problem of acquiescence. This is a significant consideration in the current study, as all the questionnaires employed were self-report, other than the Brief Psychiatric Rating Scale (BPRS), which is a mix of self-report and observation, and the National Adult Reading Test (NART). This was partly controlled for by collecting socio-demographic and psychiatric variables, and current and retrospective delusions, from patient notes. However, the benefit of self-reporting is that it elicits respondents' views directly. This was critical for the current study, as it was investigating consultants' potential negative biases in the perception of their Black and White patients. Future replication of the current study could benefit from using self-report measures that are amenable to cross-validation, perhaps with both nursing notes and behavioural category grids recording the number of negative events experienced by patients during hospital admission (Burns et al., 1999).

4.3.2.5 *Multiple Measures*

As highlighted in section 4.3.1, the number of measures employed with a small sample size compromised the generalisability of the current findings. One way of reducing the number of measures in future replication of the current study is to not include those measures that appear to have some overlap. For example, as patients' feelings about the effect of their first admission may be sufficiently elicited from the EFPA (Experience of

First Psychiatric Admission), it may not be necessary to administer the IES (Impact of Event Scale), or the CSQ (Client Satisfaction Questionnaire), particularly as they are descriptive and not diagnostic tools. Further, the IES and CSQ do not elicit those aspects of psychiatric treatment that cause more trauma or less satisfaction, which was one of the primary concerns of the current investigation. It is also possible that the ROMI (Rating of Medication Influences) is sufficiently addressed by question six of the SAI-E (Schedule for the Assessment of Insight – Extended), although this question misses some of the more subtle influences on medication compliance, which was a more primary concern of the current investigation.

4.3.3 Design

4.3.3.1 Interview

Reactivity of measurement might have influenced patients' responses two ways. Firstly, having a White interviewer might have increased the amount of negative experiences reported in order to make them feel guilty. Secondly, having a White interviewer might have increased suspicion about the motives behind the questions being asked of the interviewee. This might have reduced reporting of negative experiences and feelings, in order to increase 'social desirability' in an organization that might be perceived as institutionally racist by the patient. However, it was hoped that reassurances at the recruitment phase that the interview would have no bearing on treatment plans, and the resulting willingness to be interviewed, might have moderated suspicion and withholding information. But this would not necessarily protect against exaggeration.

There is also the question of how much Black patients will tell a White researcher about their beliefs of mental illness, particularly if the patient believes it will have implications for how long they stay in hospital. Again, it was hoped that reassurances that the interview was confidential helped to reduce this effect. However, studies investigating the matching of interviewers and patients on the basis of ethnicity did not have an impact on *recruitment* according to studies by Thompson *et al* (1996) in America. These researchers inferred that the effects of matching could have been diluted by the heavy emphasis placed on interviewer selection and training in their study. For example, both African-American and White interviewers were selected on the basis of their experience in working with low-income patients from urban settings. The current interviewer had such experience pre- and during clinical training. It may be that the effects of matching are more important for mental health service use, diagnosis, length of stay, or treatment effectiveness, as suggested by Browne (1997), and are less important for recruitment into research (Neighbours *et al.*, 1992). Additionally, Thompson *et al* (1996) make the point that, with ample preparation, both Black and White clinical interviewers can interact with patients from a variety of ethnic backgrounds. This is important, as Black interviewers remain under-represented in research.

4.3.3.2 *Missing measures*

No baseline measurement of psychosis at time of the first admission was available. Therefore, the relationship between the presence and severity of delusions at first admission, particularly persecutory delusions, and negative experiences of coercion, sedation and seclusion during the first admission was not addressed. Indeed, having

persecutory delusions could have inflated the reporting of these experiences, or resulted in the patient receiving more sedation and seclusion. The current study found no difference between the groups in the number of reported negative experiences. This may have been a function of a lack of difference in severity of illness between the groups at the time of first admission. However, the current study found no significant difference between Black and White patients in the number who (1) first noticed they were ill, (2) approached their GP, (3) understood that they were ill, (4) understood why they were admitted, and (5) agreed with their admission. This perhaps suggests that symptom severity was not significantly different between the groups at first admission.

Previous literature has shown an important relationship between insight and self-esteem (Bental *et al.*, 1991; Chadwick *et al.*, 1996). Measures of self-esteem were not employed in the current study. Although Black patients did not experience more negative events during their first admission, or have less insight than White patients in the current study, Black patients' experience of their first admission may have had a more reductive effect on their self-esteem than for the White patients. This may have revealed another variable affecting patient satisfaction, which was found to be lower for Black patients in the current study.

Another factor overlooked in the current study was the number of *forensic* mental health admissions the patients had received. The current study found that the total number of psychiatric admissions was not significantly different between the groups, and previous research has shown that Black patients have more admissions than White patients (e.g.,

Sharpley *et al.*, 2001). Therefore, patients' number of forensic admissions, which are significantly longer than non-forensic admissions, may have confounded the current finding.

After-care received following first admission was not examined in the current study. As highlighted in earlier sections, some of the current findings did not replicate previous studies. For example, Black patients were not more reluctant to return to hospital at the end of their first admission, which goes against findings by Burnett *et al* (1999) on views of re-admission. Secondly, there was no difference in the number of Black and White patients agreeing with their first hospital admission, which does not accord with the findings by Butt (2001) also examining views of re-admission. However, this may have been due to factors related to care received after first admission, therefore highlighting the need to include this factor in any replication of the current study. Additionally, though, the current study's findings on reluctance to return to hospital after first admission may have been more in line with previous studies if a continuous scale (e.g., 0-10) rather than categorical scale (yes / no) had been employed to measure this variable.

4.4 Implications of the Current Investigation

4.4.2 Theoretical and research implications

This study adds to the existing research on patient satisfaction in Black service users. Previous studies have concentrated mainly on Black service users' lack of satisfaction

about the care they receive, with little empirical comparison to satisfaction in other groups. Empirical investigation of Black patients' experiences, besides their route to admission, number of prescribed anti-psychotic medication, and after-care, has also been neglected in the literature. The current study shows that there is no difference between the groups in the number of negative experiences of the first admission, but that Black patients are younger at first admission, and that this may be associated with greater dissatisfaction in this patient group. However, dissatisfaction in Black patients may also be partly explained by the current study's finding on consultants' view of insight in their patients. This indicated that consultants' and White patients' view of their insight is more closely allied than consultants' and Black patients' view. It is possible that lack of concordance between patient and consultant may reduce feelings of satisfaction about the psychiatric care being received. However, further research into the relationship between consultants and ethnic minority patients is required before such conclusions can be drawn. As consultants did not rate their Black patients as having lower insight than their White patients, it appears that if there are opposing cultural explanations for mental illness between doctor and patient, this opposition is subtle. This suggests the need for more subtle methods of investigation to tease out the variables affecting this relationship. Alternatively, it would be interesting to investigate whether the accuracy of consultants' ratings of insight in their Black patients is constrained by how much Black patients are prepared to tell them. The issue of the patient-clinician relationship affecting assessment and self-disclosure is also likely to affect the implementation and outcome of CBT for psychosis in clinical psychology, and therefore requires attention in both the psychiatric and psychological literature. For further research in this direction, it would be necessary

to improve upon some of the methodological weaknesses of the current study. This would include incorporating a larger sample size, interviewing consultants and patients across all psychiatric settings, utilizing both observational and self-report measures, developing both prospective and retrospective designs, and possibly including interviewers blind to the purpose of the study.

In the current study, insight was found to be unaffected by levels of satisfaction, as well as negative experiences of psychiatric care. This is a new area of investigation in the insight literature, and has by no means been exhaustive in the current study. Therefore, future research needs to replicate these findings before it can be concluded that these variables are not related to insight. However, the methodological weaknesses of the current study need to be addressed in any replication. Not so new is the current study's further contribution to the inconsistent findings on the relationship between insight and the variables of depression, and severity of psychotic presentation, with the current study only finding a relationship between current insight and severity of psychosis. This may have been due to all participants having a diagnosis of paranoid schizophrenia, which has shown to have the highest levels of poor insight across the psychotic disorders (Amador, 1994).

4.4.3 Clinical implications

The aim of the current investigation was to provide evidence of areas that require improvement in the provision of psychiatric care for Black patients in Britain. The

findings of this study suggest that service providers may need to consider developing more age appropriate wards, or perhaps create wards catering specifically for the treatment of younger patients. Alternatively, there may be an argument for finding ways of treating younger, non-forensic patients in the community, without a hospital admission. However, lack of resources in the NHS is always an issue when attempting to make changes in clinical practice. It can be argued, though, that some changes might reduce costs in the longer term. For example, due the pressure on bed spaces, the NHS is frequently forced to fund beds in the private sector. If age appropriate environments for younger patients increased satisfaction with the care received, co-operation with treatment on relapse could be improved. If co-operation improved, relapse might be treated earlier, and be less likely to require in-patient treatment. This would create enormous savings in the funding of private psychiatric beds, both open-ward and forensic. More recently, Crisis Teams and Assertive Outreach Teams have been created to readdress the demand on psychiatric beds in London. However, it seems that the additional concern of how to increase Black patients' co-operation with community services has yet to be addressed in practice.

The current findings on the lack of agreement between consultant measures and standardised measures of insight suggest that in-patient and community services, at all levels of practice, may need to improve their understanding of Black patients' presentation. Training of mental health workers across settings, and across all levels of practice, as well as greater recruitment of ethnic minority mental health workers across all levels of practice, are two ways of increasing this understanding in a mental health

professionals, the majority of which are White. Training programmes would benefit from greater consultation with Black patients' families and Black user groups, which would provide an 'insight' into the interpretation of the ways in which Black patients understand their symptoms. Indeed, it has been suggested that it is counterproductive to the therapeutic goal, if not oppressive, to dismiss clients' cultural beliefs systems regarding their problems and ways of dealing with them (Owusu-Bempah & Howitt, 2002). Greater consultation with these groups can offer a wealth of knowledge and expertise regarding possible explanations and solutions for mental illness in this group, as well as for Black people's potential suspicion of predominantly White-led institutions. Further, the majority of practitioners are both born and trained in a European culture, and inevitably develop their skills and expertise from this inherited framework. Recruitment of practitioners from other cultures would be useful for challenging and developing European models and theories of mental illness, to encompass a world wide understanding of mental disorder. Further, professions working with people in modern Britain need to promote diversity as a basic professional concept, and develop dealing with diversity as a fundamental skill in clinical practice (Owusu-Bempah & Howitt, 2002).

4.5 Concluding Comments

The study aimed to investigate factors affecting insight in Black patients, as well as consultants' perception of insight in Black patients. The findings indicated that Black people do not have more negative experiences and feelings of psychiatric care at first

admission, or that these experiences and feelings affect levels of insight. The study did find, however, that Black patients are less satisfied with the psychiatric care they receive at first admission, but that this is likely to be related to a younger age of admission at first onset. These lower levels of satisfaction might also be related to the current study finding a lower degree of congruence between Black patients' presentation of insight and consultants' rating of their insight. In this case, it is possible that 'insight' is a shorthand term for the degree of congruence between psychiatric models of illness, and patients' views of their illness. Conflicts about these matters are ubiquitous in the care of psychotic patients (McGorry & McConville, 1999). The multi-dimensional complexity involved in the relationship between psychological variables and insight, and consultant perceptions and insight, suggests that separating the various influences is a complicated task. However, exhaustive investigations of this nature are both necessary and unavoidable, as insight continues to be viewed as a key factor in mental illness, despite its elusive nature. The findings on the assessment of insight in the current study highlights the importance of further investigation, particularly when the impact of assessments of insight on patient freedoms is medium security can be considerable. However, the current finding that there was no difference in consultants' mean rating of insight in their Black and White patients indicates the presence of good practice, the further development of which could reduce the costly personal and service-related implications of patients having 'poor insight'.

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Appendix 1.

Ethical Approval

Barnet, Enfield and Haringey **NHS** Health Authority

Holbrook House
Cockfosters Road
Barnet, Herts, EN4 0DR
Tel: 020 8272 5500
Fax: 020 8272 5700

Hyde House, The Hyde
Edgware Road,
London NW9 6QQ
Tel: 020 8201 4700
Fax: 020 8201 4701

Tick box as appropriate Tick box as appropriate

Chair Marcia Saunders
Chief Executive Christine Outram

28 September 2001

Ms Jules Pearson
North London Forensic Service
Camelot Lodge RSU
Chase Farm Hospital
The Ridgeway
Enfield EN

Dear Ms Pearson

939 – An investigation into the influence of institutional and personal factors on patient 'insight' in African and African-Caribbean patients with schizophrenia in a medium secure unit

Acting under delegated authority I write to inform you that the above study was considered at the LREC meeting held on 25 September 2001 and was approved subject to the following proviso:

To re-word as Caucasian/African/African Caribbean.

Approval of the above proviso must be received before commencement of the study.

Please quote LREC number 938 on any future correspondence.

Yours sincerely



Christine Hamilton
Barnet, Enfield & Haringey
LREC Administrator



Ms Jules Pearson
Sub-Department of Clinical Psychology
University College London
Torrington Place
Gower Street
London WC1E 6BT

The Royal London Hospital (St. Bartholomew's)
25 Bow Road
London E3 4LL

Aneurin Bevan House
81 Commercial Road
London E1 1RD

Our ref: RS/KO/P/01/194

22nd October 2001

Tel: 020 7655 6600
Fax: 020 7655 6666

Dear Ms Pearson

Re: P/01/194 – An investigation into the influence of institutional and personal factors on patient 'insight' in African and African-Caribbean patients with schizophrenia in medium secure units.

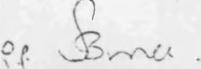
I can confirm that the ELCHA Research Ethics Committee considered the above protocol at its recent meeting. Before approval can be given, a number of issues need to be clarified:

- a) Please provide the name of the consultant at the John Howard Centre who takes responsibility for the research. (Section 1.3 of application form).
- b) Written confirmation of indemnity is requested.
- c) The Committee's standard indemnity wording for self-generated research (see below) should be used on the patient information leaflet.

We believe that this study is basically safe and do not expect you to suffer any harm or injury because of your participation in it. However, *University College London* has agreed that if your health does suffer as a result of your being in the study then you will be compensated. In such a situation, you will not have to prove that the harm or injury which affects you is anyone's fault. If you are not happy with any proposed compensation, you may have to pursue your claim through legal action.

Following written clarification of the above issues I should be able to approve the protocol on behalf of the Committee to be noted at a future meeting.

Yours sincerely



Richard Smith
Acting Chairman
ELCHA Research Ethics Committee

Chairman: Professor Elaine Murphy
Chief Executive: Carolyn Regan

replied
20/11/01

East London and The City **NHS**

Mental Health NHS Trust

20 December 2001

JF/HW



The Royal London Hospital (St Clement's)
2a Bow Road
London E3 4LL

Telephone: 020 7377 7960
Fascimile : 020 7377 7963

Ms Jules Pearson
Sub-Dept of Clinical Psychology
UCL
Torrington Place
London WC1E 6BT

Dear Ms Pearson

re: **'An Investigation into the influence of Institutional and Personal Factors on Patient Insight in African, African-Caribbean and Caucasian Patients in Medium Security**

Thank you for sending me a copy of your proposed project.

I am happy to confirm that the East London & City Mental Health NHS Trust will provide indemnity for this research project.

Yours sincerely



Dr Jan Falkowski, BSc MBBS MRCPsych MBA TD
Consultant Psychiatrist and Medical Director



Appendix 2.

Consultant Letter



Sub-department of Clinical Health Psychology
University College London, Gower Street, London WC1E 6BT

Ms Jules Pearson
Current Research Investigator
Clinical Psychologist in Training
Tel: 07780 671 837
Supervisor: Dr Janet Feigenbaum
Chartered Clinical Psychologist
and Psychology lecturer
Tel: 0207 679 5964

Dr
(Responsible Medical Officer)
.....MSU
Date

Dear Dr

Re: Doctoral Research Thesis / Schizophrenia, Insight and Ethnicity in MSUs

I am a Clinical Psychologist in Training completing my final year. This requires me to complete a doctoral research thesis. To this end, I need to recruit a total of 44 **British-born Black and White male patients with paranoid schizophrenia, without a learning difficulty or frontal lobe damage**, for an interview about their first psychiatric admission. I will be using the following assessment tools:

- (1) Experience of First Psychiatric Admission (EFPA)
- (2) The Impact of Event Scale (IES)
- (3) Client Satisfaction Questionnaire (CSQ)
- (4) Rating of Medication Influences (ROMI)
- (5) Schedule of Assessment of Insight (SAI)
- (6) Brief Psychiatric Rating Scale (BPRS)
- (7) National Adult Reading Test (NART)

I have enclosed a patient information sheet ('an invitation to take part in a project'), which outlines the nature of the study, and what is involved for your patients if they agree to participate.

This study has gained ethical approval from _____.
My next responsibility is to make sure that patients have given verbal consent to participate, before I approach them for written consent. The ethical committee requires that the initial verbal consent needs to be given to patients' RMO.

I realise you are very busy and have many demands on your time. However, I would be very grateful if you could ask those patients that meet the highlighted criteria above to read the 'invitation to take part in a project', and for you make a note of those willing to participate. It would then be my responsibility to phone you or your secretary on a weekly basis, to find out which patients are available for interview.

If you would prefer to talk through the aims of the study in more detail before approaching your patients, I would gladly answer any of your questions in person, or over the phone.

I will attempt to make contact with you over the next week to introduce myself, and to find out what would be the most convenient way to maintain contact with you over the course of recruiting patients.

I thank you in advance, and look forward to speaking with you.

Ms Jules Pearson, Clinical Psychologist in Training, UCL
Dr Janet Feigenbaum, Chartered Clinical Psychologist & Psychology Lecturer, UCL

Enc.

Appendix 3.

Patient Information Sheet

Patient Information Sheet

“Evaluating the impact of first admission experiences on patients’ understanding of why they are in hospital”

Ms Jules Pearson and Dr Janet Feigenbaum
Sub-Department of Clinical Psychology
University College London
Torrington Place
London WC1 6BT

What is the project about?

The project is about what people remember and feel about their first admission to a psychiatric ward.

What is the purpose of the project?

The project is meant to help doctors to understand how patients’ experience of their first admission can affect patients’ feelings about treatment.

Who will be included in the project?

Men in medium secure units in London.

What will the project involve?

If you decide to take part, a researcher will be asking you a series of questions about your mental state on the day of the interview. This will just involve sharing some of the things you think about on a day-to-day basis. You will also be asked your views about medication.

The researcher will then ask you a series of questions about your experiences of your first ever admission to a psychiatric ward, and how you felt about these experiences at the time. You will also be asked whether you still think about these events now, and if they upset you or not.

How long will the interview take?

It will take about 1 - 1 1/2 hours. This can be broken down into shorter interviews if you wish.

Where will the study take place?

On your ward, in a private room, so that everything you talk about will not be heard by other patients.

What will happen to the results?

Your answers will remain completely anonymous and private, unless issues around your own or others' safety arise during the interview. Otherwise, your results will be given a code number instead of your name, and no one else will know that they are yours. In the long term your results may contribute to the improvement of treatment for yourself and others.

Who will see my answers?

Again, unless issues around your own or others' safety arise during the interview, only the interviewer will see your answers. No other person will see your answers, or know that they are your answers.

Will my answers affect how long I stay here?

Your length of stay in hospital will continue to be decided by your clinical team.

Will my answers affect my treatment?

Your treatment will continue to be decided by your clinical team.

You do not have to take part in this study if you do not want to. If you do decide to take part you may withdraw at any time without having to give a reason. Your decision whether to take part or not will not affect your care in any way.

All proposals for research using human participants are reviewed by an ethics committee before they can proceed. This proposal was reviewed by Enfield & Haringey Health Authority, Local Research Ethics Committee.

If you have any further questions to ask, please contact the following person:
Dr Janet Feigenbaum (research supervisor) on tel: 0207 679 5964

Appendix 4.

Patient Consent Form



Sub-department of Clinical Health Psychology
University College London, Gower Street, London WC1E 6BT

CONSENT FORM

Appendix 5.

Study Title: Evaluating the impact of first admission experiences on patients' understanding of why they are in hospital

Interviewer's name: Ms Jules Pearson

Supervisor's name and number: Dr Janet Feigenbaum 0207 679 5964 (EFPA)

To be completed by each participant in the study:

- (1) I have read and understood the information sheet about the study **YES / NO**
- (2) In have had an opportunity to ask questions and discuss the study **YES / NO**
- (3) I have received satisfactory answers to all of my questions **YES / NO**
- (4) I have received sufficient information about this study **YES / NO**
- (5) I am willing to allow access to my medical records, but understand that strict confidentiality will be maintained **YES / NO**
- (6) I know that if there are any problems I can contact Dr Feigenbaum at the above number **YES / NO**
- (7) I understand that my participation is voluntary and I am free to withdraw from this study:
 - **at any time**
 - **without giving a reason**
 - **without affecting any aspect of my care or legal rights** **YES / NO**
- (8) Do you agree to take part in this study? **YES / NO**

Signed..... Date.....

Name in Block letters.....

Investigator's statement: I have explained the nature, demands and foreseeable risks of the current research to the participant. I have witnessed them giving written consent to participate in the study.

Signed..... Date.....

Name in Block letters.....

Appendix 5.

Experience of First Psychiatric Admission (EFPA)

EXPERIENCE OF FIRST PSYCHIATRIC ADMISSION (EFPA)

Introduction:

“the following questions are about what sort of experiences you had the first time you came to a psychiatric hospital. It doesn't matter if it wasn't a medium secure hospital like this, I would just like to know about your first admission. I understand that this may have been a very difficult time for you and that many things may be difficult to remember. There are no right or wrong answers. If you feel you cannot remember whether or not something that I ask happened, please do not feel that you have to try and think of something. It is okay if you cannot remember. If this is the case, just say 'I can't remember' and I will move on to the next question. I can also move on to the next question if something is too difficult to talk about”

ROUTES TO ADMISSION

SETTING THE SCENE (NO SCORING)

1. **who first noticed** that you might be ill or that you were behaving differently in some way SELF / OTHER (sibling, parent, friend, police, neighbour, prison warden)
.....

2. did you have a **GP** at the time you were being admitted. YES / NO

3. did you **approach your GP** about the difficulties you were having? YES / NO

4. when you were first admitted to a psychiatric ward, **who admitted you?**
SELF / OTHER (sibling, parent, friend, police, neighbour, prison warden)
.....

5. at the time, did you **understand** why you were being taken/going to hospital?
YES / NO
why were you taken to hospital? (to check understanding if says yes)
.....

6. did you **agree** with your hospital admission? YES / NO

7. were you brought into hospital under the **Mental Health Act** when you were first admitted? YES / NO
if can remember, which one?.....[section 136 (from public place) / 38 (from prison)]

were you detained in hospital under the **Mental Health Act** YES / NO
if can remember, which one?..... (section 2 / 3 / 37 / 38 / 37.41 / 47.48)

ADMISSION PROCESS

(THE REST OF THE QUESTIONNAIRE IS NOW SCORED)

1. were you brought to hospital by the **police / prison wardens** on first admission. YES / NO

PROMPT: if YES: can you remember how many **police officers/pw** there were?.....

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

2. can you remember **where** you had to wait before someone came to talk to you?

PROMPT: WAITING AREA / SECLUSION ROOM / LOCKED IN A ROOM

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

3. can you remember **how long** it was before someone came to talk you?

PROMPT: FIRST DAY / FIRST WEEK / FIRST MONTH / NOT AT ALL

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

4. can you remember how many people were in the room with you when someone came to talk to you?

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

5. did someone explain to you why you were there? YES / NO

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

6. If someone did explain to you why you were there, when did this happen?

PROMPT: FIRST DAY / 1 WEEK / 2 WEEKS

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

7. were you shown around the ward area – e.g. the ‘lounge’ area and where you would be sleeping? YES/NO

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

COERCION DURING ADMISSION

1. when did the nurses start giving you medication (NOT SEDATION / TRANQUILISATION)?

PROMPTS: FIRST DAY / FIRST WEEK / SECOND WEEK / FIRST MONTH / SECOND MTH/ NOT AT ALL

was your medication at first admission in ORAL / INJECTION / NA

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

2. were you forced to take medication? YES / NO

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE about this experience?

3. on your first admission, can you remember whether or not you were sedated/tranquilised (NOT MEDICATION) by staff when you arrived on the ward? YES / NO

PROMPTS: If YES:

a) can you remember how many times?.....

b) can you remember how many nurses were usually used to sedate you?.....

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE about this experience?

4. during your first admission were you restrained YES / NO

PROMPTS: If YES:

- a) can you remember how many times?
- b) can you remember how many nurses were usually used to restrain you?.....

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

5. during your first admission were you secluded? YES / NO

PROMPTS: If YES:

- a) can you remember how many times?
- b) can you remember how many nurses were usually used to seclude you?.....

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

6. were you drug-screened, either by blood or urine tests, during your first admission? YES / NO

PROMPT: did the drug-screening feel SPECIFIC TO YOU or part of a GENERAL WARD SCREENING?

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

7. did nurses ever search your room for drugs or weapons during your first admission? YES / NO

PROMPT: did the room search feel SPECIFIC TO YOU or part of a GENERAL WARD SEARCH?

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

SENSE OF SUPPORT AND AFFILIATION DURING ADMISSION

1. do you think that the medication made a difference to what you were thinking or believing at the time? YES / NO

PROMPT: what?.....(try to elicit reduction in distress)

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

2. can you remember whether there were other patients you felt you could talk to during your first admission? YES / NO

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

3. can you remember whether there was a member of staff (e.g. nurses, doctors) you felt you could talk to during your first admission? YES / NO

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

4. were you offered someone to talk to, like a psychologist or counsellor, during your first admission? YES / NO

PROMPTS: if no, is that something you would have liked? YES / NO
if yes, did it help? YES / NO?

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

5. were you visited by friends or family during your first admission? YES / NO

scoring: did you have a NEGATIVE / NEUTRAL / POSITIVE feeling about this experience?

6. did you ever abscond from hospital on your first admission? YES / NO – if no, go to Q 7.

PROMPT: WHY?.....

scoring: was this due to a NEGATIVE / NEUTRAL / POSITIVE feeling about the care being received?

7. If there was one thing you could have improved about your care during your first admission, what would it be?

.....

scoring: if something is named, score NEGATIVE

SCORING (total number of negative feelings):

Section 1: Admission Process _____

Section 2: Coercion During Admission _____

Section 3: Sense of Support and Affiliation _____

Appendix 6.

Impact of Event Scale (IES)

Impact of Event Scale (IES)

On (date): _____

You experienced (life event): _____

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you during the past seven days. If they did not occur during that time, please mark the "not at all" column.

	Frequency			
	Not at all	Rarely	Sometimes	Often
1. I thought about it when I didn't mean to				
2. I avoided letting myself get upset when I thought about it or was reminded of it				
3. I tried to remove it from memory				
4. I had trouble falling asleep or staying asleep, because of the pictures or thoughts about it that came into my mind				
5. I had waves of strong feelings about it				
6. I had dreams about it				
7. I stayed away from reminders of it				
8. I felt as if it hadn't happened or it wasn't real				
9. I tried not to talk about it				
10. Pictures about it popped into my mind				
11. Other things kept making me think about it				
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them				
13. I tried not to think about it				
14. Any reminder brought back feelings about it				
15. My feelings about it were kind of numb				
	0	1	3	5

This measure is part of *Measures in Post Traumatic Stress Disorder: A Practitioner's Guide* by Stuart Turner and Deborah Lee. Once the invoice has been paid, it may be photocopied for use within the purchasing institution only. Published by The NFER-NELSON Publishing Company Ltd, Darville House, 2 Oxford Road East, Windsor, Berkshire SL4 1DF, UK. Code 4930004



Appendix 7.

The Client Satisfaction Questionnaire (CSQ)

- TABLE 4
THE CLIENT SATISFACTION QUESTIONNAIRE (CSQ)

Please help us improve our program by answering some questions about the services you have received at the _____.
We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much, we appreciate your help.

CIRCLE YOUR ANSWER:

1. How would you rate the quality of service you received?

4	3	2	1
_____	_____	_____	_____
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
_____	_____	_____	_____
No, definitely not	No, not really	Yes, generally	Yes, definitely

*3. To what extent has our program met your needs?

4	3	2	1
_____	_____	_____	_____
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him/her?

1	2	3	4
_____	_____	_____	_____
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you received?

1	2	3	4
_____	_____	_____	_____
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
_____	_____	_____	_____
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

*7. In an overall, general sense, how satisfied are you with the service you received?

4	3	2	1
_____	_____	_____	_____
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

*8. If you were to seek help again, would you come back to our program?

1	2	3	4
_____	_____	_____	_____
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

WRITE COMMENTS BELOW:

*Can be used as a shorter scale.

GENERAL DISCUSSION

In summary, the CSQ appears to be a useful measure of general satisfaction with services. It possesses a high degree of internal consistency and correlates with ther-

apists' estimates of client satisfaction. Cox, Brown, Peterson, & Rowe (1978, Note 2) recently used this CSQ in a state-wide assessment of mental health service outcome.

Appendix 8.

Rating of Medication Influences (ROMI)

**Compliance
R.O.M.I.**

PART I : REASONS FOR COMPLIANCE

Day	Month	Year			

ARE YOU WILLING TO TAKE YOUR MEDICATION BECAUSE" :

	DEGREE of INFLUENCE				
	NA	None	Mild	Strong	Not Assessable
1 PERCEIVED DAILY BENEFIT You believe the medicine makes you feel better?	NA	1	2	3	9
2 POSITIVE RELATION WITH PRESCRIBING PRACTICIAN Your relationship with your prescribing doctor influences you?	NA	1	2	3	9
3 POSITIVE RELATION WITH THERAPIST Your relationship with your therapist influences you?	NA	1	2	3	9
4 POSITIVE FAMILY BELIEF Someone in your family or a friend believes that you should take medicine?	NA	1	2	3	9
5 RELAPSE PREVENTION You believe taking medication prevents your illness or symptoms from returning?	NA	1	2	3	9
6 PRESSION / FORCE You are pressured or forced to take medicine?	NA	1	2	3	9
7 FEAR OF RE-HOSPITALISATION You are afraid of being re-hospitalised?	NA	1	2	3	9

Appendix 9.

Schedule for the Assessment of Insight – Expanded (SAI-E)

1. "Do you think you have been experiencing any emotional or psychological changes or difficulties?"

- often* (thought present most of the day, most days) = 2
- sometimes* (thought present occasionally) = 1
- never* (ask why doctors / others think so) = 0

If brief show verbatim reply, otherwise summarise response. Please add explanatory comments if appropriate.

2. "Do you think this means there is something wrong with you?" (For example, a nervous condition).

- often* (thought present most of the day, most days) = 2
- sometimes* (thought present occasionally) = 1
- never* (ask why doctors / others think so) = 0

If brief show verbatim reply, otherwise summarise response. Please add explanatory comments if appropriate.

3. "Do you think your condition amounts to a mental illness or mental disorder?"

- often* (thought present most of the day, most days) = 2
- sometimes* (thought present occasionally) = 1
- never* (ask why doctors / others think so) = 0

If brief show verbatim reply, otherwise summarise response. Please add explanatory comments if appropriate.

If positive score on previous two items, proceed to 4, otherwise go to item 6.

Schedule for the Assessment of Insight (SAI-E)

4. "How do you explain your condition /disorder /illness?"

Reasonable account given based on plausible mechanisms
(appropriate given social, cultural and educational background,
e.g. excess stress, chemical imbalance, family history, etc.)

2

Confused account, or overheard explanation without adequate
understanding or "don't know"

1

Delusional or bizarre explanation

0

If brief show verbatim reply, otherwise summarise response. Please add explanatory comments if appropriate.

If positive score on items 1,2, and 3, proceed to 5, otherwise go to item 6.

5. "Has your nervous/emotional /psychological /mental /psychiatric condition (use patient's term) led to ^{upsetting feelings/hobbies} adverse consequences or problems in your life? (For example, conflict with others, neglect, financial or accommodation difficulties, irrational, impulsive or dangerous behaviour).

Yes (with example)

2

Unsure (cannot give example or contradicts self)

1

No

0

If brief show verbatim reply, otherwise summarise response. Please add explanatory comments if appropriate.

6. "Do you think your ... condition (use patient's term) or the problem resulting from it warrants (needs) treatment?"

Yes (with plausible reason)

2

Unsure (cannot give example or contradicts self)

1

No

0

If brief show verbatim reply, otherwise summarise response. Please add explanatory comments if appropriate.

7. Pick the most prominent symptoms up to a maximum of 4. Then rate awareness of each symptom out of 4 as below. (Interviewer to assess which symptoms to rate from previous interviews e.g. highest scoring on BPRS and/or from patient's current presentation).

Examples:

"Do you think that the belief ... is not really / happening (could you be imagining things)?"

"Do you think the 'voices' you hear are actually real people talking, or is it something arising from your own mind?"

"Have you been able to think clearly, or do your thoughts seem mixed up / confused? Is your speech jumbled?"

"Would you say you have been more agitated / overactive / speeded up / withdrawn than usual?"

"Are you aware of any problem with attention / concentration / memory?"

"Have you a problem with doing what you intend / getting going / finishing tasks / motivation?"

Symptom 1 - type:	Symptom 2 - type:	Symptom 3 - type:	Symptom 4 - type:
rating <input style="width: 30px; height: 30px; border: 1px solid black;" type="text"/>	rating <input style="width: 30px; height: 30px; border: 1px solid black;" type="text"/>	rating <input style="width: 30px; height: 30px; border: 1px solid black;" type="text"/>	rating <input style="width: 30px; height: 30px; border: 1px solid black;" type="text"/>

- Definitely* (full awareness) = 4
- Probably* (moderate awareness) = 3
- Unsure* (sometimes yes, sometimes no) = 2
- Possibly* (slight awareness) = 1
- Absolutely not* (no awareness) = 0

mean

If brief show verbatim replies, otherwise summarise responses. Please add explanatory comments if appropriate.

8. For each symptom rated above (up to a maximum of 4), ask patient ... "How do you explain ... (false beliefs, hearing voices, thoughts muddled, lack of drive etc.)?"

Symptom 1

Symptom 2

Symptom 3

Symptom 4

Part of my illness = 4

Due to nervous condition = 3

Reaction to stress / fatigue = 2

Unsure, maybe one of the above = 1

Can't say, or delusional / bizarre explanation = 0

mean

If brief show verbatim reply, otherwise summarise response. Please add explanatory comments if appropriate.

9. "How do you feel when people do not believe you? (when you talk about ... delusions or hallucinations)."

- That's when I know I'm sick* = 4
- I wonder whether something's wrong with me* = 3
- I'm confused and I don't know what to think* = 2
- I'm still sure despite what others say* = 1
- They're lying* = 0



If brief show verbatim reply, otherwise summarise response. Please add explanatory comments if appropriate.

Appendix 10.

Consultant Measure of Insight (SAI-hq)

Dear Dr _____

re: research into patient insight

Please could you rate the insight of the following patients. This is done on the basis of how **you** think your patients understand their past or current symptoms. These ratings are to be based on your most recent contact with the patients. Please note that I am NOT asking you to rate their insight into their index offence. I am asking you to rate their level of insight into their **mental illness**.

	0	1	2	3	4
	No awareness e.g.: "the doctors are lying about me being ill"	Slight awareness e.g.: "I will listen to the doctors, they're entitled to their opinion, but I disagree with them"	Sometimes aware, sometimes not e.g.: "I'm confused, I don't know what to think"	Moderate awareness e.g.: "I wonder if something's wrong with me"	Full awareness e.g.: "I am ill"

I would very much appreciate it if you could complete this form ASAP, as it needs to be done as close to my interview with them as possible. Please put the completed form in my pigeonhole in the office downstairs, adding the date of completion to the top right hand corner.

Thank you very much for your time.

Yours sincerely

Jules Pearson
Clinical Psychologist in Training

Appendix 11.

Brief Psychiatric Rating Scale (BPRS)

2. (a) The patient is working, but at a clearly reduced level, for example, due to episodes of non-attendance. (b) The patient is still hospitalized or written off sick. He is able to resume work only if special precautions are taken: close supervision and/or reduced working hours.
3. The patient is still hospitalized or written off sick and is unable to resume work. In hospital he participates for some hours per day in ward activities.
4. The patient is still fully hospitalized and generally unable to participate in ward activities.

2.4 Brief Psychiatric Rating Scale

Although the BPRS ("Appendix 2.6") also includes depression symptoms (items 1, 2, 5, 6, 9 and 13), the scale is constructed essentially for schizophrenic states; the total scale score should therefore be considered as a schizo-affective scale. Interpretation of total scale scores is: 0-9, not a schizo-affective case; 10-20, possible schizo-affective case; 21 or more, definite schizo-affective case. For schizophrenic states, the ten schizophrenic items on the BPRS should be summed. "Appendix 2.7" lists the ten BPRS items for schizophrenia, or, more appropriately, for 'psychotic disintegration', as a scale in its own right. (Andersen et al. 1989).

The BPRS consists of 18 items. The interviewer should assess the presence and degree of the individual items in terms of patient's condition at the time of the interview. The following six items, however, should be evaluated on the basis of the condition during the past 3 days: items 2 (psychic anxiety), 10 (hostility), 11 (suspiciousness), 12 (hallucinatory behaviour), 15 (unusual thought content) and 16 (blunted or inappropriate affect). When in doubt, the interviewer should solicit information from ward personnel or relatives. It is recommended to use the first minutes of the interview to establish a rapport with the patient before direct questions are introduced. The interview should last no more than 30 min. The interview technique does not differ in principle from clinical tradition. Pressure should not be exerted on the patient, who as far as possible should be allowed to explain his situation in his own words. The interviewer should remain unaffected by spontaneous intermissions, as these represent an integral part of the observation. The rating should always take place at a fixed time, for instance between 8:00 a.m. and 9:30 a.m., to avoid the influence of diurnal variation.

The scale is basically quantitative; it was constructed for the sole purpose of rating the current clinical picture, and it is not to be considered as a diagnostic tool. When the scale is used in repeated (weekly) ratings, each assessment must be independent of the others. The rater should therefore avoid looking at or recalling former interviews and should not ask about changes that might have taken place since the last interview; rather, he should refer to the patient's condition during the preceding 3 days. For all items each scale step encompasses the lower steps, for example, scale step '3' includes scale steps '2' and '1'. Normal function is always rated as '0'.

1 Somatic Concern

This item includes hypochondriasis. Scale steps '1' and '2' refer to non-delusional hypochondriasis and scale steps '3' and '4' to delusional hypochondriasis.

0. Not present.
1. Mild or doubtful degree of overconcern for physical health.
2. The patient expresses thoughts of organic disease (e.g. cancer or heart disease) but without delusional interpretations.
3. The complaints are bizarre (e.g. rotting inside), but the patient can briefly be reassured that this is not the case.
4. The patient is convinced that, for instance, the organs are rotted or missing, or that worms are eating the brain. He cannot even for a briefly be reassured that this is not the case.

2 Anxiety: Psychic

This item includes tenseness, irritability, worry, insecurity, fear and apprehension approaching overpowering dread. It is often difficult to distinguish between the patient's experience of anxiety ('psychic' or 'central' anxiety phenomena) and the physiological ('peripheral') anxiety manifestations which can be observed, such as hand tremor and sweating. Most important is the patient's report of worry, insecurity, uncertainty, experiences of dread, i.e. of psychic ('central') anxiety.

0. The patient is neither more nor less insecure or irritable than usual.
1. It is doubtful whether the patient is more insecure or irritable than usual.
2. The patient seems more clearly in a state of anxiety, apprehension or irritability, which he may find difficult to control. It is thus without influence on the patient's daily life, because the worrying is still about minor matters.
3. The anxiety or insecurity is at times more difficult to control because the worrying is about major injuries or harms which might occur in the future. For example, the anxiety may be experienced as panic, i.e. overpowering dread. This occasionally interferes with the patient's daily life.
4. The feeling of dread is present so often that it markedly interferes with the patient's daily life.

3 Emotional Withdrawal

This item includes the introspective experience of emotional contact with the patient during the interview. Emotional withdrawal is represented by the feeling on the part of the rater that an invisible barrier exists between the patient and the observer.

0. Not present.
1. Some (or doubtful) emotional distance.
2. Emotional reactions reduced, for example, doubtful eyecontact.
3. Emotional reactions more limited, for example, occasionally inadequate eyecontact or other indicators of a barrier of contact.
4. The emotional contact is strongly reduced or nearly absent, for example, the patient avoids eyecontact or shows other indicators of a barrier of contact.

4 Conceptual Disorganization (Incoherence)

Presenting disturbances of the thought process, from some vagueness in verbal expression to completely disorganized verbal productions.

0. Not present.

1. The thinking is characterized by some minor vagueness, but the language is conceptually not unusual.
2. Moderate disturbance in thinking. There is some difficulty in directing thoughts towards goals, resulting in emptiness in the communicative information transmitted. There may be a tendency to unusual conceptbehaviour, but most characteristic is that language resembles an engine idling in communication.
3. Marked difficulty in organizing thoughts, as evidenced by frequent irrelevancies, loosening of associations, possibly with a tendency to thought blockings or neologisms.
4. Conceptual disorganization extremely severe, resulting in gross irrelevancies and total failure of communication, (e.g. 'word salad').

5 Self-Depreciation and Guilt Feelings

This item covers the lowered self-esteem with guilt feelings.

0. Not present.

1. It is doubtful whether guilt feelings are present, as the patient is concerned only with the fact that during the current illness he has been a burden to family or colleagues due to reduced work capacity.
2. Self-depreciation or guilt feelings are more clearly present, as the patient is concerned with incidents in the past prior to the current episode. For example, the patient reproaches himself for minor omissions or failures, for not having done his duty or for having harmed others.
3. The patient suffers from more severe guilt feelings. He may express the feeling that the current suffering is some sort of punishment. Score '3' as long as the patient intellectually can see that his view is unfounded.)
4. The guilt feelings are firmly maintained and resist any counter argument, so that they become paranoid ideas.

6 Anxiety: Somatic

This item includes physiological concomitants of anxiety which are present during the interview. All anxious states should be rated under item 2 and not here.

0. The patient is neither more nor less prone than usual to experiencing somatic concomitants of anxious states.
1. The patient occasionally experiences slight manifestations such as abdominal symptoms, sweating or trembling; however, pathology is questionable.
2. The patient occasionally experiences abdominal symptoms, sweating, trembling, etc. Symptoms and signs are clearly described but are not marked or incapacitating.
3. Physiological concomitants of anxious states are marked and sometimes very worrying.

4. Physiological concomitants of anxious states are numerous, persistent and often incapacitating.

7 Specific Movement Disturbances

These represent various degrees of bizarre motor behaviour, ranging from some eccentricity in posture to severe catatonic agitation.

0. Not present.
1. Mild or doubtfully present during interview.
2. Moderate; clearly present during parts of the interview.
3. Severe; continuous motor abnormalities. Can be interrupted.
4. Extremely severe; persistent, uncontrolled motor abnormalities.

8 Exaggerated Self-Esteem

This item includes various degrees of exaggerated self-opinion, ranging from remarkable self-complacency or smugness to grotesque delusions of grandeur.

0. Not present.
1. Slightly or doubtfully increased self-esteem, for example, occasionally overestimates his own habitual capacities.
2. Moderately increased self-esteem, for example, overestimates more constantly his own habitual capacities or hints at unusual abilities.
3. Markedly unrealistic ideas, for example, that he has extraordinary abilities, powers or knowledge (scientific, religious, etc), but can briefly be corrected.
4. Grandiose ideas which cannot be corrected.

9 Depressive Mood

This item covers both the verbal and the non-verbal communication of sadness, depression, despondency, helplessness and hopelessness.

0. Not present.
1. The patient vaguely indicates that he is more despondent and depressed than usual.
2. The patient more clearly is concerned with unpleasant experiences, although he still lacks helplessness or hopelessness.
3. The patient shows clear non-verbal signs of depression and/or is at times overpowered by helplessness or hopelessness.
4. The patient's remarks on despondency and helplessness or the non-verbal signs dominate the interview, in which the patient cannot be distracted.

10 Hostility

This item represents the patient's verbal report of hostile feelings or actions towards other persons outside the interview and is a retrospective judgment of the previous 3 days. Distinguish from item 14 (uncooperativeness), which includes the formal contact during the interview.

0. Not present.
1. The patient has been somewhat impatient or irritable, but control has been maintained.

2. The patient has been moderately impatient or irritable, but provocation has been tolerated.
3. The patient has been verbally hostile, has made threats, and may nearly be physically destructive, but can still be calmed down.
4. The patient extremely hostile, with overt physical violence; physically destructive.

11 Suspiciousness

This item represents suspiciousness, distrustfulness or misinterpretations, ranging from a remarkable lack of confidence in others to florid delusions of persecution.

0. Not present.
1. Vague ideas of reference. The patient tends to suspect others of talking about him or laughing at him, feels that 'something is going on'. However, thoughts, interactions and behaviour are only minimally affected.
2. Distrustfulness is clearly evident, but there is no evidence of persecutory delusions because the beliefs are still an 'as-if' experience, thus still without influence on behaviour or interpersonal relations.
3. Persecutory delusions are present (reassurance is difficult), but they still have limited impact on interpersonal relations or behaviour.
4. Florid, systematized delusions of persecution (correction impossible) which, significantly interfere with interpersonal relations and behaviour.

12 Hallucinations

This item represents sensory perceptions without correspondence to external stimulus. The hallucinatory experiences must have occurred within the past 3 days, and with the exception of hypnagogic hallucinations, not during states of clouding of consciousness (delirium).

0. Not present.
1. Mild or doubtful degree. Hypnagogic hallucinatory experiences or isolated elementary hallucinatory experiences (e.g. hearing sounds).
2. Occasional but fully developed hallucinations (e.g. hearing voices), not affecting behaviour, i.e. limited to a few brief moments.
3. Hallucinations (e.g. hearing voices) that influence behaviour, i.e. are present most part of the day.
4. Constantly absorbed in hallucinatory experiences throughout the day.

13 Motor Retardation

Reduction in motor activity as reflected in showing or lessening of movements. Manifestations during the course of interview.

0. Not present.
1. Very slight or questionable diminution in rate of movements.
2. Mild to moderate slowness in movements.
3. Moderate to marked retardation in movements.
4. Movements are extremely slow. Motor retardation approaches (and includes) stupor.

14 Uncooperativeness

This item represents the patient's attitude and responses to the interviewer and the interview situation, in contrast to item 10 (hostility) which covers the uncooperativeness with other persons during the previous 3 days.

0. Not present.
1. Overly formal and reserved in the interview situation. Patient answers somewhat briefly.
2. Moderate resistance. Patient answers evasively or objects to some questions. Moderately hostile attitude to the interviewer.
3. Pronounced resistance. Patient answers irrelevantly or refuses to answer. Markedly hostile attitude to the interviewer.
4. Interview impossible. Patient refuses to stay in the interview situation.

15 Unusual Thought Content

This item concerns the content of the patient's verbalization and not with the organization of the language, which is rated in item 4 (conceptual disorganization). The item refers to the qualities of unusual thought content, ranging from overvalued ideas to various levels of delusional ideas. Notice that 'grandiose delusions' is rated in item 8 (exaggerated self-esteem), 'delusions of guilt' in item 5 (guilt feeling) and 'delusions of persecution' in item 11 (suspiciousness). The delusions of particular interest here are those of control, influence or depersonalization, morbid jealousy, sexual delusions, expansive or religious delusions. Rate only the degree of unusualness in thought content expressed, the significance it constitutes in the patient's mind or its influence on behaviour.

0. Not present.
1. Mild or doubtful degree (e.g. overvalued ideas).
2. Moderate degree (e.g. some delusional quality, but still an 'as-if' experience).
3. Delusions determine most of thought content and occasionally influence behaviour.
4. Overwhelming delusions determine thought content and behaviour.

16 Blunted or Inappropriate Affect

This item represents lowered ability or motivation to feel or express emotions such as grief, happiness and anger. The emotions, verbally and non-verbally expressed, are inappropriate to the situation or thought content. Essentially, emotions do not correspond to ideas. Thus, the patient might laugh or weep without recognizable cause (parathymia). This element includes: (a) any ability of emotional display not evidently related to the situation as the interviewer sees it, or to the manifest content of thought as the interviewer understands the patient's words, or (b) any more or less steady, unvarying emotional state which seems to be other than that called for by the setting of the interview, the nature of the background as known by the interviewer, and the manifest content of the patient's speech. Distinguish from item 3 (emotional withdrawal) which refers to the introspective experience of emotional contact with the patient during interview. The concept of blunted affect may be difficult or impossible to distinguish from anhedonia if it

refers to the capacity to conceal emotions, for example, the patient may be in a state of excessive anxiety without any clinical manifestations (his countenance is serene and he talks composedly about neutral topics).

0. Not present.

1. Diminished emotional responsiveness of questionable pathology. Outside the interview: less ability to express affective tone in contact with others.

2. Tendency to conceal emotional reaction or to unvary emotional modulations. Outside interview: less ability to establish closer contact with or indifference of affection for colleagues, fellow patients, or ward personnel.

3. Clearly blunted affect with a general flatness in emotional tone, possibly with a tendency to affective discharge, for example, inappropriate or uncontrolled laughter or weeping. Outside interview: less ability to establish closer contact with or indifference of affection for friends or family.

4. Clearly blunted affect and clearly affective discharges, such as excitement, rage or inappropriate, uncontrolled laughter or weeping. Outside interview: clearly lack of any feeling of having human contact or extreme indifference of affection for other persons.

17 Psychomotor Agitation

This item represents elevation in psychomotor activity level.

0. Not present.

1. Slightly or doubtfully increased motor activity, for example, lively facial expression or somewhat talkative.

2. Moderately increased motor activity, for example, lively gestures or very talkative or speech loud and fast.

3. Clearly excessive motor activity, on the move most of the time; rises once or several times during interview; flight of ideas; difficult to understand.

4. Constantly active, restlessly energetic; speech disintegrated; meaningful communication impossible.

18 Disorientation and Confusion

This item represents various degrees of clouding of consciousness with reduction in or lack of orientation in time, place or personal data.

0. The patient is completely orientated in time, place and personal data.

1. The patient has occasional difficulties but can spontaneously correct statements about orientation in time, place or personal data.

2. The patient has impairments which are not spontaneously corrected. For example, he does not know the name of the day or the date although he still names the month and year correctly; he has spatial difficulties although he is still orientated in the ward (or own home); or he has difficulty remembering names although he still knows his own name.

3. The patient is markedly disorientated. For example, he does not know the month or year although he does know which season it is, or has difficulty

Appendix 12.

National Adult Reading Test (NART)

CHORD
ACHE
DEPOT
AISLE
BOUQUET
PSALM
CAPON
DENY
NAUSEA
DEBT
COURTEOUS
RAREFY
EQUIVOCAL
NAIVE
CATACOMB
GAOLED
THYME
HEIR
RADIX
ASSIGNATE
HIATUS
SUBTLE
PROCREATE
GIST
GOUGE

SUPERFLUOUS
SIMILE
BANAL
QUADRUPED
CELLIST
FACADE
ZEALOT
DRACHM
AEON
PLACEBO
ABSTEMIOUS
DETENTE
IDYLL
PUERPERAL
AVER
GAUCHE
TOPIARY
LEVIATHAN
BEATIFY
PRELATE
SIDEREAL
DEMESNE
SYNCOPE
LABILE
CAMPANILE