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AN INVESTIGATION OF PSYCHOSIS IN CHAMORRO CULTURE: RELATING DELUSIONAL THOUGHT TO CULTURAL CONTEXT

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ABSTRACT

The present study is an investigation of psychosis in Chamorro culture - the indigenous people of the Marianas Islands. There were five primary goals of the study: 1) to present an indepth description of the delusional thought structure and content in schizophrenic Chamorros; 2) to explore the potential connection between the Chamorro cultural and historical context, and the content of Chamorro delusional thought; 3) to discover the Chamorro schizophrenics' explanatory models of their mental health problems; 4) to investigate whether Chamorro schizophrenics reported the presence of factors associated with less industrialized cultures; and 5) to evaluate the usefulness of employing a qualitative methodology in an investigation of psychotic thought processes. Twenty Chamorros diagnosed as schizophrenic from mental health facilities in Saipan and Guam were interviewed. An interpretive cultural analysis was conducted to relate content categories to the cultural context. Results indicated that, with the exception of two culture-specific delusional themes (witchcraft and poisoning), there were no remarkable differences in delusional thought content between North American and Chamorro schizophrenics. The explanatory models described by the informants were also similar to those expected in North American mental health clients. Informants reported the strong presence of extended family; however, this influence was not always positive. The informants also described considerable stigmatization of mental health clients. In general, the findings indicate that there is an amalgamation of Western and Chamorro cultural content, an adoption of Western explanatory models, and few factors characteristic of less industrialized cultures. This likely reflects the Chamorro history of colonization and Westernization, and the current cultural context of American and Chamorro values and beliefs. Finally, a qualitative, cultural analysis proved to be a useful tool to understand the experience and world view of schizophrenic individuals.

This methodology generated detailed data which allowed the informants the freedom to construct their own stories. Suggestions for cross-cultural, individual psychotherapeutic treatment with schizophrenic individuals are offered.

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CHAPTER I

INTRODUCTION

Schizophrenia is a profoundly disabling mental illness that significantly interferes with an individual's basic daily functioning in work, social relations, and self-care. One of the primary features which contributes to the debilitating nature of schizophrenia is a severe disturbance in the affected individual's cognitive functioning. According to the current diagnostic system for mental disorders (DSM-IV; American Psychiatric Association, 1994), delusional thought, one of the primary symptoms of this disturbance, impairs the individual's own reasoning and judgement as well as her or his ability to communicate with others.

Many authors have investigated the influence of factors such as biological predispositions, psychodynamic issues, existential crises, historical and political contexts, economic situations, and changes due to industrialization/urbanization, on the development and manifestation of chronic mental health problems. Authors writing in the area of cross-cultural psychology and psychiatry have emphasized the role of cultural factors in the expression of mental health difficulties. In addition, individuals from the World Health Organization (Cooper & Sartorius, 1977; Sartorius, Jablensky, & Shapiro, 1978) and others (Warner, 1994) provide evidence suggesting that schizophrenic individuals from less industrialized countries have a more favourable prognosis than those in more industrialized countries[1], and therefore postulate that many social characteristics of less industrialized cultures (e.g., size of family and community, flexibility of work and social roles) exert an ameliorating effect on schizophrenic symptoms.

The indigenous Chamorro culture in the Marianas Islands of Guam and Saipan provides an excellent opportunity to explore these issues. The Chamorro people, similar to other indigenous people, have been under the rule of other nations since the 1500s, and

therefore have experienced a long history of oppression, acculturation, and social change. In addition, these islands have recently been experiencing a period of rapid growth and industrialization; each of these factors may be reflected in the population's mental health difficulties. Unfortunately, there has been an absence of psychiatric research conducted on the Chamorro culture. Therefore, there are five primary goals of this study: 1) to present an in-depth description of the delusional thought found in Chamorro individuals diagnosed with schizophrenia; 2) to explore how Chamorro culture (i.e., the history, values, and beliefs of the Chamorro people) is reflected in and related to the content of their delusional ideas; 3) to inquire as to whether Chamorro schizophrenics identified factors associated with less industrialized countries (e.g., extended family support) as beneficial; 4) to learn about Chamorro schizophrenics' understanding and interpretation of their delusional symptoms and their recommendations for useful psychological, psychiatric and societal interventions; and 5) to explore the costs and benefits of using a qualitative research methodology to examine psychotic thought.

Literature Review

This research is based upon a review of literature spanning the fields of psychiatry, psychology, sociology, and cultural psychiatry/anthropology. A general discussion of the basic characteristics of delusional thought and schizophrenia is presented in the first section of this review. An examination of several major approaches to delusional thought is outlined in the second section of this paper: the biological approach, the psychodynamic approach, the existential approach, the social phenomenological approach of R. D. Laing, the sociopolitical approach, and the cultural approach. The third section contains an in-depth description of the Marianas Islands (Guam and Saipan): geographical and demographic characteristics; history dating from pre-Western contact to the present; cultural characteristics; and the impact of

industrialization on the sociocultural characteristics of the Chamorros. Finally, mental health issues on Guam and Saipan are specifically addressed.

Characteristics of Delusions

Several definitions of delusions have been offered in the psychological and psychiatric literature. The recently revised edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association, 1994), the predominant classification system of the North American mental health profession, defines a delusion as:

> a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture. (p. 765)

Other authors (see e.g., Winters & Neale, 1983; Butler & Braff, 1991) have identified several general consistencies across a variety of definitions of delusions: a delusion is a belief that is considered false or abnormal; a delusion can be considered false on the basis of either logical evidence (that is, the belief is contrary to rational judgement) or sociocultural evidence (that is, the belief is not shared by members of a common religious or cultural group); a delusional belief is relatively unchangeable, even when presented with compelling contradictory evidence; and the delusional individual should possess sufficient intellectual abilities to evaluate the veracity of her or his belief.

While considered false or irrational, delusional thought shares some commonalities with nondelusional thought. Butler and Braff (1991) cite several studies which illustrate how nondelusional individuals can be overly confident in their beliefs despite contradictory evidence. It has also been suggested that, rather than viewing delusional thought as either present or absent, delusions may be seen on a continuum ranging from self-deceptions, which have a relatively low degree of conviction, preoccupation, and implausibility, to delusional

thoughts, which have a relatively high degree of conviction, preoccupation, and implausibility (Winters & Neale, 1983).

In an effort to deepen understanding of delusional thought, a number of theorists have provided a classification system for different types of delusions. According to Winters and Neale (1983), Bleuler (1950) proposed that delusions fall into two classes: basic and elaborative. Basic delusions, as defined by Bleuler, are those major themes that develop primarily from affective situations, whereas elaborative delusions result from basic delusions which have expanded to more and more areas of the individual's beliefs. These elaborations were said to be motivated by the individual's need to explain her or his confusing experiences.

Other early theorists such as Jaspers and Schneider distinguish between primary and secondary delusions (Hingley, 1992). According to these authors, primary delusions are those which are too bizarre to be related in an understandable way to the individual's personality, life experience, background, or underlying conflicts. In contrast, secondary delusions are more common, and are understandable in terms of these various factors. In a similar vein, the DSM-IV (APA, 1994; see also Kaplan & Sadock, 1992) also makes a distinction between bizarre and nonbizarre delusions in its diagnostic criteria. Delusions are considered bizarre when they involve phenomena which are considered implausible by the individual's culture or subculture (e.g., being controlled by a dead person). Nonbizarre delusions, on the other hand, are those beliefs which are false, yet could conceivably occur within a particular culture (e.g., being followed by the CIA).

Delusions are also often categorized according to their structure. The following descriptions outline some of the more common types of delusions (APA, 1994; Kaplan & Sadock, 1992; Spitzer & Endicott, 1978):

- jealous type: a delusional belief that one's sexual partner is unfaithful without supporting evidence.

- erotomanic type: a delusional belief that another person, usually of higher status, is in love with oneself.
- paranoid type: includes persecutory delusions, delusions of reference, control, and grandeur.
- persecutory type: a delusional belief that one is being conspired against, persecuted, cheated, followed, poisoned, etc.
- of reference: a delusional belief that apparently meaningless events, objects or persons have particular and unusual significance for oneself.
- of control: a delusional belief that one's thoughts, feelings, or behaviors are being controlled by an external force, including:
    - thought broadcasting: a delusional belief that one's thoughts are being broadcast so others can hear them.
    - thought insertion: a delusional belief that the thoughts of someone else are being inserted into one's head.
    - thought withdrawal: a delusional belief that one's thoughts are being removed from one's head.
- grandiose type: a delusional belief that one possesses superior powers, knowledge, identity, or a special relationship to a prominent person.
- nihilistic type: a delusional belief focused on the nonexistence of oneself, others, or the world.
- somatic type: a delusional belief that involves a disease or disfigurement of one's body.
- of poverty: a delusional belief that one has lost or will lose all of her or his material possessions.
- systematized: false belief or beliefs united by a single event or theme.
- of self-accusation: false feeling of remorse and guilt.

In addition to structure, delusions may be further specified in terms of their content; that is, the specific ideas, concepts, or situations which are described in the delusion. For example, an individual may hold the belief that she or he is being followed by the CIA; the structure of this delusion would be classified as persecutory, whereas the content would be the belief in being followed by the CIA.

According to the DSM-IV (APA, 1994), delusional beliefs are often the defining feature of psychosis: for the diagnoses of *Schizophrenia*, *Schizophreniform Disorder*, *Schizoaffective Disorder*, and *Brief Psychotic Disorder* (*Brief Reactive Psychosis* in DSM-III-R), delusions are one of five characteristic symptoms; for the diagnoses of *Psychotic Disorder due to a Generalized Medical Condition* and *Substance-Induced Psychotic Disorder* (DSM-III-R used the terms *Organic Delusional Disorder/Organic Hallucinosis* for both disorders), delusions are

one of two characteristic symptoms; for the diagnoses of *Delusional Disorder* and *Shared Psychotic Disorder* (referred to as *Induced Psychotic Disorder* in DSM-III-R), delusions are the only characteristic symptom. Although there may be similarities in the content and structure of delusional thought associated with schizophrenia and delusional thought of other psychotic disorders, for the purpose of the present paper, only delusions associated with diagnoses of schizophrenia are considered, as the majority of research and theory has been based specifically upon schizophrenic delusions. Future research into the relationship among the spectrum of psychotic disorders is needed to suggest whether the symptomatology associated with each are qualitatively different.

Theories of Delusional Thought

From the time of the early theorists writing in the area of psychopathology, there has been a great deal of literature advancing theoretical explanations of delusional thought specifically, and schizophrenia more generally. A useful organization of these theories has been put forth by Winters and Neale (1983), and is frequently cited by more recent theorists such as Butler and Braff (1991) and Hingley (1992). This organization provides a particularly valuable framework for the present study, as it divides theories of delusional thought on the basis of their emphasis on the inherent meaning of an individual's delusions.

Winters and Neale (1983) propose two major models of delusional thought: defect models and motivational models. Proponents of defect models assume that delusions reflect an underlying defect or deficit within the delusional individual. These theories emphasize the importance of defects most commonly in biological or cognitive-attentional processes, while they deemphasize the importance of the meaning of delusional thought or other psychotic symptoms; for example, genetic defects and deficits in information processing and perception are included in this category.

Motivational models, in contrast, are those which assume that an individual develops delusions for psychological reasons, and which view delusions as fulfilling certain functions within the individual; these models place greater emphasis on the meaning of delusional thought than do defect models. Motivational models can be further divided into two theories: "attributional" theory and "relief from aversion" theory (Winters & Neale, 1983). Attributional theory asserts that a psychotic individual is motivated to develop delusions to explain her or his unusual or abnormal perceptual experiences. For example, Maher's (1974) version of attributional theory suggests that delusions are rationally developed beliefs which are created by the individual to explain her or his unusual or irrational experiences. Empirical support for this theory comes from studies which have elicited delusional thoughts in nonpsychotic individuals by presenting them with altered sensory experiences (see e.g., Zimbardo, Anderson, & Kabat, 1981). Relief from aversion theory suggests that an individual develops delusions because they serve to provide relief from aversive emotional states, such as anxiety or self-blame. Proponents of the relief from aversion theory are frequently authors with psychodynamic or existential approaches. These theories are outlined in more detail later in the paper.

Another useful framework for the understanding of theories of delusional thought which is relevant for present purposes stresses the degree of contextual focus of each theory. Each theoretical approach contains implicit and/or explicit assumptions of the etiology of schizophrenia and its symptomatology. Recommendations for the alleviation of the distress of schizophrenic individuals follow from these assumptions. One way that assumptions regarding the etiology and treatment of schizophrenia differ across theories is the extent to which they focus on the individual rather than the larger societal context. Therefore, each

theory may be conceptualized on a continuum from intraindividual focus to larger societal focus.

With these frameworks in mind, the next section outlines the major contemporary theories of delusional thought. In order to provide the reader with some familiarity with the major assumptions of a defect model, the biological model is presented first. Although the impact of biological factors on the etiology and treatment of schizophrenic delusions is not the focus of the present study, it remains important to acknowledge the role of these influences. The remainder of the discussion concentrates on the following major motivational models of delusions: the psychodynamic model, the existential/phenomenological model, the social phenomenological model of R. D. Laing, the sociopolitical model, and the cultural model. For each theory, the discussion provides an outline of the theory, including major theoretical and empirical works, and concludes with an articulation of its underlying assumptions with respect to the meaning of delusional thought and contextual focus. The cultural model primarily, and sociopolitical model secondarily, provide the major focus as theoretical frameworks in the interpretation of the results of the present study.

Defect Models

Biological model. This area of research centers primarily on the biological basis of schizophrenia, rather than on the biological basis of delusions, specifically. However, as the biological model assumes that delusions are one symptom of schizophrenia, and the biological factors which cause schizophrenia therefore also cause delusional thought, a discussion of the biological etiology of schizophrenia is appropriate. The biological model may be classified as a defect model as it views schizophrenia as caused by a defect in the genetic material, biochemistry, or brain structure of the individual. An extensive discussion of the biological basis of schizophrenia is beyond the scope of the present study. The purpose of this

subsection is, therefore, to outline briefly several branches of research which suggest biological contributions to schizophrenic symptoms and related patterns of behavior.

There appear to be five main areas of evidence for the biological basis of schizophrenia: genetic factors, biochemical abnormalities, structural abnormalities, organic factors, and epidemiological studies. Genetic studies have pointed to the hereditary nature of schizophrenia, and have shown that the risk of developing schizophrenia is significantly correlated with the degree of genetic material shared with an individual diagnosed as schizophrenic (see e.g., Hanson, Gottesman, & Meehl, 1977). Gottesman (1991) has suggested that the risk for developing schizophrenia ranges from 1% in the general population to 48% in individuals with a monozygotic twin with the diagnosis. These findings are supported by studies of families with a schizophrenic parent, adopted children with a schizophrenic parent, and monozygotic twins reared apart. However, it is important to note that even the risk for monozygotic twins who share identical genetic material is only 48%, which suggests that environmental factors play a crucial role in the development of schizophrenic symptomatology. Therefore, as summarized concisely by Davis (1987), it can be concluded that "a genetic predisposition for schizophrenia is a necessary--but not sufficient--condition for the emergence of the disorder" (p. 92).

With this conclusion in mind, a related hypothesis on the development of schizophrenia has been referred to as the "diathesis-stress theory" (Sarason & Sarason, 1993, p. 359). This theory, as articulated specifically with relation to schizophrenia by Zubin (see e.g., Zubin & Spring, 1977), suggests that all human beings have some level of vulnerability to schizophrenia determined by genetic, prenatal, and postnatal factors, which ranges from low risk to high risk. According to this model, if an individual's combination of vulnerability and life stress exceeds a critical amount, that individual will develop schizophrenia. Although most

current researchers appear to agree that schizophrenia is an interaction of biological factors, coping skills, environment and life events (Sarason & Sarason, 1993), there is a great deal of disagreement on the nature of the environmental and life event factors which provide the stress.

A second major area of inquiry into the biological basis of schizophrenia comes from investigations into the brain biochemistry in individuals with this diagnosis. Considerable evidence has been found for what is called the "dopamine hypothesis" (Seeman, 1993). Proponents of this perspective suggest that an excess of the neurotransmitter dopamine, at certain synapses in the brain, is responsible for the positive symptoms of schizophrenia (i.e., delusions and hallucinations). According to Sarason and Sarason (1993), three specific hypotheses have been developed to explain this dopamine excess: 1) an excess of dopamine may be released into the synapse by the presynaptic neuron; 2) an excess of dopamine may remain in the synapse due to either the inefficient breakdown of the neurotransmitter or a dysfunction in the neurotransmitter reuptake process in the presynaptic neuron; and 3) there may be an overactivity in the postsynaptic neuron due to an excess of presynaptic neurons or an oversensitivity to dopamine. Sarason and Sarason suggest that the third hypothesis is currently best supported in the research literature.

Support for the dopamine hypothesis comes from four lines of evidence (see e.g., Nicol & Gottesman, 1989; Seeman, 1993; Tsuang & Loyd, 1986). First, studies have shown that large doses of amphetamines, which are known to increase levels of dopamine and norepinephrine at the synapse, are capable of producing psychotic symptomatology in previously nonpsychotic individuals, and when given to schizophrenic individuals, are likely to exacerbate their symptoms. In addition, cocaine use has been shown to inhibit dopamine reuptake (Sherer, Kumor, Cone, & Jaffe, 1988). Second, evidence indicates that the positive

symptoms of schizophrenia are reduced by treatment with antipsychotic medication, and the medications' effectiveness in reducing symptoms is related to their effectiveness in blocking postsynaptic dopamine receptors (Seeman, 1993). Third, an excess of antipsychotic medication can produce symptoms similar to Parkinson's Disease, a disease which is thought to be caused by shortage of dopamine in specific areas of the brain. L-dopa, a medication given to Parkinson's patients to increase their levels of dopamine, has been known to produce psychotic features in some individuals. Fourth, evidence has suggested an elevation in the number of dopamine receptors in the post mortem brains of schizophrenic individuals who had or had not taken neuroleptics, and in never-medicated living schizophrenics (Seeman, 1993).

Recently, there has been considerable evidence for the role of glutamate receptor dysfunction in schizophrenia (see e.g., Benes, 1995; Olney & Farber, 1995; Tsai, Passani, Slusher, & Carter, 1995). These studies indicate that schizophrenia may be related to a hypofunction of certain glutamate neuronal systems. Olney and Farber (1995) suggest that dysfunction of the glutamate receptor N-methyl-D-aspartate (NMDA) could be responsible for many of the major features of schizophrenia, including the full range of positive, negative, and disorganized symptoms. Benes (1995) also supports this hypothesis, stating that there may be neuropathological changes in both the glutamate and gamma-aminobutyric (GABA) systems within the cingulate gyrus of schizophrenic patients. Tsai et al. (1995) assert that the efficacy of antipsychotic medication in schizophrenic symptom reduction may be due to an increase in glutamatergic activity.

A third area of investigation into the biological basis of schizophrenic symptoms comes from studies of brain structure and central nervous system abnormalities; in particular, studies of neural metabolism using methods such as computerized tomography (CT), positron emission tomography (PET), and studies of brain structure using CT and magnetic resonance

imaging (MRI). One hypothesis that has emerged in the literature is that negative symptoms of schizophrenia (e.g., reduced emotional responsiveness, poverty of speech) are related to enlarged ventricles, the cavities in the brain which contain cerebrospinal fluid (Robbins, 1993). Other findings suggest an increased ventricle/brain ratio, and a decrease in the size of the cerebrum, cranium, frontal lobes, and temporal-limbic structures (see e.g., Shelton & Weinberger, 1986). For example, Flaum, O'Leary, Swayze, and Miller (1995) found that schizophrenic symptom severity was associated with larger ventricle volumes and smaller temporal lobe, hippocampal and superior temporal gyral volumes. In a meta-analytic review of 53 studies, Elkis, Friedman, Wise, and Meltzer (1995) indicate that schizophrenic patients had significantly greater ventricular enlargement than mood disordered patients. However, Chua and McKenna (1995) suggest that lateral ventricular enlargement may be a risk factor for schizophrenia, rather than a causative agent. Finally, Turetsky, Cowell, Gur, and Grossman (1995) found that schizophrenic individuals had higher levels of cerebrospinal fluid in the temporal lobes bilaterally. However, the exact relationship between ventricle size and schizophrenic symptomatology is difficult to estimate, as other conditions are also associated with enlarged ventricles, such as traumatic head injury and alcoholism (Sarason & Sarason, 1993). Therefore, some authors have suggested that enlarged ventricles are more likely related to psychotic disorders in general, rather than schizophrenia specifically.

In addition, researchers have indicated the presence of abnormalities in the cerebral cortex of schizophrenic individuals. Weinberger and Knable (1995) suggest that schizophrenia is a developmental abnormality affecting the connection between the prefrontal cortex and the medial temporal cortex. Selemon, Rajkowska, and Goldman-Rakic (1995), in their investigation of neuronal density in schizophrenic, schizoaffective, Huntington's, and normal patients, found that schizophrenic individuals showed increased neuronal density and slightly

decreased cortical thickness in the prefrontal and occipital areas. They suggest that this abnormally high neuronal density in the schizophrenic cortex indicates that neuronal atrophy may be the anatomical substrate for deficits in information processing associated with schizophrenia. Weinberger, Aloia, Goldberg, and Berman (1995) report that dysfunction in the prefrontal cortex in schizophrenic patients has a greater effect on individual behavior when the prefrontal cortex is required to interface with working memory-related neuronal systems that share information across neural networks involving the prefrontal and limbic cortices.

It has also been suggested that a dysfunction in the cerebellum of schizophrenic individuals might contribute to this disorder. Martin and Albers (1995) conclude that the anterior vermis and fastigial nucleus of the cerebellum plays an important role in schizophrenic disorders, and that findings on the neurochemistry and vermian-fastigial-forebrain pathways are consistent with current hypotheses on the neurochemical imbalances in schizophrenia.

A fourth area of evidence for the biogenic view of schizophrenia comes from studies linking psychotic symptoms and external insults on the brain. According to authors such as Davis (1987), research has implicated factors such as traumatic head injury, tumors, drug intoxication, birth trauma, and diseases such as epilepsy in the etiology of schizophrenia.

A final area of investigation into biological factors associated with schizophrenia, according to Davis (1987), is based on the findings from epidemiological studies of schizophrenia. He states that research supporting the biological hypothesis has shown that the symptoms of schizophrenia, the age of onset, and gender ratio are similar across cultures, findings which would imply a biological basis for the disorder. The findings and conclusions from these epidemiological studies, however, are not without criticism, and are revisited later in this paper.

Although the relationship between the specific content of delusional thought and biological factors has not been addressed in the literature, many authors (see e.g. Cummings, 1985; Signer & Isbister, 1987) have suggested that the presence of delusions may be associated with certain forms of central nervous system dysfunction, such as disorders affecting the limbic system, the basal ganglia, and the prefrontal cortex (Butler & Braff, 1991; Robbins, 1993). Benson and Stuss (1990), for example, postulate that frontal cortex dysfunction not due to external trauma plays a role in the genesis of delusions. They suggest that prefrontal activity is necessary for self-analysis; that is, the ability to self monitor which is crucial in the recognition of the appropriateness of delusional ideation or the validity of sensory perceptions. An impairment in this ability is important in the formation and maintenance of delusions and hallucinations. According to the authors:

> ...reality testing is, to a great degree, dependent on competent frontal lobe function. Failure to be self-critical and perform reality testing in the face of correct knowledge suggests high-level prefrontal malfunction. In this concept, the occurrence of delusions in schizophrenic patients implies prefrontal malfunction. (p. 410)

Nasrallah (1985) hypothesizes that Schneiderian delusions, such as thought broadcasting, thought insertion, and thought withdrawal, may be associated with left hemisphere dysfunction, a weakening of left hemisphere dominance, and a shift in brain laterality. He suggests that a deficit in interhemisphere integration results from an increased width of the interhemispheric commissure and the corpus callosum. This deficit leads to a loss of interhemispheric awareness, so that the schizophrenic patient "functions with two anatomically communicating but neurochemically unintegrated spheres of consciousness" (p. 275). Each hemisphere would therefore regard input from the other as coming from an outside source - delusions of influence from outside, thought control, etc. It will be interesting to see whether future empirical evidence supports this hypothesis.

Other authors have supported the association between of cerebral cortex dysfunction and the presence of delusional thought. Joseph (1986) suggests that frontal lobe damage can result in disinhibition and cortical overresponsiveness, and overstimulation of the language and other cortical areas, with accompanying tangential, fantastical, and grandiose associations. Levine and Grek (1984) found a tendency for frontotemporal lesions to occur more frequently in individuals exhibiting delusions. They also purport a relationship between delusions and ventricular enlargement or sulcal widening. Anderson (1988) suggests that Capgras delusions (delusions of doubles) may result from lesions of the neural pathway for visual recognition during the stage where visual images are connected with affective familiarity.

According to many authors (see e.g., Davis, 1987; Erchak, 1992; Kleinman, 1988b), the biological model is currently the predominant conceptual model for understanding schizophrenia. In the past few decades, this model has regained its ascendency over psychological and social models as recent advances in technology have enabled researchers to have access to previously unobtainable information about brain chemistry and structure.

In summary, the biological model makes the following assumptions: 1) schizophrenia and related behavior patterns are disorders or illnesses, with delusional thought as one symptom; 2) defects within the genetic, biostructural, and/or biochemical processes within the individual are responsible for schizophrenia and related behavior patterns; 3) the focus of this area of investigation is specifically the individual, with little or no consideration of the individual's social, political or cultural context - at most, biological theories may raise some question as to the impact of the environment on the biological functioning of the individual, such as brain injury, viral infection, etc.; 4) inherent meaning within the delusional symptoms associated with schizophrenia is less important than the elimination of the symptom; and 5)

the appropriate avenue for alleviation of the delusion (symptom) and the illness (schizophrenic disorder) is through individual, biological interventions such as pharmacotherapy.

Motivational Models

Psychodynamic model. The psychodynamic viewpoint when applied to schizophrenia asserts that delusional thought content is meaningful when interpreted within the context of the individual's history as understood by psychoanalytic theory. For example, Arieti (1955, 1974), a psychoanalytic theorist, believes that some kind of organization can be distinguished in even the most bizarre or irrational thoughts; when one is able to understand this organization in the context of the individual, then one can understand its meaning. Aside from several broad generalizations which can be made about the various psychodynamic approaches to human problems, it would appear from a review of relevant literature that there are several psychoanalytic interpretations of schizophrenia. With this in mind, this section outlines the general contentions of some of the major psychodynamic approaches as they pertain to delusional thought. The reader is directed to two chapters written by Stone (1991a, 1991b) for a detailed review of psychodynamic approaches to schizophrenia in general.

According to many psychoanalytic theorists, schizophrenia can be understood as "a specific reaction to an extremely severe state of anxiety, originated in childhood, reactivated later in life" by various psychological factors (Arieti, 1955, p. 43). Stone (1991a) and others (e.g., Hingley, 1992) suggest that psychodynamic models conceptualize schizophrenic symptoms as a reflection of unresolved developmental crises in the earliest phase of life. During early childhood, various "narcissistic defenses" (Vaillant, 1971, p. 116) strongly resembling psychotic experiences, such as "delusional projection" and "denial" of external reality (Hingley, p. 350), are part of normal development. These defense mechanisms are common in healthy individuals before the age of five; for example, a young boy who asserts

that "girls do so got penises" (Vaillant, p. 116) is using the mechanism of denial in a fashion appropriate for his age.

Klein (1952, cited in Zuk, 1989) uses the term "paranoid-schizoid position" to describe the developmental stage of mentation for the first six months of life, and proposes that trauma in later life will reactivate this early paranoid-schizoid style of thinking in individuals who have experienced an unresolved conflict during the first few years of life.

According to many theorists (see e.g., Hole, Rush, & Beck, 1979; Winters & Neale, 1983), a key element in the psychodynamic theory of delusions is the defense mechanism of projection. These authors purport that delusional schizophrenic individuals project onto others their own inner state, conflicts, wishes, or parts of the self that are painful, anxiety-provoking, and therefore unacceptable. An example of this thesis is evident in the psychodynamic explanation for persecutory and grandiose delusions. This explanation, originated in the works of Freud (1958, cited in Zuk, 1989), was expanded by authors such as Sullivan (1953) and Arieti (1974), and remains cited as the predominant psychodynamic theory on the development of delusions (see e.g., Hingley, 1992; Hole, Rush, & Beck, 1989; Winters & Neale, 1983; Zuk, 1989). According to Zuk, Freud developed the theory with his analysis of the published memories of President Schreber, a paranoid individual, whose delusions Freud believed were caused by repressed homosexual feelings which were socially unacceptable, produced overwhelming anxiety, and were therefore distorted and projected onto others. It was thought, as Arieti (1955) describes, that the schizophrenic individual unconsciously identifies the object of her or his homosexual feelings as a persecutor, since both the object and the persecutor evoke disturbing feelings; she or he would prefer to think of the individual as a persecutor rather than as lover to avoid the feelings of guilt associated with socially unacceptable homosexuality. However, in his later work, Arieti (1974) states that there is

nothing about homosexuality itself which contributes to psychosis; rather the social ostracism associated with this "'unacceptable' sexual orientation" (p. 118) causes anxiety in the individual, which may lead to schizophrenic symptoms. In addition, Winters and Neale (1983) state that the empirical support for the role of repressed homosexuality is often weak and conflicting, and is less convincing for female paranoid schizophrenics than for males.

Arieti (1955, 1974), based on the ideas of Sullivan, directs this theory away from its emphasis on the projection of repressed homosexual feelings to repressed negative feelings about the self. He believes, as did Klein and others, that trauma in early childhood contributes to the development of delusions in schizophrenic adults. Arieti describes three stages in which delusions of persecution, grandiosity and thought control develop. First, the child introjects, or internalizes, the negative, critical attitude directed toward the child by her or his parents. Second, the child accepts this critical attitude about herself or himself, and therefore hates or controls herself or himself as the parents did. Finally as an adult, as Sullivan (1953) suggests, after an attack on her or his self esteem, the individual experiences a state of panic leading to psychosis, where the individual begins to project this negative self attitude onto parents or parent substitutes. Therefore, as Arieti outlines, the schizophrenic adult does not hate herself or himself, someone else does. Arieti proposes that it is psychically easier for the schizophrenic individual to project intense hostility onto and retaliate against imaginary persecutors than the true objects of this hostility, namely her or his parents. For example, with a persecutory delusion, the condemnatory attitude of the parent, and subsequently the individual, is projected onto the persecutory actions of the FBI. Arieti believes that delusions of thought control develop in a similar fashion: the people or objects who control her or his thoughts symbolize the parents who were forcing her or him to think the way they wanted. Arieti states that it is also at this point that grandiose delusions may

develop, as the individual is more able to attribute all the positive characteristics to herself or himself which were not permitted in her or his early childhood environment.

Current psychodynamic theories place less emphasis upon the role of repressed homosexuality and negativity of the parents in the development of delusional thought; ego functions and early childhood factors are now considered an important component of psychodynamic approaches to schizophrenia. However, authors such as Stone (1991b) suggest that psychodynamic formulations should be considered within the context of biological and genetic evidence for schizophrenia. He believes that psychodynamic theory has important contributions to the understanding of the experience of schizophrenia, but should be understood as part of schizophrenic phenomenology, rather than the cause of symptomatology.

In general, the psychodynamic theory of schizophrenic delusions makes the following assumptions: 1) schizophrenic symptoms and therefore delusional thought are the result of disturbances in early childhood development; 2) delusional thought is meaningful and understandable within the context of psychodynamic theory and the individual's own personal history; and 3) the most appropriate method of intervention for individuals suffering with this difficulty is psychoanalysis, where the therapist provides a safe environment to facilitate strengthening of the ego, and offers psychodynamic interpretations reflecting the significance of delusional content to underlying unconscious concerns or environmental events (Hingley, 1992).

Existential model. The existential model of delusional thought is based upon existential or phenomenological principles, and has influenced inquiry into schizophrenia in two ways. First, existential theorists focus their investigations on the content of delusions, and have hypothesized that particular themes about human existence are prevalent in psychotic

thought. For example, Ey (1955, cited in Arthur, 1964) asserts that an individual's subjective experience is formed in part by the "major themes of human existence" (Winters & Neale, 1983, p. 241) which are common to all human beings. Themes such as God, death, freedom, and the like, dominate the content of schizophrenic delusions just as they dominate all subjective reality. Forgus and DeWolfe (1974) found support for this hypothesis; namely, that the dominant themes in a schizophrenic individual's delusional system reflect the dominant themes in her or his construction of reality, such as self, sex, competence, and interpersonal relationships. In addition, Niv (1981) proposes that the symbols evident in psychotic delusions are in fact reflections of the "failures, deficiencies, moral breaches, and reprehensible acts that were painfully present in the sufferer's Existence" (p. 246). Therefore, authors writing from an existential perspective maintain that the key concepts common to all human beings are symbolically represented in the content of delusional thought.

Second, theorists associated with existential psychiatry have developed a method of exploring and ultimately understanding the meaning underlying delusional thought. Havens (1987), for example, discusses the development of existential psychiatry as a discipline, beginning with Jaspers, Minkowski, and Binswanger. The combined work of these three philosophers led to the articulation of the "existential method:" a focus on the inner experience of the individual; a complete freedom from expectation or prejudice on the part of the clinician; the development of empathy or rapport with the "sick" aspects of the client; and an acceptance and use of the clinician's spontaneous, emotional reactions to the client. Therefore, this method requires a stance of subjectivity on the part of the therapist, and a focus on the unique qualities of the individual (Davis, 1987).

Whereas psychodynamic approaches interpret meaning through the use of universal principles and symbols in conjunction with information from the individual's personal history,

the existential method necessitates the interpretation of meaning through the use of symbols unique to the individual (Niv, 1981). Only by truly understanding the individual's "world design" (Winters & Neale, 1983, p. 240) or world view, is one able to understand the meaning in her or his delusional thought. Niv, for example, suggests that within the context of psychotherapy, the use of empathic understanding in the search for meaning in delusions within the context of the life experience of the individual may lead to the breakdown of the delusional experience. She provides the following example of such an interpretation:

> A bizarre somatic delusion began to disturb an otherwise healthy 88-year-old married man, who felt little insects invading his genitalia and spreading to his brain. Only after admission to past marital infidelities, sexual excesses and visitations to brothels, which were confessed to his wife and the therapist, did his delusion begin to dissolve. (p. 243)

As is evident from Niv's example, the delusion of insect infestation is meaningful to this particular client because of his life experiences, rather than any theoretical hypothesis regarding the meaning of insects generally. Niv implies that the interpretation of the "true" meaning of the client's delusion was instrumental in helping this man to recover from his psychotic symptoms.

As is the case with the psychodynamic approach to delusional thought, existential methods have focused primarily on philosophical discussions rather than explicit suggestions on the technical aspects of the method (Havens, 1987). However, Schmolling (1984) provides an empirical example of both existential content and method in his case study investigation of a male schizophrenic individual. Schmolling interprets his client's often bizarre and delusional statements within the context of his life experiences, and concludes that an overarching theme evident in his communications was a strong belief in uncertainty - that "nothing is definite" (p. 139). This client did not exhibit the 'normal' need for certainty and predictability. Schmolling suggests that this pattern of thought may provide a defensive function against the

overwhelming certainties in human existence - death, illness, loss, insecurity, etc. Only by adopting a delusional thought system was Schmolling's client able to cope with these "givens of existence" (p. 147).

Therefore, an existential approach to the understanding of delusions asserts that 1) delusional thought is inherently meaningful; 2) one can understand delusional thought by interpreting symbols unique to the schizophrenic individual's life experience, without the use of universal symbolic representations and unconscious mechanisms; 3) delusional thought may serve as a coping strategy for the struggles inherent in all human existence; and 4) the provision of interpretations of meaning to the delusional individual serves to dissolve the delusional system.

The social phenomenological model of R. D. Laing. A discussion of the various approaches to understanding schizophrenia would be incomplete without specific reference to the writings of existentialist and antipsychiatrist, R. D. Laing. Laing has developed an extensive theory of the development and phenomenology of schizophrenia, making use of concepts and ideas from psychoanalytic, existential, phenomenological, and family systems theories, and extending the focus of investigation from the individual to the family and larger society. His ideas are particularly pertinent to the present study as Laing attempted to combine individual, family and societal factors in his understanding of the schizophrenic individual's experience. The present study examines these factors, with a specific emphasis on how the schizophrenic individual understands her or his experiences.

The other important feature of Laing's work which makes it relevant is its focus, at least theoretically, on the impact of the larger societal context on the development of schizophrenic symptoms, and its critique of Western societal values. His focus on the family, specifically the parents of schizophrenic individuals, clearly "our first and closest authority

figures" (Kanter, 1974, p. 310), his identification with the schizophrenic individual as the victim of the oppressive social system, his critique of capitalist Western society, and his forays into mysticism and communal living, held a strong appeal for members of the 1960s counter-culture. As some in 1990s academia have also adopted a critical approach, Laing's call for analysis of the impact of society on mental health, his critique of social processes, and his recognition of the experiences of oppressed groups such as psychiatric patients, may be rediscovered by authors writing in the area of social, political and cultural approaches to mental health.

Laing defined as "schizophrenic" someone who "has come to have attributed to him [*sic*] behaviour and experience that are not simply human, but are the product of some pathological process or processes, mental and/or physical, nature and origin unknown" (Laing, 1967, p. 17); that is, an individual who "has been diagnosed as such and has come to be treated accordingly" (p. 19). With the majority of his writings in this area taking place during the 1960s, he is said to have viewed the schizophrenic individual "as society's ultimate underdog" (Sedgwick, 1982, p. 102); he approached schizophrenic individuals as an emancipator out to free the oppressed psychiatric patient. Although a controversial figure in the field of clinical psychiatry, he has contributed significantly to the understanding of the schizophrenic experience. Several works are of prime importance here: The Divided Self (1960), The Politics of Experience (1967), The Politics of the Family (1971), and in cooperation with Esterson, Sanity, Madness, and the Family (1964).

Throughout his work, Laing insisted that all human behavior is "valid and potentially intelligible" and that "none of it should be shunted off into a garbage heap for incineration by sanitary technicians" (Sedgwick, 1982, p. 100). Laing believed that schizophrenic symptoms, including delusional thought, when viewed within their context, are reasonable and "sane," but

are rendered incomprehensible by the decontextualized medical model. The family unit, rather than the individual, was Laing's primary focus of recrimination. He believed that all families are repressive agents of socialization which lead individuals to an advanced state of alienation. Families of schizophrenic individuals are particularly damaging due to the highly distorted and paradoxical nature of their communication. The family situation is so unbearable for the schizophrenic individual that she or he succumbs to psychotic processes in order to "live in an unliveable situation" (Laing, 1967, p. 79).

According to Sedgwick (1982), Laing acknowledged that his understanding of schizophrenia had been limited to the context of the family, and that more work was necessary to broaden the contextual focus. At that point, the language Laing used to describe his understanding of schizophrenia became more socially committed. He strongly believed in a critical appraisal of "the larger context of the civic order of society - that is, of the *political* order, or the ways persons exercise control and power over one another [italics in original]" (Laing, 1967, p. 85). He was said to have equated the "small-scale assaults of modern psychiatry" with "the huge lunacies and systematic violence perpetrated by the world system of imperialism" (Sedgwick, 1982, p. 94).

Specifically, according to Laing, the process of socialization which takes place in Western capitalist society is a highly repressive form of social control which forces individuals to view the world from a specific perspective which functions to maintain the existing social order. He outlined the destructiveness of human beings and society:

> We all live under constant threat of our total annihilation. We seem to seek death and destruction as much as life and happiness. We are as driven to kill and be killed as we are to live and let live. Only by the most outrageous violation of ourselves have we achieved our capacity to live in relative adjustment to a civilization apparently driven to its own destruction. (1967, p. 49)

He proposed that this violation of ourselves through the use of defense mechanisms such as splitting and repression, inevitably leads to profound alienation, and that schizophrenic individuals may actually be less alienated than nonschizophrenics. Eventually, Laing went on to suggest that schizophrenic experiences could be liberating, in that psychosis could be instrumental in helping alienated individuals overcome their alienation (Sedgwick, 1982).

Despite his reiteration that the capitalist societal context was integral to the generation of alienation and to the understanding of schizophrenic experience, a major criticism of Laing's work was his apparent lack of commitment to an elaboration of his critique. Many authors (see e.g., Kanter, 1974; Sedgwick, 1982) suggest that the implication of Laing's theoretical work was the development of an integrative theory of individual, microsocial and macrosocial relationships - the implication that "the manipulation of psychotic delusion through phenothiazines would be linked to the suppression of political dissent through bludgeon or gallows" (Sedgwick, p. 104); however, as Laing's career progressed, it became evident that his references to civic and political order were limited to the family and hospital, rather than the economy, class structure, and bureaucracy, and that "ultimate responsibility for alienation and psychic repression resides in the family" (Kanter, 1974, p. 308). Laing stopped his detailed analysis with the family unit and left unexplored the role of the family within the larger social structure (Kanter, 1974; Bartlett, 1976). In fact, once the social conflict of the 1960s had subsided, Laing was quick to repudiate his socialist and mystical approach to schizophrenia and adopt a less controversial position. According to Sedgwick (1982) "since emerging from his phase of radical politicking he has made no further general pronouncements on the nature of society" (p. 105). During the 1970s and 1980s he waged a "campaign of normalisation" (Sedgwick, p. 107) against all of his unique and radical ideas of the 1960s: madness, mysticism, the medical model, socialism, and the like. This renunciation

of his more radical ideas was a disappointment to the individuals who were looking to Laing to drastically revise the mental health system and psychiatric treatment.

Although Laing strongly implicated the family and the larger social system in the etiology of schizophrenia, his approach to alleviating psychotic distress was directed at the individual. Laing believed that the psychiatric treatment of schizophrenic individuals was a "form of violence perpetrated in order to maintain the social order" of the family (Collier, 1977, p. 155). In its place, he proposed a safe environment of encouragement and guidance, such as Langley Hall, developed by Laing and his colleagues, within which schizophrenic individuals could experience their psychosis without intrusive psychiatric intervention (Antonio, 1973).

Sedgwick (1982) suggests that at one point during his left-wing period, Laing did advocate social change aimed at larger levels, such as factories, universities, hospitals, etc.; however, these recommendations were limited in their frequency and depth. It is also noteworthy that Laing did not suggest family therapy as a means for alleviating distress in a schizophrenic individual. Laing's extensive focus on the individual and relative neglect of the social context as the medium for change elicited criticism from many authors, such as Kanter (1974) and Jacoby (1973), who argued that when the units of analysis are the family and individual, the possibility of pursuing social change disappears.

Although his own proscriptions for change were limited to the individual schizophrenic, Laing implicated the larger social order in his extensive critique of traditional psychiatric methods. He suggested that the treatment of schizophrenic and other psychotic individuals is a political act, and is "related to the preservation of the existing social order and power structure" (Antonio, 1973, p. 22). Laing's view of psychiatric treatment as social control of psychotic individuals, as cogently elaborated by Antonio, proposes that psychotic individuals

are subversive to the social order in that they experience and communicate alternative realities which challenge the normative assumptions of society. Antonio argues that the maintenance of an agreed-upon set of assumptions about 'the way things should be' is essential for maintaining social order; doubt about the natural order is a threat to the stability of that society. The role of psychiatrists, and presumably other mental health professionals, is to prevent psychotic individuals from "piercing the blanket of mystification and reification inherent to normal alienation" (Antonio, p. 23) by ensuring that their thoughts and experiences are invalidated. As Antonio states, Western society "acts swiftly against the transgressor to maintain the world of belief and to protect the sleep of the normally alienated" (p. 24).

Despite his strong belief that schizophrenic behavior and communication is meaningful within its context, Laing's works concentrate on complex descriptions of the context of family and society, rather than discuss the intricacies of meaning interpretation. However, given his foundation in existential/phenomenological theory, one would expect his interpretive approach to exhibit similarities with the approach of existentialist authors discussed above. While the existential perspective viewed psychotic symptoms as intelligible within the context of the individual's life history, Laing extended the individual's life history to include the specific context of the family. For example, in Sanity, Madness and the Family (1964), Laing and Esterson describe a female client with a paranoid delusion that the hospital staff were withholding her telephone messages. In Laing and Esterson's analysis of her family, it became evident that her family members were not attempting to contact her by telephone as frequently as she thought, and yet her family made no attempt to make the client aware of this. According to Laing and Esterson, her delusion may be understood within her family context: "a mistrustful perception of the hospital was necessary for her if she was to maintain her trust in her family" (p. 112).

In summary, Laing makes the following assumptions in his various works on the phenomenology of schizophrenia: 1) schizophrenic symptoms, including delusions, are inherently meaningful; 2) these symptoms are intelligible within the context of the family and larger society; 3) schizophrenic symptoms provide the individual with a means to cope with a dysfunctional family system and a destructive social system; and 4) the means for alleviating the distress of the schizophrenic individual is found in support and encouragement of the psychotic process without chemical interventions.

Sociopolitical model. Several authors have recently addressed the issue of meaning in schizophrenic delusions from a political perspective (see e.g., Glass, 1981, 1985, 1987; Harper, 1992; Heise, 1988). In general, these theorists assume that delusions are inherently meaningful, and incorporate the larger socioeconomic and political contexts into their understanding of delusional thought. This section outlines in detail some of the political perspectives offered from authors working in psychiatry, sociology, and political theory. First, a social constructionist approach to delusions as described by Harper is discussed. Second, Glass's theory on the political message of schizophrenic delusions is outlined. Finally, Mirowsky and Ross' (1983) study investigating the relationship between paranoia and powerlessness is reviewed.

Harper (1992) uses the process of deconstruction, which he defines as "a process which reveals hidden contradictions and meanings within texts" (p. 357), to examine the concepts of paranoia and delusion as outlined by the DSM-III-R (APA, 1987). His goal in conducting such an investigation is to consider the wider sociopolitical context of delusions, as well as to explore the possible ways in which the current psychiatric definition of delusions serves professional interests.

First, Harper takes issue with the notions of truth, falsity, and reality inherent in current diagnostic definitions. He states that the DSM-III-R definition uses terms such as "false personal belief" and "external reality," thereby assuming a realist epistemology and denying the validity of alternative views. Harper, as a proponent of the constructionist perspective, argues that there are often several interpretations of perceptual phenomena, and therefore more than one view of reality may be possible and valid. This belief questions the DSM-III-R's reliance on the concept of reality. Harper concludes that "whatever the reality of reality it is clear we may construct different versions of it and that those which dominate are often the ones asserted by those in powerful positions" (p. 360). He raises the point that part of the DSM-III-R definition of delusions is that the belief is not accepted by other members of the culture or subculture, and the validity of a belief is based upon the number of people who believe it. This implies, according to Harper, that beliefs held by the majority are accurate representations of reality, while the beliefs of minorities are deluded. He offers the case of paranoia as an illustrative example of this phenomenon, suggesting that it is often permissable for those in power to be paranoid, as in Senator McCarthy's investigation of communist activities in the United States, but is not permissable for marginalized individuals to express similarly paranoid ideation.

Harper goes on to state that some authors have argued that there may be a legitimate basis for paranoid beliefs, offering several accounts of telephone tapping and use of private detectives as evidence. He cites authors such as Smail (1984) who suggest that feelings of paranoia and suspicion may be adaptive in a society "with an increasing emphasis on the individual, regulated by the objectifying gaze" which "watches and monitors its citizens" (Harper, 1992, p. 361). Thus, according to Harper, the particularly powerless position held by most paranoid individuals may be seen as an argument put forth in order to convince

nonparanoid individuals of the state of society, in a similar fashion to those making political, scientific and evangelical religious arguments.

According to Harper, the dominance of the medical approach to paranoia specifically, as well as schizophrenia in general, has historically been driven by the need to legitimize the medical and psychiatric profession; such functions continue to be served to the present day, with schizophrenic diagnoses serving to exert social control and to justify the existence of the psychiatric profession. Harper concludes that delusions are not merely a focus of mental health professionals, but instead a source which asserts their legitimacy. He is not suggesting that mental health professionals are intentionally conspiring against delusional individuals; however, he does believe that the "professional, cultural and ideological context of diagnostic definitions cannot be ignored since some views may serve professional interests more than they serve the needs of service users" (p. 365).

Harper suggests that alternative conceptualizations of psychotic behavior are currently developing which will provide direction for clinical practice as well as support for mental health professionals, and he makes two suggestions in this regard. First, he proposes that clinicians should be cautious when making the diagnosis of paranoia, and be aware of the larger context which leads to the client's behavior being regarded as deluded in the first place. Second, similar to ideas expressed by psychodynamic and existential theorists, Harper advises that rather than viewing delusions as pathological, clinicians should treat them as metaphors. He stresses the importance of accounts which treat delusions as legitimate realities, necessitating alternative approaches to treatment.

A second approach to the political understanding of delusional thought in schizophrenic individuals has been cogently outlined by Glass (1981, 1985, 1987). He believes that delusional thought is a profoundly meaningful part of human experience that, once decoded, is

intelligible and logical. He states that delusions are comprised of symbols of specific events, ideas, or concepts whose meaning is inaccessible to the observer. These symbolic attempts at communication should be taken seriously, he argues, and not dismissed as incoherent "ramblings." To ignore these delusional messages, according to Glass, is to ignore an essential part of human nature. He states that "no matter how bizarre the delusion, or how far it is from the rational consensus, it is still human language filled with symbolic meaning and commentary" (1987, p. 413).

Based on his experience in working with schizophrenic individuals, Glass (1981, 1985, 1987) suggests that their delusions contain strong political themes based on power relationships in Western society. According to Glass (1981), power in delusional thought is characterized by a strong emphasis on domination - the simultaneous expression of domination in one image and victimization and annihilation in the other. He states that the relationship between images of power and experience of victimization reflects analogues of the general political relationships which appear consistently in any political environment: domination, defilement, manipulation, destruction, devaluation, bodily enslavement, etc. He offers as an example a client whose delusions included the ability to "wield 'cosmic, galactic power'" and "cosmic forces do[ing] brain scans" (p. 576) reflecting the political analogues of simultaneous domination and manipulation.

Glass (1981) suggests that within the schizophrenic individual, these power images serve to connect the self with such overwhelming events, people, or presences (e.g., God, the Virgin Mary) that the threat of annihilation is eliminated. These images also help to defend against their need for closeness from others and to compensate for their identification with worthlessness. These delusional ideas provide a means of survival against what Glass calls the "very real fear of annihilation at the hands of the external world, particularly other human

beings" (1985, p. 69). However, Glass (1981) asserts that only the political imagery of domination and victimization are evident in the schizophrenic individual's delusional world; the politics of community - images of caring, closeness, cooperation, and mutuality - have no functional significance for the schizophrenic individual.

Glass (1987) views delusions as a critique of what he sees as the power relations inherent in society: the power of desire and frustration, the power of significant others in transforming self perception, the power of society in defining and terrorizing the self. However, this form of social commentary is rejected by the "rational consensus" (p. 405) in Western society, which "blunts their implicit criticism" (p. 407) and its symbolic meaning by labeling it as madness and pathology. This, according to Glass, is the central paradox of the rational consensus: delusional individuals are excluded and their delusions about power are deemed pathological, but the pathology in Western society's political and organizational structures is ignored. As Glass states, "what is called 'pathological' in the setting of the mental hospital becomes 'normal" and sane under the power of the rational consensus" (p. 416). Glass points out that ruthlessness, nonempathic reason, manipulativeness, the need to drive and dominate, are desirable and admirable qualities in Western, if not all industrialized, societies. Initially, one may disagree with this extreme, pessimistic statement. However, when one's attention is directed toward who is rewarded in Western society - by financial power and status - Glass' accusations become less outrageous: leaders of large corporations who make decisions primarily based upon the profit motive rather than human concerns; powerful politicians who declare war on some countries and provide assistance to others, who cut back on social welfare programs while making deals with large corporations; the individuals whom our media promotes and comodifies - serial killers, ultraviolent superheros,

and the like. Often these individuals whom Western society glorifies do not achieve their status through values of community; they do so by means of exploitation and manipulation.

Glass (1985) suggests that delusional individuals are excluded from Western society because of the subversive nature of their experience; he states that "what we do not want to see stirred up in ourselves - extremes of scorn, hate, fear, dread, and need - we make invisible by hiding the persons who exhibit these extremes and by objectifying their speech, studying it as some aberrational, sick dynamic" (p. 13). The exclusion of schizophrenics protects Western society's sense of psychological reality, its own values and accepted patterns of behavior. That culture rejects schizophrenic thought is interpreted by Glass to mean that it contains threatening information that is easier to deal with by labeling it as mad.

However, it is important to note that Glass is not suggesting that the schizophrenic individual is a social critic who freely chooses to criticize Western society by espousing ideas which comment on power relationships. Rather than proposing that the political system of Western society causes schizophrenic delusions, Glass (1985) sees both systems, political and delusional, as originating in similar psychodynamic structures resulting from unconscious processes in early childhood. He states that:

> in view of the uncertainty of political life and its often paranoid assumptions, early developmental structures combined with social influences may exercise some role in the practice of politics. Paranoia is the most obvious of these internal forms of distortion, but there are many more: the obsession with control, the need to dominate, actions having little empathic concern for others, ruthlessness, powerseeking, lack of conscience, the devaluing of others, and grandiose projects. (1987, p. 417)

In essence, Glass is suggesting that, as psychoanalytic theorists such as Melanie Klein and others have discussed, schizophrenic delusions stem from a regression to a very early psychodevelopmental stage, and these same unconscious processes drive the Western political system. Therefore, by listening to and by attempting to understand the themes of

power and exploitation in schizophrenic delusions, we can learn about power in the Western political system. His suggestions are directed to political theorists, for them to not only focus on the economic and historical world, but also on the "inner self, its peculiar configuration, languages, origin, and consequences" (1987, p. 434). He also makes recommendations for therapists working with delusional individuals, emphasizing psychoanalytic principles and the importance of the therapeutic relationship. In addition, Glass' ideas are implicitly if not explicitly critical of Western political structures as he portrays society as replete with messages about domination, victimization, alienation, and the like. Although a critical examination of power relationships within therapy may follow from Glass' critique of Western society and emphasis on individual psychotherapy, he unfortunately does not comment on the issue of the power imbalance inherent in therapeutic relationships.

Mirowsky and Ross (1983) provide both theoretical and empirical evidence on the specific relationship between paranoia and powerlessness. Based upon prior research and theory, the authors hypothesize that paranoid ideation develops from a general belief that important outcomes are determined by external forces, to a more specific belief that others are manipulative and may block the achievement of goals, to even more specific persecutory beliefs. The authors assert that certain sociodemographic positions, particularly those with low socioeconomic status, are characterized by objective experiences of powerlessness, victimization and exploitation. This powerlessness leads to a belief that important outcomes in life are controlled by external forces, rather than by choice and effort. Mirowsky and Ross call this a belief in external control. This sometimes accurate belief often "represents an awareness of objective conditions" (p. 229); that is, when individuals have little power, as is the case for individuals with low socioeconomic status, low income, low education, and low social status, they learn that more powerful others have control over the outcome of important

life events. This belief in external control, according to Mirowsky and Ross is the "first step in descent to paranoia" (p. 229).

The second step in the development of paranoid ideation occurs in the interaction between the belief in external control and the threat of victimization or exploitation. The authors define mistrust as the "cognitive habit of interpreting the intentions and behavior of others as unsupportive, self-seeking and devious" (Mirowsky & Ross, 1983, p. 229). They propose that individuals become mistrustful because of prior mistreatment of themselves or of others whom they know. The authors state that mistrust is greatest where mistreatment or victimization is greatest, and that individuals in lower socioeconomic positions are more likely to be victimized (presumably by rich or powerful individuals, either through forced economic hardship or unsafe living conditions). Therefore, belief in external control combines with an acute awareness of the potential for victimization experienced by those in lower socioeconomic positions to produce an experience of mistrust. Mirowsky and Ross suggest that although mistrust may serve to protect individuals, it often develops into a maladaptive stance of paranoia.

This development of paranoia from a position of mistrust is a somewhat more ambiguous process. Mirowsky and Ross cite a study by Lemert (1962) on the development of paranoia in groups of individuals who are dependent on one another to achieve their objectives, and whose cooperation requires trust. According to the findings of this study, when an already mistrustful individual is unsuccessful or loses status, and begins to question the support of other group members and the implicit group rules, the others band together and exclude the individual. Mirowsky and Ross conclude that when individual success is dependent upon the help and cooperation of others, the belief that others cannot be trusted may evolve into hostility and paranoia.

Mirowsky and Ross developed an empirical test of the relationship between socioeconomic status, belief in external control, mistrust, and paranoia. Using data from a mental health survey of individuals from Texas and Mexico, they assessed several sociocultural (social class, ethnicity, minority status, age, and sex), social-psychological (belief in external control, mistrust, and social desirability), and psychopathological (paranoia) variables. The results indicated an interaction between socioeconomic status and belief in external control: the lower the socioeconomic status, the stronger the association between belief in external control and mistrust, and the higher the belief in external control, the stronger the association between low socioeconomic status and mistrust. The authors interpret these findings to indicate that neither a belief in external control nor socioeconomic status alone are sufficient to lead to the development of mistrust; that is, the individual who holds a strong belief in external control is not likely to become mistrustful if she or he is from a high socioeconomic position; likewise, the individual from a lower socioeconomic position is not likely to become mistrustful if she or he does not hold a belief in external control.

The results also suggested that belief in external control, mistrust, and paranoia were higher for individuals in positions of lower socioeconomic status, where victimization and exploitation are most common. In addition, females were found to have a higher belief in external control than males, and the effect of low socioeconomic status on mistrust and paranoia was greater for females than males. Although this finding is not discussed in detail in their paper, it does provide support for Mirowsky and Ross' theory if one makes the assumption that the position of women is analogous to that of individuals with little socioeconomic status; that is, women are also powerless, and are more often exposed to threats of assault, harassment, and other forms of victimization and exploitation than men.

However, this is inconsistent with the research which indicates that schizophrenia is more prevalent in men than women (see e.g., APA, 1994).

Unfortunately, Mirowsky and Ross do not make any specific recommendations for interventions with paranoid individuals. They do, however, discuss whether beliefs in external control, mistrust and paranoia are adaptive for individuals in low socioeconomic positions, and conclude that while some degree of caution is beneficial, "there is little evidence that mistrust and paranoia provide actual security and there are good reasons to think they are counterproductive" (p. 238).

Although the authors discussed here, Harper (1992), Glass (1981, 1985, 1987), and Mirowsky and Ross (1983), take a very different approach to the understanding of delusional thought, they all make the following assumptions: 1) delusional thought is inherently meaningful; and 2) the larger sociopolitical context is an important area of focus for understanding schizophrenic delusions. However, far from presenting a coherent body of knowledge, these political models differ in their suggestions for interventions. As stated earlier, Harper suggests that being aware of the context of diagnosis is important, and that clinicians should view delusions as metaphors, or even legitimate views, rather than evidence of pathology. Glass suggests the use of psychoanalytic principles for the interpretation of schizophrenic delusions. Mirowsky and Ross do not make suggestions for potential interventions, although an approach of prevention is consistent with their ideas. However, as these authors all focus their understanding on the larger sociopolitical context, interventions aimed at the larger context, such as changes in social policy, might follow.

Cultural model. A vast amount of literature from disciplines such as cultural or medical anthropology, sociology, and psychiatry addresses mental illness in general, and schizophrenia in particular, from a cultural perspective. Authors in this area, such as Arthur

Kleinman (see e.g., 1977, 1987, 1978, 1988a, 1988b, 1995; Lewis-Fernández & Kleinman, 1994), have made significant contributions to the understanding of cross-cultural mental health theory and methodology. In addition, considerable research has been conducted elucidating the nature of schizophrenia through investigations of epidemiology, cross-cultural differences and similarities, and the effects of cultural and societal variables on the manifestation of psychotic symptoms. The present study draws heavily on the cultural model as a means of understanding the experiences described by the informants. As the cultural approach to the understanding of schizophrenia is likely to be unfamiliar to those steeped in the field of psychology, this review begins with a discussion of some of the basic assumptions of cultural psychiatry and its theoretical base. Next, this section outlines the major contributions to schizophrenia research and theory, and concludes with an examination of the literature on cultural models of delusions specifically.

Before delving into a description of cultural psychiatry, it is prudent to first discuss the concept of culture itself. Jenkins (1994) defines culture as "a context of more or less known symbols and meanings that persons dynamically create and re-create for themselves in the process of social interaction...the orientation of a people's way of feeling, thinking, and being in the world" (pp. 99-100). Hughes (1993) conceptualizes culture as "a socially transmitted system of ideas - ideas that shape behavior, categorize perceptions, and (through language) give names and thereby a putative 'reality' to selected aspects of experience" (p. 7). Triandis (1993, 1994, 1995a, 1995b, 1996) expands the definition of culture to describe what he calls a "cultural syndrome." He defines a cultural syndrome as:

> a pattern of shared attitudes, beliefs, categorizations, self-definitions, norms, role definitions, and values that is organized around a theme that can be identified among those who speak a particular language, during a specific historic period, and in a definable geographic region. (1996, p. 408)

Like Jenkins, Triandis (1995a) also views culture as emerging from social interaction; he states that, "as people interact, some of their ways of thinking, feeling, and behaving are transmitted to each other and become automatic ways of reacting to specific situations. The shared beliefs, attitudes, norms, roles, and behaviors are aspects of culture" (p. 4).

Several characteristics of a group's geographical context may influence culture (Jahoda, 1995). Based upon a historical analysis of culture studies, Jahoda (1995) emphasizes the influence of factors such as the climate (e.g., arid, tropical, temperate, arctic, etc.), potentiality of natural disasters (typhoons, earthquakes, volcanos, etc.), island versus mainland living, proximity to large bodies of water, and modes of subsistence (hunting, farming, collecting, fishing, commerce, etc.) on the culture of a society.

In their model of culture, Berry, Poortinga, Segall, and Dasen (1992) distinguish three modes of culture transmission: vertical (i.e., from parent to child); oblique (i.e., from other adults to child); and horizontal (i.e., from peers from childhood to adulthood). Jahoda (1995) adds the category of culture transmission from adult to adult. In addition, the media, such as television, literature, music, and the like, should also be considered an important source of transmission, although this can be viewed as vertical, oblique, or horizontal.

Therefore, there appear to be three important components in a definition of culture: 1) feelings, thoughts, and behaviors; 2) a basis in a certain geographical, historical, linguistic context; and 3) propagation by social interaction.

Hughes (1993) suggests that the concept of culture is based upon two kinds of data: "behavior (what people do, say, and think), and artifacts (what they have made in the form of art, artifacts, architecture, and technology)" (p. 15). This second type of data is what the general public often refers to as culture - dance, opera, symphony, etc. For example, one

might hear North Americans complain that the town they live in 'does not have any culture,' meaning they are unable to attend theatres, art galleries, etc.

According to Triandis (1995a), one of the most important aspects of culture is the "unstated assumptions" (p. 4) which underlie the shared beliefs, attitudes and behaviors of a people. He states that individuals are unaware of the implicit assumptions of their culture, and are often only made aware of them and their limitations when they come into contact with a different culture that holds different assumptions.

Authors writing in the area of cultural psychiatry, often called cross-cultural, transcultural, comparative, or comparative-ecological studies (Gaines, 1988; German, 1984), focus on the relationship of cultural variables to the onset, clinical characteristics, and outcomes of mental health difficulties in various cultural settings. Kleinman (1988b), for example, views psychiatric diagnosis as an interpretation of an individual's experience rather than a description of objective reality. This interpretation differs systematically depending on the theoretical orientation, clinical specialty, institutional setting, and cultural background of the clinician involved. He suggests that most psychiatrists fall prey to the pitfalls of positivism, in that they assume that observations are direct representations of reality, and that phenomena such as depression and schizophrenia are "'things' in the real world" (p. 11). According to Kleinman, psychiatric diagnoses are not discrete entities; they are categories of interpretation, "the outcomes of historical development, cultural influence, and political negotiation" (p. 12).

Lewis-Fernández and Kleinman (1994) state that North American psychology and psychiatry hold three culture-bound assumptions which bias concepts of mental health and illness. First, North Americans assume an egocentric understanding of the self, where the self is a "self-contained, autonomous entity, characterized by a unique configuration of internal attributes that determine behavior" (p. 67; see also Markus & Kitayama, 1991). The majority

of the world, according to the authors, posits a sociocentric view, where the self is defined in relation to a network of social relationships. A second major assumption is the notion of mind-body dualism, which separates the brain from the mind, and places a higher truth value on the brain. However, most other cultures do not make this distinction, and experience suffering "in an integrated, somatopsychological mode" (p. 67). Third, North American mental health professionals conceptualize culture as beliefs which are superimposed upon a biological reality, thereby reducing cultural beliefs to obstacles which must be overcome.

Other authors have directed similar critiques. Corin and Lauzon (1992, 1994) assert that the present psychiatric perspective views subjectivity in the process of diagnosis as a position to be avoided. The authors (Corin & Lauzon, 1994) claim that psychiatry believes it will resolve the uncertainty of the cause and course of psychiatric disorders through advanced technology once genetic and neurochemical factors are elucidated. From this perspective, abnormal or unusual behaviors are conceptualized as symptoms of disease rather than expressions of experience.

Implicit within most Western models of psychiatry is a belief, argues Kleinman (1977, 1988b), that exaggerates biological dimensions and deemphasizes cultural dimensions (see also Erchak, 1992). Within this model, biology is assumed to determine the cause and structure of mental disorder, whereas cultural and social factors shape the content. He offers as an example a contemporary psychiatric interpretation of the paranoid delusions of a schizophrenic individual: biological factors create the structure of the delusional thought process, while cultural and social beliefs determine the content of paranoid thinking. Therefore, a paranoid individual in the United States may express persecutory delusions regarding the CIA, while a similar individual in Russia may express delusions about the KGB.

The process of their delusions is the same and is caused by biological variables; the content of their delusions is different and is influenced by sociocultural variables.

In contrast, Kleinman (1987, 1988b; Lewis-Fernández & Kleinman, 1994) believes that what are viewed as psychiatric symptoms are dependent on cultural variables. Instead of the traditional distinction between "disease" - the malfunctioning or maladaptive biological processes - and "illness" - the personal, interpersonal, and cultural reaction to disease, he suggests that disease is not a culture-free entity waiting to be discovered; disease is an explanatory model, and culture shapes "our explanations of disease" (Kleinman, 1977, p. 4). This perspective emphasizes the interaction of personal, social, and cultural factors which construct the experience of illness (Corin & Lauzon, 1992). Although disease may respond to technological interventions, such as chemotherapy, illness frequently does not, and must be addressed separately. What Kleinman (1977, 1987, 1988b) calls anthropological psychiatry suggests an alternative model where disease (biological factors) and illness (cultural and personal processes) occur together and dialectically interact; where at times one is a more powerful determinant of expression and outcome of the disorder, at times the other, but for the most part, it is the interaction between the two which is of utmost importance in determining the expression of the disorder, and should therefore be considered together. For example, he argues that the same "disease" may have different expressions of illness behavior, and that it is the illness process which is influenced by cultural and social factors. Depression expressed as back pain may be the same disease as depression expressed as existential despair, but each has different symptoms, course, and treatment protocols.

While acknowledging Kleinman's criticisms, the present study, as a psychological research project, adopts a Western model of mental health and illness. As the purpose of the study was to investigate the delusional thought of Chamorro individuals diagnosed as

schizophrenic, there is an underlying assumption that in all cultures there are individuals who hold beliefs that are considered unfounded by the majority of their culture. This assumption served as a framework to enter the research situation and guide the interview process.

Others have argued about the cultural relativity of psychiatric symptoms (see e.g., Allan, Tydingco, and Perez, 1985). Penningroth (1973), for example, states that mental health professionals' judgements about what is 'normal' and 'abnormal' are often influenced by their own cultural values, that is, on what they have learned to consider symptoms of 'mental illness.' Penningroth and Penningroth (1977) propose further that not only are concepts of 'mental illness' culturally relative, but also the practices derived from those concepts. Depending on the cultural background of both the professional and client, mental health professionals presented with the same behavior will differ significantly in their understanding, description, classification and treatment.

Kleinman (1988b) also points out that psychiatric diagnosis has both political and legal ramifications: political in that a diagnosis of mental disorder justifies a judgement of disability and eligibility for public assistance, and legal in that such a diagnosis can alter the rights and responsibilities of individuals to make their own choices. He states that the medicalization of disorders is a form of social control, as physicians have replaced legal, religious, and other community leaders as controllers of behavior. This medicalization can be positive, according to Kleinman, in the case of the disability programming which functions to redistribute wealth in North American society by medicalizing problems of poverty and unemployment. However, medicalization may also trivialize and deny social problems, such as the use of psychiatric hospitalization in the former Soviet Union to label political dissidents as ill in order to isolate and discipline them.

There are many benefits to studying the cultural aspects of mental health. Kleinman (1988b) asserts that the study of culture is extremely important in contemporary psychiatry because of its implicit and explicit criticisms of traditional cross-cultural research on mental disorder and treatment. Investigations of the similarities and differences in mental health symptoms in various cultures emphasize which elements of disorder are culturally specific and which are more generalizable across cultures. From this understanding, it becomes possible to suggest which symptoms are more influenced by sociocultural factors and which are more influenced by biopsychological factors. For example, Westermeyer (1988) states that if marked differences in delusions are evident across cultures, then a sociocultural explanation with culture-specific, or *emic*, features may be relevant; however, the observation of considerable similarities in delusions across cultures would favor a biopsychological explanation of an *etic*, or intercultural nature. The discovery of those etic factors, argues Westermeyer, facilitates the assessment and treatment of psychological problems across all cultures, and contributes to a more general scientific understanding of human beings in general. However, according to Lin and Kleinman (1988), "it will be a great mistake if future research does not pay at least as much attention to sociocultural factors as it does to the biological dimensions of the condition" (p. 29).

The cross-cultural study of mental health issues brings with it certain problems. First, difficulties are likely to arise when one applies psychiatric categories of understanding from one culture to the mental health problems of another. Kleinman (1977, 1987, 1988b) calls this the "category fallacy" which he defines as "the reification of one culture's diagnostic categories and their projection onto patients in another culture, where those categories lack coherence and their validity has not been established" (1988, pp. 14-15). He suggests that this bias occurs frequently in traditional psychiatry; cross-cultural research tends to be conducted by

Western psychiatrists or indigenous professionals who have received training in the West or in departments of psychiatry dominated by Western paradigms. Kleinman (1977) suggests that the "ideal" cross-cultural study of schizophrenia, for example, would involve soliciting detailed phenomenological descriptions of the schizophrenic experience obtained from indigenous peoples, so as to compare these descriptions with professional explanations of schizophrenia and the associated behavior. These accounts could then provide a basis for making cross-cultural comparisons and explore the influence of culture on schizophrenic illness. He reports that, at that time, there were no such studies of schizophrenia in the literature.

Westermeyer (1988) echoes Kleinman's concern over the category fallacy, and suggests that several difficulties are likely to occur when this mistake is made: the behavior and psychological understanding from other cultures is likely to be misunderstood; many professionals may assume that Western-based findings have relevance for their societies, and therefore initiate assessment and treatment programs which are inappropriate for individuals of their culture. Westermeyer calls this imposition of one culture-bound explanation on others "academic imperialism" (p. 212). In order to avoid the category fallacy and academic imperialism, Westermeyer suggests that researchers and practitioners should enter a new culture from a learning orientation; they might benefit from consulting indigenous mental health professionals and laypersons regarding local mental health models (i.e., etiology, behavioral expression, and theories of treatment). In this way, foreign researchers and mental health professionals may be less likely to impose their conceptual frameworks on the culture under study, and may be more likely to develop models which are respectful of and useful to the indigenous peoples. This suggestion has also been directed toward other types of psychological research. Postpositivist methodologies such as action research or advocacy-based research invite joint participation between researcher and participant, where the goal is

often to empower oppressed peoples by helping them to understand and change an oppressive social system (Lather, 1991).

German (1984) raises an interesting point regarding the Western bias of much cultural research. He states that the division of countries and cultures into "developing" and "developed," as displayed by the World Health Organization (WHO) studies of schizophrenia, is a gross oversimplification. This "cultural chauvinism" (p. 95), where Western theorists identify other cultures as "developing" or "extended-family based" or "mythical-poetical" or "subsistence" or "preliterate" or "non-technological," serves to categorize all nonWestern societies as uniform and homogeneous. He goes on to argue that if researchers were able to move away from this form of ethnocentricity, it may become evident that our commonalities as human beings are more important than our differences. In addition, the use of such terms is also demeaning to nonWestern societies, as it depicts individuals from those cultures as "primitive" or "crude."

As stated earlier, an important contribution of cultural psychiatry to the understanding of schizophrenia is the several, large scale epidemiological studies conducted over the past 20 years. In 1973, the WHO began its International Pilot Study of Schizophrenia (IPSS), the "most rigorous and systematic multicultural comparison ever undertaken to study mental illness" (Kleinman, 1988b, p. 20). According to Sartorius, Jablensky, and Shapiro (1978), the primary researchers on the project, the goals of this study were: to explore whether schizophrenic disorders existed in different parts of the world; to identify similarities and differences in schizophrenic individuals of different cultures; to determine whether dissimilarities existed due to differences in the particular diagnostic practices of the culture or from actual culture-related differences in the manifestations of the disorder; and to determine whether there were any differences in course and outcome of schizophrenia across different

cultures. Based upon samples of psychotic individuals from research centers in India, Nigeria, Columbia, Denmark, United Kingdom, the Soviet Union, and the United States, IPSS demonstrated that there were indeed core psychotic symptoms that were clearly evident in all cultural centers. This significant finding - the existence of similar patterns of schizophrenic behaviors in spite of significantly different sociocultural contexts - was taken as evidence by some authors for a biological basis for schizophrenia. German (1984) states that the WHO studies demonstrated:

> ...that schizophrenic disorder is not the exclusive property of certain types of society, of certain child-rearing practices, or of certain levels of economic development or educational development or technological development. If such factors are relevant to schizophrenia, their relevance must be in terms of influence rather than in terms of primary causation. (p. 90)

The IPSS data also provided interesting information on the existence of delusional thought across cultures, documenting that delusions are more common than other symptoms (e.g., loose associations, catatonia) in psychotic patients (Winters & Neale, 1983). Delusions of reference were present in 67% of psychotic individuals; delusions of persecution in 64%; and delusions of control in 48% (World Health Organization, 1973).

Kleinman (1988b), in his discussion of the WHO studies, suggests that, although the IPSS showed that individuals from different cultures could be demonstrated to exhibit similar psychotic symptoms, there were significant problems with the strength of these conclusions. First, according to Kleinman, most patients were excluded from the study because they did not meet the strict inclusion and exclusion criteria developed by the research team; that is, only individuals "within an age range of 15-44 years who had nonorganic psychotic illnesses of a recent onset and who would be available for followup" were included for study (Sartorius, Jablensky, & Shapiro, 1978, p. 103). The authors created a homogeneous sample of individuals which likely did not represent the range of schizophrenic cases in those societies,

and therefore, excluded those would likely show the most significant differences across cultures (Kleinman, 1977). Second, despite this potential bias in sample selection, there were important cross-cultural differences which Kleinman accuses the WHO authors of de-emphasizing. For example, certain symptoms differed in prevalence across the various cultural centers, and the course of schizophrenia was better for individuals in nonindustrialized societies and worse for those in industrialized societies.

The WHO appeared to take Kleinman's accusation seriously, as this last finding was the basis for a second, large scale cultural study of schizophrenia initiated by the WHO, called the Determinants of Outcome study (DOS; Sartorius, Jablensky, Korten, & Ernberg, 1986). This study involved the assessment of over 1300 cases of "first-contact incidence" schizophrenia (Kleinman, 1988b, p. 20); a new, more representative sample of individuals from India, Japan, Nigeria, Columbia, Denmark, the United Kingdom, and the United States who presented themselves at a health or mental health agency with their first episode of psychosis were recruited for study. Information was gathered from patient and family member interviews, as well as assessments of symptomatology, risk factors, and the course of disorder over a period of several years. This study's major findings provided strong supporting evidence for significant differences between industrialized and nonindustrialized societies in prevalence (number of existing cases), but not in the incidence (number of new cases per year) of schizophrenia. It was suggested that this difference was due to a better course and outcome in nonindustrialized countries. Sartorius, Jablensky, and Shapiro (1978) strongly defended their findings; "these differences in the course and outcome of the schizophrenic disorders in nonindustrialized and developed countries could not be related to a systematic bias in the selection of patients for study" (p. 106).

After the publication of the DOS findings, several authors attempted to provide explanations for the better course and prognosis of schizophrenia in nonindustrialized countries. Some authors (see e.g., German, 1984) suggested that the better course and outcome in nonindustrialized countries is due, not to social or cultural variables, but to diagnostic complications; that is, the differences in outcome between industrialized and nonindustrialized societies reflect different types of schizophrenia rather than different cultural contexts. However, this hypothesis, though frequently suggested, has not as yet been supported by research. Other authors, such as Sartorius, Jablensky, and Shapiro (1978), Lin and Kleinman (1988), and Cooper and Sartorius (1977), have hypothesized the existence of certain characteristics in nonindustrialized societies which somehow protect vulnerable individuals from chronic deterioration, or the existence of certain characteristics in industrialized societies which exert a negative influence on the course and outcome of schizophrenia. Some of these characteristics are discussed below.

First, some authors have implicated social isolation and support as key factors in the outcome of schizophrenia (Cooper & Sartorius, 1977; Lin & Kleinman, 1988). Most nonindustrialized countries are sociocentric; that is, there is an emphasis on social relationships, and social isolation is an unusual experience, even for the disabled. Communities tend to be smaller and more self-sufficient, and foster a world view where expectations and obligations of social help from the extended family are common and accepted. Industrialized societies, on the other hand, tend to be egocentric, where isolation, alienation, and loneliness are common experiences for some members. Communities tend to be large, and there is little expectation that social help will be offered from outside the nuclear family. Therefore, individuals in nonindustrialized societies may have an advantage in

reestablishing social support after experiencing psychotic difficulties as compared to those from industrialized societies.

Second, authors have implicated differences in the family context of nonindustrialized versus industrialized societies. According to Lin and Kleinman (1988), the ascendancy of the nuclear family in industrialized countries has necessitated that smaller family units accept responsibility for the caretaking of schizophrenic individuals. This strain on family resources is likely to bring about unrealistic expectations for change and excessive emotional demands and criticism, characteristics to which schizophrenics are particularly vulnerable (Brown, Birley, & Wing, 1972; Leff & Vaughn, 1985; Vaughn & Leff, 1976). Nonindustrialized countries rely more heavily on extended family support and resources, and therefore may be less likely to interact in a demanding, critical manner, due to such a sharing of social resources.

Third, differences in the nature of employment between industrialized and nonindustrialized societies have been postulated as influencing the course and outcome of schizophrenia (see Cooper & Sartorius, 1977; Lin & Kleinman, 1988; Warner, 1994). In nonindustrialized societies, particularly in more traditional village settings, employment is more often assigned than sought. Work roles tend to be integrated with other aspects of daily life and their assignment is based less on performance than in industrialized societies. Schizophrenic individuals returning to work are likely to work with friends or relatives in a more permissive, protective setting. However, the return to work for schizophrenic individuals in industrialized countries is often problematic. A disruption in one's work record is often an obstacle to securing employment, and the job search and its accompanying rejection is likely to be a frustrating and disheartening experience. Furthermore, the work itself in industrialized societies may be competitive, so even once employment is secured, a "profound sense of marginality and insecurity lingers on" (Lin & Kleinman, 1998, p. 562). Work relationships tend

to be more distant and less protective than those inherent in nonindustrialized work settings. Therefore, schizophrenic individuals from nonindustrialized societies are more likely to have some type of work waiting for them, and often find it easier to return to and maintain their previous work roles than those from industrialized societies.

A fourth consideration suggested by some authors (e.g., Lin & Kleinman, 1988; see also Goffman, 1961; Scheff, 1966, 1974, 1976) is the role of stigma in the maintenance of schizophrenic symptoms. Lin and Kleinman argue that many nonindustrialized countries stigmatize psychotic individuals to a lesser degree than industrialized countries. Nonindustrialized societies tend to use biological and/or supernatural factors as explanations for psychiatric problems, which reduce the personal responsibility, and therefore the stigma, attributed to the individual. Industrialized societies, on the other hand, propose theories of mental illness which identify personality and psychodynamic defects within the person. These individually-focused theories set the stage for the stigmatization, rejection, and self-blame of the schizophrenic individual. In addition to the stigma associated with the causation of psychosis, when society's expectation is that schizophrenia is an acute problem from which individuals recover, as is the case in nonindustrialized countries, normalization is likely to occur more quickly. However, as the message in industrialized societies is often that the mentally ill are a hopeless, incurable lot, chronicity and stigma are extremely likely.

Unfortunately, Lin and Kleinman do not address the idea that contemporary industrialized societies, such as Canada and the United States, also rely a great deal on biological explanations for psychiatric difficulties, and yet continue to stigmatize the psychotic individual. These authors also do not comment on research which describes the family shame and devastating stigma experienced by individuals in less industrialized countries (see e.g., Gaw, 1993).

A fifth contribution to the differences in course and outcome in schizophrenic individuals has been referred to as the "differential survival of vulnerable individuals" (Lin & Kleinman, 1988, p. 563). According to Lin and Kleinman, research findings from several areas suggest that a high proportion of individuals with a diagnosis of schizophrenia may have suffered from perinatal and/or neonatal brain damage. Several authors (see e.g., Cooper & Sartorius, 1977; Lin & Kleinman, 1988) propose that in nonindustrialized countries, most "vulnerable" individuals would fail to survive long enough for a schizophrenic break to occur. In more industrialized societies, these 'biologically disadvantaged' children would be more likely to survive to maturity, as industrialization is accompanied by advances in medical technology which result in decreased birth, infant and childhood mortality rates. However, there appear to be flaws in the logic of this hypothesis, and it is unclear whether there has been any evidence to support it. Childhood premorbid patterns and adolescent prodromal signs, such as social withdrawal, do not suggest vulnerability to higher mortality, particularly in more sociocentric societies.

Other factors associated with industrialization which have been suggested by authors such as Kleinman (1988b) include the following: the increase in community size which accompanies industrialization and population growth brings schizophrenic individuals together in larger numbers, which makes it more difficult for them to blend into the community and results in their rejection from the community; the economics of disability and the investment that mental health programs have in maintaining long term clients; and factors such as the bureaucratization of the mental health system, the social welfare system, and the adversarial nature of the legal system involved in determination of disability of and benefits for patients, provide serious impediments to relinquishing the sick role.

Although the above discussion did not address delusional thought in particular, one might speculate that the cultural model makes the following assumptions about delusions: 1) delusional thought reflects the cultural context of the individual; 2) understanding the meaning of delusional thought involves an examination of the cultural beliefs, values, and ideas; 3) classification and treatment of mental health difficulties must be conducted with sensitivity to cultural issues, and must not fall prey to "academic imperialism" by imposing Western explanations of mental health problems on other nonWestern cultures; 4) there are several factors inherent in nonindustrialized societies which may ameliorate the course and outcome of schizophrenic symptoms; and 5) appropriate interventions for schizophrenic individuals may occur at the individual or community level.

Description of Guam and Saipan

Although Guam must be differentiated from the Saipan on the basis of its membership in the United States' Trust Territory of the Pacific, for the present purposes, the islands of Guam and Saipan will be referred to collectively as the Marianas Islands when appropriate. The purpose of this section is to provide the reader with a brief description of the Marianas Islands, their history, and the Chamorro culture. First, the region's geographic characteristics are discussed. Second, a description of the demographic characteristics of the islands is provided. Third, the history of the islands from the pre-contact period (before contact with Western influences), the Spanish period (1565-1898), the first American period (1898-1941), the Japanese period (1941-1944), the second American period (1944 to present), and a discussion of the present involvement of the American government on Guam and Saipan are presented. Fourth, a discussion of the values and beliefs of the Chamorro people is provided. Finally, the impact of industrialization and urbanization on the Chamorro culture is examined. These discussions on the history and cultural background of the Chamorro people are taken

primarily from Aguon (1993), Barusch and Spaulding (1989), Bretania-Shafer (1989), Carano and Sanchez (1964), Mayo (1984), Stanley (1992), and Underwood (1973, 1987).

Geographic Characteristics

Guam is an island in the Western Pacific Ocean and is the southernmost of the Marianas Islands. It is the largest island in the Micronesian region and the largest land mass between Hawaii and the Philippines. The island is 209 square miles in area. The northern part of the island consists of coral limestone, while the southern part of the island is volcanic and mountainous.

Saipan is the largest island in the Commonwealth of the Northern Marianas Islands (CNMI), which are a chain of 14 volcanic islands in the Northwest Pacific Ocean, seven of which are permanently inhabited. The island chain is approximately 375 miles long, and lies 1500 miles east of the Philippines and starts approximately 1000 miles south of Japan. Saipan is 123 square kilometres in area.

The climate of the Marianas Islands is warm and humid with two seasons: the dry season from January through May, and the wet season from July through November. The annual rainfall averages 85-115 inches. Because these islands are located in the typhoon belt, they are occasionally exposed to the devastating effects of typhoons.

Demographic Characteristics

Guam's total population as of 1990 is 133,152 (Stanley, 1992), and is comprised of at least 15 identifiable ethnic groups, including Chamorros (45% of the total population), Filipinos, Caucasians, Koreans, Japanese, African-Americans, East Indians, Palauans, Vietnamese, Chinese, and Spanish. Twenty percent of the total population is United States Military Personnel (Stanley, 1992).

Saipan's total population of 43,345 is considerably smaller than that of Guam; an estimated 18,766 of these individuals are registered aliens (Stanley, 1992). According to Stanley (1992), the population of Saipan increased 158% over a 10 year period; the population jumped from 16,780 in 1980 to 43,345 in 1990. Approximately one quarter of the population on Saipan is descended from Carolinians who arrived from the Caroline islands in the late 1800s. It is interesting to note that compared to Guam, whose wages are similar to those on the U.S. mainland, Saipan's wages are very low (the minimum wage is currently $2.75), and despite high unemployment, aliens such as Filipinos, Chinese and Koreans constitute 82% of the work force. These aliens are traditionally employed in jobs which are exempted from the minimum wage law; that is, in occupations such as domestic help and construction, aliens receive as little as $150 per month. There are over 25 garment factories on Saipan which employ thousands of non-resident aliens (mostly Filipinos and Thais, although increasing numbers of Chinese workers are entering Saipan). According to Stanley (1992), many of these garment factories are sweatshops where labor laws are violated, employees are confined to barracks outside working hours, and are sent home if they complain about working conditions.

Given both Guam and Saipan's association with the United States, English and Chamorro, the language of the indigenous people, are the co-official languages. Although English is the primary language of instruction in education, business, and legal capacities, on Guam only 36% of the population speak "only English" at home (Government of Guam, 1988, p. 155). This proportion is likely to be lower on Saipan, although the exact percentage is unknown.

History of the Marianas Islands and their People

Much of what is known about the early Chamorro culture is taken from accounts of the early Spanish missionaries. Unfortunately, there is little published information available from other sources on this period of Chamorro history. A recent movement among Chamorro academics, youths, and activists has been to develop a new narrative on pre-contact Chamorros, and the Spanish contact with the Chamorro people. These alternative accounts are used in this paper whenever possible. Therefore, in reading the following descriptions from Spanish reports, it is important to consider the impact of the Spanish power over the early Chamorros and the role of colonization on the nature of what information is presented, and how the Chamorro people are characterized.

Archeological studies indicate that the first inhabitants of the Marianas were people who had migrated from southeast Asia approximately 4,000 years ago. The people of Guam and Saipan were of one race (Stanley, 1992). These pre-contact Chamorros relied primarily on fishing and farming, and lived in scattered farms rather than villages (Oliver, 1961). Their society was based on a caste system and they traced their lineage through a matrilineal clan structure (Stanley, 1992).

Women played a powerful role in early Chamorro society, particularly within the family. According to the first Spanish missionaries, it was the mother who ruled the household and was responsible for making decisions on family life, inheritance, and property (Garcia, 1937, cited in Bretania-Shafer, 1989). Women were also responsible for the preservation and transmission of Chamorro culture and language.

Chamorros clans were comprised of several families. Each family consisted of a married couple, their children, and other relatives. The families belonging to the clan were bound by strong social, economic, and ceremonial ties and obligations.

Information about the religion of the Chamorro people is also based on reports from the early Spanish missionaries. Apparently, although there were no temples, sacrifices, idols, or practices which reflected religious beliefs, the Chamorro believed that the souls of their ancestors were sacred and powerful. Chamorros both feared and respected the souls of their ancestors, and believed them to be their invisible guardians (Thompson, 1947). There was also evidence of professional sorcerers who contacted the spirit world on behalf of the living to ask for success in warfare or food gathering, to bring rain, or to cure illness.

The Chamorros first contact with Western explorers was in 1521 with a visit from the Spanish explorer, Magellan. According to Bretania-Shafer (1989), Magellan's "encounter with the inhabitants of the island marked the first of a series of contacts that have changed the lives of the Chamorros" (p. 98) and which "redefined the Chamorro identity, their way of life, and what their role would be in a land that, in the future, was to be subjected to the governance of external entities" (p. 99). Magellan and his crew introduced the Chamorros to metals used for both tools and weaponry. They were also subjected to violence from the Spanish when Magellan gave orders to burn houses and boats, as well as kill several men and women, when he mistakenly believed some of his small boats had been stolen.

Guam was officially claimed by Spain in 1565, but was not visited by missionaries and settlers until 1668, when the Spanish "began the extirpation of the Chamorro religion in favor of Catholicism" (Penningroth, 1973, p. 4). After an unsuccessful attempt to resist the Spanish soldiers, the Chamorros of the Northern Marianas Islands (Saipan, Rota, and Tinian), were relocated to Guam. When they returned to the Northern Marianas in 1816, they found the islands had been settled by Carolinians. The two cultures lived peacefully together, with the Chamorros farming, and the Carolinians fishing (Stanley, 1992).

According to some accounts, the Chamorros met the Spanish with respect and friendliness, but under Spanish rule were subjected to a series of abuses. The Spanish imposed religious prohibitions and practices which eventually altered the original family and societal structure of the Chamorros. These religious prohibitions included the baptism of all Chamorro babies, the disparagement of the Chamorro spiritual healers, and the destruction of the "great houses" where unmarried men and women were allowed to live together.

The Chamorro people were also subjected to new laws which affected their family structure and relations between men and women (Bretania-Shafer, 1989). Under Spanish Catholic rule, the matrilineal extended family of the pre-contact Chamorros was gradually changed to the patriarchal nuclear family. In addition, the Spanish required the Chamorros to be trained in specialized trades and crafts that paid wages, thereby changing their subsistence economy to a more capitalist economy.

The imposition of religious beliefs consequently led the Chamorros to revolt against their colonizers. These revolts, coupled with new diseases introduced by the Spanish, contributed to massive depopulation of the Chamorro people. Experts have noted that there were as many 30,000 pre-contact Chamorros, and by 1786, the population had decreased to 1,500 (Underwood, 1973).

After years of Spanish-Chamorro conflict, the Spanish redistributed land to every family unit, thereby creating a new class system. Descendants of Chamorro upper class and those of Spanish decent were allowed to maintain large tracts of land. The Spanish encouraged agriculture and animal husbandry by introducing farm animals and European fruits and vegetables to the island. By this time, the Chamorro people had become dependent on the Spanish for direction and support in economic, political and religious spheres (Poehlman, 1978).

After 300 years of Spanish acculturation, Guam was ceded to the United States in 1898 as a result of the Spanish-American war. By that time, Catholicism and other aspects of Spanish existence were deeply entrenched in the Chamorro way of life, and the "Americans began a still continuing process of democratization and technological change" (Penningroth, 1973, p. 4). The first 40 years of American rule were characterized by a "series of do's and don'ts" (Souder-Jaffrey, 1987, p. 32). The American leaders made pronouncements on marriage and divorce, church and state, feasts and social events, and language. The government that was established over those first years became a major social institution, impacting upon the daily lives of the Chamorro people.

Saipan, on the other hand, was purchased from Spain by Germany in 1899. Governor Fritz from Germany was responsible for considerable development on the island, including building roads, and forcing families to plant food crops on their land. Guamanian Chamorros were offered free land on Saipan (Stanley, 1992).

Japan invaded Saipan and seized the islands from Germany in 1914. At that time, a wave of Japanese, Koreans, and Okinawans settled on the island, developing sugarcane and pineapple factories. By the time of the Second World War, according to Stanley (1992), there were twice as many Japanese nationals as Chamorros. On December 8, 1941, Japan also invaded Guam and ruled both islands until July, 1944. Again, the Chamorro people were forced to internalize a new set of standards imposed by a new government. They were instructed in Japanese culture and language, and "quickly learned how to show allegiance to the Japanese government. People who did otherwise were severely punished or killed" (Bretania-Shafer, 1989, p. 106).

Once America had 'liberated' Guam and Saipan from the Japanese at the end of the Second World War, another series of dramatic changes took place. The American policy of

"rapid acculturation of the Guamanian [and Northern Marianas] population was to be 'benevolent' and pursued aggressively through education of the children" (Barusch & Spaulding, 1989, p. 64). The people of Guam, Saipan, and the rest of Micronesia, were given U.S. citizenship, and greater measures of self government. However, because of the intensive war damage to the islands, thousands of Filipino workers were brought to Guam to work construction. At that time, the military population outnumbered civilian, and 34% of Guam land was used by the federal government (Underwood, 1987).

This period of reconstruction brought with it a new sense of identity for the Chamorro people. They began to identify themselves with the values and beliefs of the Americans. These values were primarily perpetuated by the educational system and the media which used English as a means of communication. Government officials pressured Chamorros and other ethnic minorities to speak English in public places by, for example, placing signs in Guam government offices stating "English is the official language of Guam. No other language will be spoken during working hours" (Penningroth, 1973, p. 5). Moreover, all children who were heard speaking any language other than English during school hours were ridiculed and punished (D. Duenas, personal communication, August, 1994).

It is important to note, however, that although generally the Chamorro people outwardly expressed gratitude and loyalty toward the Americans for their liberation, some were concerned about the reconstruction efforts. Chamorros were paid less than Americans, and the government was taking control of more and more prime agricultural land. Therefore, the postwar period was yet another era where Chamorros were subjected to intensive acculturation processes by an external government.

In 1975, the Northern Marianas signed the Marianas Covenant, which differentiated them from Guam. The islands were no longer a member of the Trust Territory, as Guam was,

but became a Commonwealth similar in status to Puerto Rico. The Covenant brought several advantages to the Northern Marianas Islands: they became eligible for the U.S. food stamp program, Medicaid, school lunch programs, education, and elderly assistance. In general, the U.S. has control of defense and foreign affairs on the islands, while the Commonwealth is internally self-governing (Stanley, 1992).

According to Chamorro historians, the period of time from 1962 to the present represents the "modern" era. Underwood (1987) has identified the following events as factors contributing to the rapid modernization of Guam, and to some extent Saipan, that has occurred over the past 25 years. First, the devastation caused by Typhoon Karen in November 1962, necessitated major reconstruction which was designed to make the islands look more like an American community. Second, U.S. federal programs were increased for the government, which contributed to increased public assistance such as welfare and public housing. Third, the elimination of the Naval Security Clearance meant that the islands were open to other countries for tourism and investment, and subsequently the economy was transformed from one of self-sufficiency to one of consumerism. While the creation of a tourist economy allowed the island to begin to generate its own funds, the increase in federal aid was at the same time fostering economic dependence on the U.S. federal government. Fourth, Guam's governmental structure was also in transition, as a two party political system was established. At that time, the government was becoming focused on Guam's political future and the identity of the Chamorro people. By 1973, laws were passed to establish bilingual education and make Chamorro an official language. Fifth, the growth of mass media played a significant role in the further acculturation of the Chamorros. By the late 1970s, cable television was introduced, allowing many Chamorro homes access to the same television media as American homes; "to date, Guam has access to live television news

reports from the U.S., has access to at least 25 television channels and most recently can purchase items seen on television by calling a toll-free number" (Bretania-Shafer, 1989, p. 114). In addition, the local Marianas Islands newspaper was purchased by an American publication company and became one of a chain of newspapers owned by an external organization. Stanley (1992) comments on the industrial and economic growth of Saipan, in particular, when he states that "the 20th century hovers like a helicopter slowly descending on Saipan, where most of the homes have cable TV. But, while thoroughly Americanized, the Northern Marianas islands are friendlier and more inviting than Guam" (p. 230).

It becomes obvious upon examination of the economic, social and cultural history of the Chamorro people that they have been, since the arrival of the Spanish missionaries in 1668, in the lowest social rank on the island (Mayo, 1984). From the time of Spanish colonization through to Japanese then American rule, Chamorros were unable to advance to higher ranks in the social hierarchy. Even today, in the private domain or private sector economy, few Chamorro individuals occupy top positions; however, in the public, government service sector, Chamorros are not only evident in the upper positions, but in most other positions as well. Mayo (1984) concludes that from an economic perspective, Chamorros' status is perhaps lower than other ethnic groups; whereas from a political perspective, their status is higher than other groups. Therefore, "stated in terms of control of the sources of power, Chamorros are only in partial control of their society" (Mayo, 1984, p. 147).

Cultural Characteristics

Some authors contend that there is no Chamorro culture and no pure Chamorro individuals because of the integration of various cultures (Spanish, Japanese, American, Filipino) with Chamorro culture through exposure and intermarriage. A review of the literature related to Chamorro culture reveals that certain aspects of the Chamorro way of life remain,

despite hundreds of years of being governed by external governments and being forced to internalize external values.

Underwood (1979, cited in Bretania-Shafer, 1989) identifies several values underlying the Chamorro belief systems. First, family authority and family ties are primary in all social relationships, even taking precedence over legal prescriptions. For example, family members will do everything they can to get another member a job, regardless of what qualifications are needed. This reliance of the strength of family ties is often viewed by Westerners as nepotism, a behavior which is supposedly prohibited in North American bureaucracies.

Second, interdependence among people is more highly valued than personal independence. This value is one of the most important guiding principles of how people should interact. Chamorros emphasize behaviors such as sharing work, group decision-making, consideration of nuclear and extended family members in all activities and behaviors, and the maintenance of informal reciprocal exchange networks where individuals come to one another's aid. The dominant value is one of the group, not the individual. All behaviors are weighed against the opinions of others, particularly the family and the village. According to Penningroth (1973), "what others may think or say or do is far more important to an individual that his [*sic*] own interests and desires" (p. 8).

Third, there is a deep respect for Chamorro elders, where old age brings with it wisdom. Elders are respected for knowing what younger people do not, irrespective of who they are. However, these feelings are reciprocated by the elderly, as they are very concerned with the welfare of younger family members. Chamorros believe that elders have the power to impart both wisdom and evil upon young people.

Fourth, Chamorros believe that nature must be lived with and not struggled against. This value reflects the Chamorro belief that human beings are limited in their ability to control

their own environment. For example, the Chamorro believe that *taotaomona*, ancestral spirits or supernatural beings who live in the jungle, are more powerful than human beings, and may cause illness if angered. Chamorros not only recognize the limited role they as human beings play in affecting their environment, but also the limited role they have in changing themselves.

Finally, a sense of shame governs daily behavior for the Chamorro people. The concept of shame serves as a guide in social situations. As the power of the social group is one of the most important influences on Chamorro behavior, any behavior which shames the group is considered a serious social violation.

Yamamoto, Silva, Justice, Chang, and Leong (1993) offer an elucidating set of distinctions between "traditional" and "Western" (p. 102) cultures, many of which apply to the Chamorro culture described above. For example, while traditional societies value extended family, Western societies emphasize the nuclear family. Other examples include: "income-producing linked to kinship ties" versus "income-producing independent of kinship ties;" "status determined by age and position in family" versus "status achieved by own efforts;" "relationships by kin obligatory" versus "relationships by kin permissive;" "relationships determined by role and position in family" versus "relationships determined by individual choice." On the other hand, there are several examples of traditional attributes which do not pertain to Chamorro culture; that is, where Chamorro values are similar to Western values. For example, there are no longer arranged marriages in Chamorro culture, the specialization of economic functions appears to be on the increase for Chamorros, and the mortality/fertility rate resembles Western society. In addition, it appears that Chamorros are similar to other Asian societies, such as the Japanese and the Koreans, in that they are "traditional cultures and are thus tied to the past in terms of factors such as ancestor worship and the belief in the

importance of maintaining historical traditions while developing into modern industrialized societies" (Yamamoto et al., 1993, p. 102).

The traditional Chamorro values discussed earlier are also consistent with a perspective of collectivism, as compared to the Western, U.S. mainland perspective of individualism. Triandis (1995a) defines collectivism as a:

> ...social pattern consisting of closely linked individuals who see themselves as parts of one or more collectives (family, coworkers, tribe, nation); are primarily motivated by the norms of, and duties imposed by, those collectives; are willing to give priority to the goals of these collectives over their own personal goals; and emphasize their connectedness to members of these collectives. (p. 2)

Countries such as Brazil, India, Russia, and Japan are considered more collectivist cultures. As an example of behavior from an individual espousing collectivist values, Triandis (1995a) describes an incident where an Indian engineer declines a position far from home, despite considerable financial benefits. She or he would do so because she or he would feel that staying close to family members is more important than financial status. In the United States, an individualist is likely to make the opposite decision, because of the belief that parents and children are independent entities and should make decisions based upon what is best for the individual.

On the other hand, individualism, found in countries such as the United States, France, England, and Germany, is defined by Triandis as:

> ...a social pattern that consists of loosely linked individuals who view themselves as independent of collectives; are primarily motivated by their own preferences, needs, rights, and the contracts they have established with others; and emphasize rational analyses of the advantages and disadvantages to associating with others. (1995a, p. 2)

For example, a person in an individualistic culture would be unlikely to inform her or his supervisor that a parent has just died. The individualist would assert that that is private information which is inappropriate to share with someone as distant as a supervisor.

However, in a collectivist society, there is an assumption that a supervisor is like a parent who has an obligation to meet the needs of employees. Nevertheless, Triandis does submit that both collectivist and individualist elements can be found in most countries, albeit in different combinations.

In addition to collectivist-individualist dimension, Triandis (1996) offers several other dimensions of culture, four of which are particularly relevant to Chamorro culture: 1) tightness - a tight culture has many norms that apply across many situations, where even minor deviations from those norms are criticized or punished, whereas a loose culture has few norms and only major deviations are criticized or punished; 2) cultural complexity - a complex culture has a large number of cultural elements, such as norms, values, and beliefs, whereas a simple culture has fewer cultural elements; 3) activity-passivity - an active culture contains elements such as competition, action, and self-fulfilment, whereas a passive culture contains elements such as reflective thought, cooperation, and letting others take initiative; and 4) horizontal-vertical relationships - a vertical culture is one where hierarchy is important, and ingroup authorities make decisions about social behavior, whereas a horizontal culture is one where social behavior is more egalitarian.

Triandis (1996) states that these syndromes are interrelated; that is, certain elements are likely to be seen in combination in certain cultures. Therefore, smaller societies tend to be tight, passive, simple, and vertical collectivist, as the Chamorros once were, whereas larger societies tend to be loose, active, complex, and vertical individualist cultures, such as the United States. It may be hypothesized that as the Chamorro culture becomes increasingly Westernized, and the community itself becomes larger, their cultural organization will continue to shift to a more loose, complex, active, vertical individualist culture.

As alluded to earlier, these explicit Chamorro values are complicated, however, by the influence of Western beliefs and culture. According to Penningroth (1973; see also Penningroth & Penningroth, 1977), instead of blending, Western and Chamorro values appear to co-exist within the society and within each individual member, in what these authors call the "split-level phenomenon" (1973, p. 5). Each Chamorro acts simultaneously according to two very different value systems. Although this may appear inconsistent to Western individuals, Chamorros do not experience this split as contradictory; rather, the values of the West are believed to be "true," but the values of Chamorros are believed to be "really true." Almost all value conflicts, Penningroth and Penningroth assert, are resolved in favor of the Chamorro values.

Penningroth (1973) provides several examples of this phenomenon. With respect to religious values, Chamorro individuals are primarily Roman Catholic. However, there is also a widely-held belief in *taotaomona*, a belief which dates back to pre-Christian Chamorro religion; "on one level it is 'true' that there is only one God. On the other level it is 'really true' that only a foolish, reckless man [*sic*] will fail to propitiate the *taotaomona*" (1973, p. 6).

With respect to the Chamorro class system, Guam and Saipan are considered open and democratic societies with strong values of equality. However, individuals from "low" Chamorro families often wish they could socialize with individuals from "high" class families; "on one level it is 'true' that everyone is equal. On the other level it is 'really true' that a virtual caste system limits social mobility" (Penningroth, 1973, p. 6).

While Western medicine is prevalent on Guam, there are certain conditions, particularly those which are believed to involve the supernatural influence of the *taotaomona*, for which Chamorros will seek consultation from a *surohano*, a traditional healer:

> on one level it is 'true' that sickness and disease are caused by physical phenomena such as bacteria. On the other level it is 'really true' that many

> conditions, especially those for which Western medicine can offer no immediate cure, are supernaturally caused and must, therefore, be supernaturally cured. (Penningroth, 1973, p. 7)

Impact of Urbanization/Industrialization

Over the past 40 years, Guam and Saipan have been undergoing a period of rapid growth, industrialization, and "Americanization" (Barusch & Spaulding, 1989, p. 61). Certainly from a cursory glance, the islands appear American "from its publically [*sic*] fervent displays of patriotism to its largest MacDonald's [*sic*] hamburger stand in the world" (Penningroth, 1973, pp. 2-3). There have been significant consequences of this rapid modernization on the Marianas Islands and their people; according to Bretania-Shafer (1989), "within a span of 15 years Guam has transformed from a quiet rural setting to an environment inundated by all the fixings of modernization: tall building structures, sophisticated technology (computerization), six-lane roads, air-conditioned homes, fast food franchises (MacDonald's [*sic*]), hotels, etc." (pp. 115-116). Moreover, this modernization has also entailed an increase in social problems, such as crime and chronic use of public assistance. Aguon (1993) reports that Chamorro individuals are the major recipients of welfare, low cost housing, food stamps, and programs for the mentally retarded and drug dependent, and comprise the majority of inmates in Guam's correctional facilities. One may assume that these effects may be similar, though less pronounced, on Saipan.

Mayo (1984) has discussed the impact of this rapid urbanization, the process where material and non-material elements of culture, behavior, and ideas which originate in urban settings are acquired by individuals, on the nature of social life on Guam. He states that Chamorro society has transformed from a clan-based agricultural economy to a wage labor market economy. Social status is no longer proscribed by others, but acquired through achievements. Although kinship ties continue to be important among the Chamorro people,

nonfamilial ties have become increasingly significant; coworker relations, political party and labor union memberships, and interactions with others from larger institutions, all have taken on a more significant role in social intercourse. Impersonal social interactions are becoming the norm, where contact between individuals who have little personal knowledge of each other is being fostered by institutions such as banks, shopping centers, movie theatres, etc.

Barusch and Spaulding (1989) conducted a study to examine the effects of "Americanization" on relationships between Chamorro family members. Their intent was to investigate the relationships between Americanized Chamorro youth (young people who have adopted American values and ideals) and their grandparents. As discussed earlier, prior to American colonization, family relationships with elders were characterized by values of cooperation, mutual assistance and respect. Through a series of interviews with Chamorro elders, these authors discovered several changing patterns of family relations. First, the authors suggest that intergenerational assistance in the form of sharing residences, spending time with their children, and having close relationships with extended families, is still more prevalent in the Chamorro culture than in the U.S. However, the elders in their study also reported that there is not the same level of assistance today as there was in their youth. Because of increasing pressures on young people, such as pressures from work, education, etc., there is a significant decrease in the amount of family interaction and intergenerational assistance. Second, Barusch and Spaulding also found evidence for a "language gap" (p. 70), as many elders reported that their grandchildren are able to speak only English and therefore are unable to communicate with their elders in their preferred language. This language gap significantly interferes with the traditional functions of a grandparent in Chamorro families, particularly in the transmission of family histories and values. The authors conclude by highlighting the paradoxical nature of Americanization: "Americanization has

brought improved nutrition, sanitation, and health care, even as it threatens intergenerational assistance and communication" (p. 77).

Mental Health Issues on Guam and Saipan

Unfortunately, there is very little published research on mental health issues on Guam and the CNMI, particularly compared to the research available on other Micronesian islands such as Chuuk and Palau. However, research conducted on these other islands is not applicable to the Chamorro culture, as the people on each island have vastly different histories, values, beliefs, and societal structures. Therefore, this section outlines in detail what has been written specifically on Chamorro mental health. Again, it may be assumed that the conclusions made for Saipanese Chamorros are similar to those which may be offered for Guamanians.

In an unpublished paper entitled The effect of local cultural values and criteria of deviance on the delivery of mental health services on Guam (Penningroth, 1973), and in a subsequent published paper entitled Cross cultural mental health practices on Guam (Penningroth & Penningroth, 1977), Penningroth and Penningroth, mental health professionals involved in the development of the first Guamanian community health center on Guam, discuss in detail a variety of issues pertaining to mental health. Of particular interest is their discussion of Chamorro conceptions of mental illness. In Chamorro, there are two words and one phrase used to describe 'crazy' behaviors: *caduco*, *atmariao*, and *malango e luna*. However, each of these descriptors have different connotations, and are used to describe different behaviors.

The phrase *malango e luna* can be translated literally as "his [*sic*] head is sick" (Penningroth, 1973, p. 11), or she or he is "sick in the head" (Penningroth & Penningroth, 1977, p. 45). This descriptor may be used to describe individuals who are *caduco* or

atmariao, but regardless of its use, this phrase is a literal statement, and refers to someone who has something physically wrong with her or his head.

Caduco is the word most frequently translated into English as 'crazy,' and has the same variations in meaning in Chamorro as it does in English. It is often used as slang, as an indication of scepticism, or a "recognized behavioral abnormality" (Penningroth, 1973, p. 12). A *caduco* individual is said to "talk bad words," "does what no one else would do," is "forgetful (in the sense of preoccupied)," or "has something on his [*sic*] mind" (Penningroth, p. 12). For example, an individual who stays up all night, puts flowers in the road, directs traffic, or uses obscene words is likely to be described as *caduco*.

Atmariao is the descriptor used in Chamorro as 'insane' may be used in English. It holds more serious connotations, and is rarely used as slang. An *atmariao* individual is said to "talk in a false way," "not know what he [*sic*] is doing," "cannot understand what you are saying," and will always be *atmariao*; her or his behavior may improve, but she or he will always be *atmariao*. For example, an individual who talks to herself or himself, runs away from home, does not seem to know what she or he is doing, and does not respond to any interventions, is likely to be considered *atmariao*.

Behaviors described as *caduco*, *atmariao*, or *malango e luna* may be distinguished from 'bad' or 'wrong' behaviors when the actions of the individual appear to be purposeless, and when the individual does not appear to know what she or he is doing (Penningroth, 1973). If there is a stated purpose underlying the behavior, then the individual would be considered 'bad' rather than 'crazy.' *Caduco* and *atmariao* may be distinguished from each other by the extent of social disruption, or infringement upon others, caused by the behavior. The more extreme the behavior, the more the social disruption, and therefore the more likely the individual will be labelled *atmariao* rather than *caduco*.

According to Penningroth and Penningroth (1977), there is little concern for causation of behaviors labelled *caduco* or *atmariao*. Chamorro individuals accept these difficulties as facts of life, much like natural disasters. The exception to this rule is *chet not maipe*, a physical illness with supernatural causes, which is described as the "hot sickness...[whose] symptoms include fever, boils, blisters, marks on the skin, some types of paralysis, other varied bodily ills" (p. 46). *Chet not maipe* is assumed to be caused by the supernatural forces of the *taotaomona*, and therefore treated by the local *surohano*.

Penningroth and Penningroth (1977) propose several important recommendations for the treatment of mental health difficulties in the Chamorro population. First, they suggest that professionals establish treatment goals which are consistent with Chamorro cultural values. Any goals which appeal to the Western 'truth' rather than the Chamorro 'real truth' are unlikely to succeed.

Second, the authors recommend that mental health workers adopt the Chamorro explanations for *caduco* and *atmariao*; that is, explain the unusual behaviors as *malango e luna* or 'weakness,' rather than intrapsychic conflicts. They also suggest that Western and Chamorro professionals develop cooperative working relationships with one or more *surohanos*, so that Chamorro mental health clients may have the benefit of working with both treatment methods.

Third, Penningroth and Penningroth (1977) propose a modification of the Western labeling process. Since an individual labeled *atmariao* remains so for life, it is more beneficial to the client and family to redefine *atmariao* behaviors as *caduco*, in order to reduce stigma and rejection. The authors also emphasize the irrelevance of Western diagnostic and classificatory systems in a culture such as Guam, as the classifications do not translate into

Chamorro in an understandable fashion, and may therefore lead to the permanent labeling of an individual as *atmariao.*

Fourth, the authors suggest using treatment methods which are consistent with Chamorro theories of causation, and their values, beliefs, and healing practices. Medications, they assert, may be extremely valuable in reducing symptoms, but their use must be reframed to fit with Chamorro understanding of mental health difficulties. Other therapies such as group therapy are also effective modes of treatment, as the group is a powerful influence over behavior. However, these authors suggest, based on their experience working with Chamorro mental health patients, that individual therapy aimed at increasing self awareness or exploring feelings are relatively ineffective.

Finally, Penningroth and Penningroth (1977) suggest that issues of morality and social deviance be addressed within the Chamorro social context. Mental health professionals should be careful when dealing with behaviors labelled 'bad' (morally disapproved) or 'wrong' (socially disapproved), as judgement on these issues is primarily the responsibility of the family or social group. The authors recommend intervening in such matters only when asked to by the group or family. As an example, Penningroth and Penningroth discuss a case of marital conflict, where the couple's parents, extended family members, or respected community members such as a mayor or priest, rather than professionals, are expected to intervene by interpreting who is 'right.' Chamorros are unlikely to accept explanations of social discord as a problem or emotional disturbance, and are likely to reject any suggestion of psychotherapeutic intervention to resolve conflicts.

In a rare empirical study of mental health issues on Guam, Osburn (1977) conducted research using psychiatric records from the Guam Department of Mental Health and Substance Abuse. She examined the records of individuals who had been diagnosed with

schizophrenia. Typical symptoms upon admission included auditory and visual hallucinations, delusions, violent and aggressive behavior, suicidal attempts, and the use of drugs and/or alcohol. Delusional thoughts noted in the admission records of Chamorro individuals in particular included delusions of grandeur (e.g., thought wife was Joan of Arc) and persecutory delusions (e.g., house bombed by *taotaomona*). Osburn also discusses the Chamorro approach to schizophrenic symptoms. According to Osburn, the family of an individual with schizophrenia is able to tolerate significantly more abnormal behavior than would an outsider. Traditionally, individuals with bizarre behaviors were kept at home and cared for by family members; occasionally this care involved being "locked in closets" or "confined to an area by a rope or chain" (p. 9). Osburn reports that there is considerable stigma attached to symptoms of mental illness, and treatment at the Mental Health Center is sought only if the symptoms begin to interfere with school, work, or home responsibilities. As many families believe that symptoms of mental illness are punishment from God, they are likely to hide their unusual family member as long as possible to avoid embarrassment. Once the individual is involved in treatment, the family is likely to transfer responsibility for the care of the person to the mental health staff. It appears that Osburn's suggestions are contradictory to those values said to be inherent in a nonindustrialized country, and in fact, the treatment of Chamorro psychotic individuals, in some ways, resembles that of more industrialized societies. It is possible that the impact of many years of American involvement has influenced the Chamorro people's perception and treatment of psychosis. This apparent contradiction may be illuminated through the process of the present study.

Overview of the Present Study

Statement of the Problem

It is evident from the present literature review that there are many theories of schizophrenia and delusional thought, each with its own set of assumptions on the etiology and treatment of schizophrenia. However, the theory one chooses for one's own work depends upon one's own assumptions and values. Therefore, an articulation of the assumptions of the present paper will serve as a rationale for the adoption of a cultural model of schizophrenia and delusional thought.

A first assumption of the present paper, and of Western cultural psychiatry, is that biological and cultural factors interact to shape and influence the schizophrenic's symptomatic experience. The structure of delusional thought (e.g., persecutory or grandiose) is determined by psychobiological factors, and is therefore similar across vastly different societies. At the same time, the content of delusional thought (e.g., God or ancestral spirits) is influenced by the cultural norms, beliefs and values of each society. For example, the structure of delusions may take the form of persecution regardless of the culture, whereas the content of the persecutory delusion may be the CIA if in the United States, the KGB if in the former Soviet Union, and so on.

As discussed earlier, Kleinman and others have criticized Western psychiatry for imposing Western psychiatric labels and concepts on nonWestern cultures, that is, the "category fallacy." However, this issue is somewhat complicated in the present research situation. The research site for the present study was a Western-based mental health system; the sample consisted of informants receiving Western mental health treatment. In effect, the concepts of schizophrenia and delusions had already been imposed on the Chamorro culture through the U.S.-directed mental health centers. Conceptions of mental health and illness

prior to the establishment of a Western mental health system are unclear. Therefore, the present study did not intend to impose these concepts on a nonWestern culture where their validity had not been established. It assumed that these concepts were relevant to the present sample of informants currently attending Western mental health treatment.

A second assumption of this paper is that, as outlined in the previous section, schizophrenia has a better course and outcome in less industrialized countries than in industrialized countries. As forcefully stated by Gaines, "the more urbanized and industrialized the setting, the more malignant becomes the illness" (1988, p. 157). Therefore, in accordance with various theorists (e.g., Cooper & Sartorius, 1977), it is believed that there are several factors which are responsible for this considerable difference in prognosis between industrialized and nonindustrialized countries, such as family support and social isolation, the nature of employment, and the influence of mental illness stigma.

Third, a value of the present research is an attitude of prevention and social action for dealing with psychosis as well as other mental health difficulties, in addition to the use of individually-focused interventions. Therefore, the assumptions of the cultural model as discussed earlier, which suggest the influence of various cultural factors on the course and outcome of schizophrenia which may be developed and utilized in the prevention of chronic mental health difficulties and public education campaigns, fit best with the values of prevention and social change.

The Chamorro culture on Guam and Saipan provides an excellent opportunity to explore these assumptions, as these islands have their own unique history and set of cultural beliefs. In addition, these islands have been experiencing a period of rapid growth and industrialization, as well as increasing Westernization. This cultural context allows the

exploration of the impact of these factors on the delusional thought of schizophrenic individuals.

Purpose of the Present Study

As there has been little research conducted on the mental health of the Chamorro people, and the cultural model of schizophrenia and the impact of industrialization needs to be explored further, the primary purpose of this study is to explore and describe the structure and content of delusional thought in Chamorro schizophrenic individuals and their understanding of these experiences, with the intention of making recommendations for treatment for individuals diagnosed with schizophrenia. The study also explores the reflection of culture and life experience in delusional thought by examining variations in delusional content across individuals with different life experiences.

There were five primary goals of the present study. First, I wished to present an in-depth description of the delusional thought found in Chamorro individuals diagnosed with schizophrenia in both structure and content themes. Second, based upon the cultural theory presented earlier, I wished to explore the potential connection between the Chamorro cultural and historical context, and the content of Chamorro schizophrenic individuals' delusional thought. Third, based upon the findings of cross-cultural research on schizophrenia, I intended to investigate whether Chamorro schizophrenic individuals reported the presence of factors characteristic of less industrialized countries said to ameliorate the course and outcome of schizophrenia, such as extended family support, occupational support, etc. Fourth, I was interested in learning about Chamorro schizophrenics' understanding and interpretation of their delusional symptoms and their recommendations for useful psychological (e.g., psychotherapy), psychiatric (e.g., psychopharmacology) and societal interventions (e.g., public education). Finally, I attempted to evaluate the usefulness of employing a qualitative

research design as outlined below in an investigation of psychotic thought processes, and make recommendations for future qualitative research in psychopathology and cultural psychology.

Research Questions

As "one typically finds research questions, not objectives or hypotheses written into qualitative studies" (Creswell, 1994, p. 70), some general research questions may be considered, given the previous literature review. However, in qualitative methodology, it is expected that research questions and expectations evolve and change during the research process, and therefore, the questions presented below should be considered guidelines present as the data collection phase of the study began; other questions arose during the interview process, and are discussed in the Results and Discussion chapter of this paper.

First, I was interested to see whether the delusional content of Chamorro schizophrenic individuals would be reflective of the cultural context; that is, would the content reflect a mixture of American and Chamorro beliefs, concepts, values, etc.? More specifically, I wanted to investigate whether the informants' delusional thought would contain references to primarily Chamorro features (e.g., *taotaomona*), primarily Western or modern features (e.g., radiowaves, videogames), or some combination of the two. I expected that the latter possibility was most likely, as the descriptions of Chamorro culture reviewed previously suggested a Western-Chamorro combination of cultural features in other aspects of the culture. I also expected the history and current sociopolitical context would be reflected in their delusional structure; that is, there would be examples of delusions of persecution and control.

Second, I wanted to explore the potential applicability of the research conducted by the WHO on the better course and outcome of schizophrenia in less industrialized cultures to the

Chamorro culture. As the Chamorros are in the midst of rapid change, I was interested in whether there remained features of their traditional culture, which were suggested by Cooper and Sartorius (1977), Lin and Kleinman (1988), and Warner (1994), which might ameliorate their symptoms. I was also interested in what the informants saw as helpful and not helpful in their experience with the mental health system. In general, I expected that family support and a reduced emphasis on stressful employment would be reported as helpful by the informants.

Third, I was focused on exploring the theories the Chamorro informants themselves used to understand their symptoms and life difficulties, as well as what interventions they would recommend. From my review of the literature, as well as my discussions with mental health staff who endorse Western models of psychopathology, I expected that there would be a mixture of themes in their theories, with a predominance of biological/neurochemical explanations, and few references to witchcraft and spiritual explanations.

CHAPTER II

METHOD

Assumptions and Rationale for a Qualitative, Ethnographic Design[2]

According to Creswell (1994), qualitative inquiry is a "process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting" (p. 1). The decision to implement a qualitative research design is dependent upon several implicit assumptions which are extremely important to articulate prior to undergoing the research process (Creswell, 1994). First, qualitative designs are concerned primarily with the research process rather than the outcomes or products of the study. Second, qualitative designs are interested in the meaning people attribute to their life experiences and their world view. Third, the primary instruments for data collection and analysis are qualitative data, rather than information gained through inventories, questionnaires, or machines. Fourth, qualitative research involves fieldwork in a natural setting, where the investigator physically visits the individuals, setting, site or institution to observe or record behavior. Finally, qualitative research involves an inductive model of reasoning where the researcher allows abstractions, concepts, hypotheses and theories to arise from the data themselves.

In general, many authors suggest that a cultural approach to the investigation of mental health issues necessitates a qualitative design; "only in-depth assessments that go beyond superficial responses and gain access to intimate concerns are adequate to the study of how perceived social situations and meaningful relationships relate to illness" (Kleinman, 1988b, p. 67). Ethnography, an area of research evident most strongly in anthropology (although some psychologists are beginning to use the term "ethnographies"), is both a process and a product (Agar, 1980). It is research where "some person (a social science

researcher) collaborates with another person (variously called *subject, respondent,* or *informant* [italics in original]) to create a social relationship within which an exchange of information occurs" (Agar, 1980, p. 1); at the same time, the term ethnography can refer to the end product of that process - a book which focuses on a particular group, which discusses the history, the physical, biological and social environments, the behavior, and the beliefs of that group.

Qualitative methodology in general, and ethnography in particular, is well suited to the aims of the present study for several reasons. First, Kleinman (1995) states that ethnographic methods are "well positioned" (p. 195) to investigate areas at "the margin of medicine, such as lay perspectives, the experiential aspects of illness and care, alternative medicine, the local community context of polity and practice, deviance..." (p. 195). This study, which had been rejected for a medical research grant, likely because its focus was not sufficiently medical, was also not appropriate for the more humanities-based granting bodies; it belonged perhaps "to the no-man's-land that runs between science and the humanities" (Kleinman, 1995, p. 195).

Second, as Marshall and Rossman (1989) and others suggest, a qualitative research design is indicated for exploratory research, where there may be a considerable lack of previous research or theoretical formulations, and there has been a call to explore and develop a more extensive theoretical understanding of the phenomenon (see also Creswell, 1994). Contrary to other methodologies, ethnographic methods necessitate a certain flexibility which is consistent with an exploratory approach. There are less likely to be definite questions, definite samples, etc. (Agar, 1980). As indicated earlier, there has been relatively little research conducted on mental health issues in the Chamorro population, as well as a lack of specific literature on the effects of industrialization on delusional thought.

Third, research studies where the context of the phenomenon under investigation is of vital importance are also well suited for qualitative, ethnographic designs. Obviously, the Chamorro cultural context as described in the first chapter was integral to the research questions under study. In order to study that context, it is important to establish long-term, diffuse relationships with indigenous people, in addition to specific, short-term relationships with informants (Agar, 1980).

Finally, quantitative designs may be less appropriate for the nature of the research questions articulated in the previous section, as quantitative studies tend to lose the rich source of data available through unstructured, personal interviews, where questions, concepts, and beliefs can be investigated further as needed, rather than left for future studies.

Role of Researcher

Many authors (see e.g., Creswell, 1994; Marshall & Rossman, 1989) have discussed the importance of clearly articulating the role of the researcher in qualitative research. In the case of the present study, one which involves not only qualitative methodology but also cross-cultural issues, this articulation becomes even more critical. Therefore, this section discusses the impact of factors such as past experience, biases, and values of the researcher, as well as issues of research site entry and ethical considerations, with the goal of making explicit potential influences of researcher variables on the informants and the research process, and outlining the attempts to minimize these influences as much as possible.

As data collection for the present study took place on Guam and Saipan, with informants being mental health clients from the local Chamorro culture, it was vital to consider in advance several factors which may complicate the research process, and those which may facilitate it. First, the issue of the difference in culture, race, political and historical context, etc. of myself and my informants must be discussed. The fact that I am White, Western,

female, and a researcher may have set up resistances for the informants I wished to interview. They may have viewed the research process in general and my questions in particular as intrusive, and therefore the information I received might be distorted in some way. I also had not lived with the Chamorro culture and did not speak the language, and therefore I would have been unfamiliar with some of the concepts and experiences described by informants, and may have been insensitive to the subtleties of their descriptions. In addition, it was unavoidable that I would bring a Western bias to the research situation - assumptions about culture, family, mental health, etc.

I took several steps in an attempt to minimize the impact of these factors on the data collection process. First, I consulted many Chamorro individuals to learn about their culture. Prior to my developing this research project, in order to familiarize myself with the Chamorro culture, beliefs and values, I met with several Guamanian mental health professionals and laypersons - some Chamorro, some North American. In our discussions, these individuals outlined Chamorro history, Chamorro perspectives on the family, mental and physical health, religion, Western and Japanese involvement in the development of Guam and the CNMI, and other issues which they believed important in my understanding of Chamorro culture. When I returned to the area to begin data collection, I consulted with other Guamanian and Saipanese individuals to ensure that I learned the implicit cultural rules of social interaction. For example, Penningroth (1973) notes that it is always necessary for professionals to identify their name, their exact title, their relation to an authority (in the case of mental health professionals, the authority is usually a doctor), and how the interview will help that authority help the client. At that point the professional must ask permission to ask questions. According to Penningroth, "permission is never refused and the information always more complete" (p. 8).

I was also fortunate to have taught three courses in mental health (Abnormal Psychology, Introduction to Clinical Psychology, and Micronesia and Mental Health) to students pursuing their Master's Degree in Counseling Psychology at the University of Guam, at which time I was able to have lengthy discussions on Chamorro attitudes towards mental health, the influence of American culture on the Chamorro people, and more generally, Chamorro values and beliefs.

Second, I received the help of individuals who were fluent in Chamorro language and culture, who provided consultation before, during, and after the data collection and interpretation process. Two Chamorro senior undergraduate psychology students from the University of Guam who were interested in gaining research experience, fulfilled the role of Cultural Consultants in return for course credit. Ms. Boddy was a Chamorro born on Kosrae, in the Federated States of Micronesia, and attended elementary and high school on Rota and Saipan. Mr. Smith was born and raised on Guam. In particular, the Cultural Consultants provided a useful "checking" function, where I was able to discuss possible interpretations and conclusions made from interview data. It should be noted that, according to many Chamorros, there are very few Chamorro individuals on Guam and Saipan who are not fluent in the English language, and so Chamorro-to-English translations of interview data was not necessary. However, in the few cases where informants used Chamorro concepts, the Cultural Consultants provided elaboration on and clarification of word meanings.

In addition to regular weekly meetings where we discussed methodological considerations, cultural issues, and analysed transcripts in detail, these students were required to attend a participatory course in qualitative methodology conducted at the University of Guam. They were also currently taking clinical psychology and psychology practicum courses, where they were involved in discussions regarding the suitability of

Western models of mental health in the Chamorro culture. Therefore, these Cultural Consultants were not only well versed in the Chamorro cultural context, but were trained in qualitative research methodology and mental health issues (see Appendix A for biographical descriptions of Cultural Consultants).

Third, although it is impossible to be aware of the impact of all of my assumptions, biases, and values, the following is a discussion of some of the personal factors which may have influenced the research process. Being born and raised in a White, middle-class Canadian family, I have limited experience with the cultural and racial issues experienced by the Chamorro people. As discussed in the previous section on culture, a significant difference between my culture and the Chamorro culture is that the Canadian culture, although perhaps less than the continental U.S. culture, is more individualistic, whereas the Chamorro culture is more collectivistic (see e.g., Triandis, 1995a, 1995b). For instance, from my discussions with Chamorro individuals, I understood that the Chamorro concept of family is different from the North American concept. As mentioned earlier, the importance of the clan, extended family, "connections," and land ownership in Chamorro culture contrast sharply with North American perspectives which tend to place less importance on extended family and "who you know," and more emphasis on the nuclear family and relying on oneself to obtain success. In addition, the Chamorro history of being a people governed by other cultures (Spanish, Japanese, American), brings with it a certain perspective with which I have not had any experience. Moreover, I have been steeped in North American media culture and an emphasis on the value of industrialization and urbanization. This exposure to North American media and its associated values have only recently become prevalent on Guam and Saipan. However, throughout the last few years of my education I have begun to consider and question the values of North American society, and the merits of an excessive focus on

individualism, industrialization, and technology. The questioning of these values has undoubtedly led to my interest in researching mental health in less industrialized cultures. Again, in an attempt to reduce the impact of these biases and values on the research, I discussed such issues with the Cultural Consultants when relevant, as well as attempted to remain aware and make explicit these and other values when they arose.

From my experience during the interview process, these steps taken before and during data collection were instrumental in my success in recruiting informants, in helping them to feel comfortable in the interview situation, and thereby reducing the impact of my cultural context on the data themselves.

Another aspect of the present research situation that was considered was the impact of the mental health difficulties of the informants on the interview process. At times, individuals with a diagnosis of schizophrenia can be difficult to follow or keep focused on topics under discussion. As part of the symptomatology of schizophrenia, these individuals may find interpersonal contact discomforting, and rapport may be difficult to establish. I have been fortunate enough to have substantial experience in working with psychotic individuals. I have conducted psychotherapy with schizophrenic individuals where focus and rapport were important issues to consider, and I have been trained in ways to accommodate difficulties in interaction and communication that may arise. However, given the substantial differences between a mainland U.S. psychiatric hospital and a Guamanian/CNMI mental health center, I was concerned that there would be difficulties in establishing rapport with Chamorro informants. I discussed these concerns with the Cultural Consultants, as well as other local laypersons, and attempted to use their suggestions during the interviews. Fortunately, I found that most informants were very eager to discuss their experiences, and I experienced little difficulty establishing a comfortable interview atmosphere with most informants.

I had previously met with the acting director, Nory Santz, M.D., the director of clinical services, Maimie Belajadia, Ed.D., and several staff of the Guam Department of Mental Health and Substance Abuse, and Marcia Meckler, M.D. of the Commonwealth Health Center in Saipan, and I received permission to conduct my research in those setting (see Appendix B for correspondence pertaining to the acceptance of the research project).

A final consideration for qualitative researchers, suggested by Marshall and Rossman (1989), is the issue of reciprocity; the researcher must offer some compensation for the time, effort, and information which the informant offers. The informants were advised that after all interviews had been completed and the dissertation had been defended, a document would be prepared for and distributed to all informants and to mental health staff. This document will include a summary of general conclusions, a brief discussion of the implications of the results of the study, and a means to contact me should they have any questions about the results.

Site and Sample Selection

As stated earlier, the sites from which informants were recruited were 1) the Department of Mental Health and Substance Abuse in Tamuning, Guam, which houses a small inpatient psychiatric unit, a day treatment center, an outpatient mental health center, and case management services, and is responsible for providing services to the entire population of Guam; and 2) the Commonwealth Health Center in Saipan, which provides inpatient and outpatient psychiatric treatment to individuals with chronic mental health problems in Saipan. In both locations, individuals with a wide variety of mental health difficulties (e.g., psychosis, mood disorders, substance abuse and dependence) are able to receive individual, group, family and/or psychopharmacological therapy. It was hoped that, in addition, individuals would be referred to me from persons in the community, such as school staff and laypersons, who have knowledge of potential informants. However, this proved to be a very difficult task, and

no informants were recruited in this manner. Due to the stigma of mental health problems in the Chamorro culture, any family who had a potentially psychotic member but had not sought help from the mental health system, was extremely reluctant to discuss their difficulties with someone outside the family.

Initially, it was proposed that a sample of Chamorro psychotic mental health clients be drawn using a purposive sampling method; no attempt was to be made to obtain a random or representative sample. As articulated by Creswell (1994), the "idea of qualitative research is to **purposively** select informants (or documents or visual material) that will best answer research questions" (p. 148). Consistent with the goals of exploratory qualitative research, the purposive sampling technique allows the researcher to purposefully look for individuals who represent certain life experiences or realities, and ideally provides the broadest scope of information possible. In particular, the maximum variation sampling technique (Patton, 1980), which serves to draw a sample with "unique variations that have emerged in adapting to different conditions" (Lincoln & Guba, 1985, p. 200) was to be used. However, given the small population of Chamorro mental health clients who were willing to discuss their life experiences with a stranger, the sample of informants consisted of any individual who fit the criteria outlined below and agreed to participate.

As one of the key characteristics of the qualitative method is the ongoing examination and revision of the data collection process, this section will serve to outline the principles, goals, and guidelines for sample selection, and a discussion of how these guidelines were implemented during data collection.

Generally, as the focus of the present study was the thoughts and ideas of Chamorro individuals who have had experience with or are currently experiencing psychotic processes, participation in this study was limited to those individuals who met two criteria. The first

criterion was that the individuals must identify themselves as Chamorro. The second criterion was having been identified by mental health staff as being in the "active" or the "residual" phase of one of the subtypes of schizophrenia (paranoid, disorganized, undifferentiated); that is, those who have experienced or are experiencing delusions, and possibly other psychotic symptoms such as hallucinations, incoherence, and/or loosening of associations according to DSM-IV (APA, 1994) criteria.

I was able to rely on the expertise of mental health professionals to recommend potential informants with an official diagnosis of schizophrenia or who have exhibited the afore-mentioned symptoms. Therefore, although during the interview process it was quickly obvious whether the informant had in fact had experience with delusions, for the purposes of the present study, steps to confirm the official diagnosis of schizophrenia were not attempted.

Again, the reality which presented itself during the data collection phase was one where access to prospective clients was limited, and so sampling became a matter of locating and gaining permission to speak with individuals who met the two criteria outlined above. Despite these limitations, I was able to meet with individuals with a varying degree of contact and experience with, and attitudes toward, Western industrialization, as well as other characteristics such as religiosity, gender, marital status, education and employment experience. Data collection was terminated when all potential informants had been contacted and those who consented were interviewed.

Description of Informants

The total sample consisted of 20 individuals from the islands of Saipan and Guam. Five individuals were residents of Saipan; 15 were residents of Guam. Two of the Saipanese informants were inpatients at the Commonwealth Health Center; the other three were involved in the case management/outpatient program. The majority (13 informants) of Guamanian

informants attended the day treatment program at the Guam Department of Mental Health and Substance Abuse, and the remaining two individuals were involved with case management services. There were equal numbers of males and females. The age range of the 13 informants who divulged this information was from 24 to 59 years, with an average age of 38 years. Those who did not give their age also appeared to be within that range (see Appendix C for other demographic information).

Joe V., a Chamorro mental health professional from Saipan, was interviewed to provide interpretations from the perspective of someone who was inside the culture, being Chamorro, and yet, because of his Western graduate education in mental health and experience in the United States, was also able to step outside the culture (see Appendix D for Joe V.'s biographical data).

In addition to the formal data collection phase of the present study, I also made many informal observations of the Chamorro culture, beliefs, and values, during my stay on Guam and Saipan. I lived on Saipan for a total of 9 months, where I had the opportunity to live and work with many Chamorro people. I taught college courses and conducted workshops, and was an aerobics instructor at the Northern Marianas College and a private health club. When I first arrived on island in June, 1995, I taught university psychology courses to school teachers and counselors, most of whom were Chamorro or Carolinian, had been educated in the United States, and had returned to raise families and work on Saipan. During the fall semester, I taught Educational Psychology to undergraduate education majors, Stress Management to police cadets, and conducted two workshops for Master Teachers on listening and supervisory skills. Within these educational settings, the students were extremely helpful in providing insights about the Chamorro culture and values.

With respect to social interactions, I lived on the family compound of a large Chamorro family, who included me in several of their celebrations and rituals. I became friends with a few local people of whom I could ask detailed questions about their cultural beliefs and values. I also became close friends with another "alien" (a non-U.S. citizen) like myself, who was able to share his perspective on and experience with the Chamorro culture. In addition, while attempting to secure permanent employment on Saipan, I gained considerable experience with several bureaucracies - in particular, the Commonwealth Health Center and the Department of Immigration and Labour. I also spent considerable time on the island of Guam, and I noticed several differences between Guamanian and Saipanese Chamorros. From this range of interactions, I was able to gain a complimentary perspective on Chamorro culture to accompany the insights gained from the formal interviews.

Data Collection Procedures

The first step in the data collection procedure was to prepare for the interview (Lincoln & Guba, 1985) by finding out as much detail as I could about the informants and their culture, practicing the interview with a "stand-in," and deciding on my own role, style of dress, level of formality, etc. These preparations were conducted with the help of the Cultural Consultants, and are discussed in the Results and Discussion section of the paper.

Interviews took place at locations that were mutually convenient to both myself and the informant: either the informant's home, or the mental health department offices. In addition, two other data collection methods were used in order to obtain as much information as possible. First, I kept a journal during the data collection process in which I recorded my thoughts and ideas about interpretations, reactions to interview content, potential biases, and any other ideas and personal experiences which I believed were important to note. Second, at the end of each interview, I took detailed notes on any qualities that were not accessible

through the transcription of audiotapes. I also recorded my own thoughts and feelings which I experienced both during the interview and upon reflection, as well as any immediate themes that came to mind. In addition, any themes that were immediately evident that might be helpful were incorporated into future interviews, and informants were given the opportunity to comment upon them. In this way, the interview schedule was constantly modified to reflect new information and perspectives.

Interviews were conducted in a open-ended, semi-structured format using the in-depth interviewing method described by Marshall and Rossman (1989). These authors describe this type of interview as resembling a conversation which explores general topics but "otherwise respects how the participant frames and structures the responses" (p. 82). Attempts were made to investigate the topic areas of interest in the present study, while allowing the informants to direct the flow and direction of the interview through their free associations (see e.g., Corin & Lauzon, 1994). Provided the informant had given permission, each interview was audiotaped. Three individuals refused to be audiotaped, and so extensive notes were taken during the interviews and written in an interview format. It was fortunate that these particular informants spoke very slowly, and so the notes taken were almost verbatim. Therefore, the potential influence of the process of interview reconstruction was minimized.

Informants were given the opportunity to switch off the taperecorder at any point, and to request to have portions or the entire interview erased; none of the informants requested such action.

With respect to securing permission to meet and interview potential informants, the following steps were taken to ensure that I gained permission in a manner that was protective of the rights of those involved. I worked closely with professional staff who first approached prospective informants, explaining the study in general terms (my role as researcher affiliated

with the University of Guam, Northern Marianas College and University of Windsor; and the content of the interview). I was subsequently given the names of individuals who agreed to meet with me. I was introduced to these individuals by staff, and interview appointments were arranged. There were also several informants who were introduced to me on the Day Treatment Unit on Guam, without having had previous discussions with staff. These individuals were then given the opportunity to agree or decline to participate. A few individuals did decline to participate; appointments were set up with those who agreed.

Every attempt was made to be sensitive to the rights and needs of these informants, including their rights to informed consent and confidentiality. Potential informants were asked to sign a consent form outlining the purpose and requirements of the study, and given a copy of the consent form for their records (see Appendix E). The consent form also contained a means for contacting me at the University of Guam, the Northern Marianas College, and the University of Windsor should any questions or concerns arise. The informants from the Department of Mental Health (DMH) in Guam were also required to sign an official DMH consent form to release information to me (see Appendix F). The procedure allowed that if there was any doubt as to whether an informant was able to give informed consent due to psychotic thought processes or for any other reason, the interview was to be terminated and rescheduled for a later date. However, those who agreed to be interviewed appeared to understand the concepts outlined by the consent form. As the consent form was read by the informant, I summarized the consent form content in colloquial terms, observing the informant's verbal (e.g., "yeah," "o.k.," "I understand,") and nonverbal (e.g., nodding, raising of eyebrows, eye contact) behavior so as to determine whether or not the informant understood her or his rights, and the nature of the study.

I advised the informants that participation in the research study was completely voluntary, and that they had a right to terminate the interview at any time, as well as request that the interview not be included in the study, or that their audiotape and interview notes be destroyed. A few informants did request that their interview be terminated, by making statements such as "I'm tired," "I'm hungry," or "Can I go now?"

I also explained to informants in detail the following steps taken to ensure their anonymity: I assigned each informant a number which was used to identify her or him from that point on - no other identifying information was attached to any materials such as notes, audiotapes, etc.; her or his consent form was stored in a separate location with no way to match the consent form to any interview data. All materials were stored in a location to which only I had access. In addition, I assured the informants that mental health staff would not have access to interview data, transcripts, or the unedited dissertation. A separate document without direct quotations will be provided to mental health staff to continue to ensure informant anonymity.

I then discussed with the informants the intended use of their data. I advised them that the information collected would be used for purposes of my doctoral dissertation, and possibly subsequent publication in a scholarly journal or book. I also suggested that in future, other mental health researchers may request to view interview transcripts, notes, or other data material, but reminded them that their confidentiality would be protected.

With many of the informants, particularly those who appeared nervous or hesitant, after the initial introduction, I gave the informant and myself a chance to "warm up" (Lincoln & Guba, 1985, p. 270) by asking general kinds of questions; for example, "how long have you lived here?" The function of the warm up period was to give the informant an opportunity to practice responding to me in a relaxed atmosphere, to gain important information about how

the informant was viewing the context of the interview, and to gauge the formality and approach of the informant. However, with some informants, particularly those who were more disorganized in their speech or those who were anxious to begin discussing their life experiences, the interview began with a discussion of their symptoms or their hospital experiences. Therefore, the format of the interview varied depending on the presentation of the informant.

The interview itself had seven main content areas (see Appendix G for the interview schedule). These areas of interest were inquired about in no certain or fixed order, as much of the style, formality, and progress of the interview was determined by the approach of the informant. As there was a considerable range of psychotic symptoms displayed by the informants, from those individuals with mildly disorganized speech and few loose associations, to those who were actively psychotic with delusional systems and severely disorganized speech, interviews were conducted with the presenting symptomatology in mind; questions were modified or omitted, others were added, depending on the ability and tolerance of the informant. For the purposes of this description, however, I will refer to content areas in a general order.

First, I inquired about the following personal characteristics and life experiences: age; education; family constellation; living arrangements; source of referral to mental health agency; whether they had ever lived off island and if so, where. Second, I attempted to gain a broad sense of the informant's experiences with psychotic thinking. Third, I explored the informant's own understanding of those experiences with delusional thought. Fourth, I asked the informant whether various factors in the community and the mental health system had been helpful or unhelpful. Fifth, I raised issues which had been mentioned by other informants, particularly concerning traditional Chamorro beliefs, and asked for feedback from

the informant on these ideas. Sixth, provided that the informant did not appear fatigued, I asked about other potential topics of interest, such as reflections on her or his own culture, and her or his feelings toward the Western influences on Chamorro culture, etc. Finally, informants were encouraged to bring up any topic that they found relevant to the discussion which they believed had not been addressed. After the interview was complete, informants were given the opportunity to express their reactions to the interview and to discuss any questions, concerns, or discomfort that had arisen.

Unfortunately, not every question was able to be posed to every informant for the following reasons: some informants terminated their interview before all questions could be asked; some exhibited pressured speech, and it was difficult to get responses to some questions; some perseverated on certain topics, and it appeared fruitless to pursue other avenues; a few informants were very withdrawn, and often responded with "yes" or "no" answers. Consistent with a phenomenological approach, all comments and digressions offered by the informants were considered important, as "they reveal the webs of meaning that form the [informants'] world view and the symbolic and imaginary strategies that frame the [informants'] relationships to the world and to themselves" (Corin & Lauzon, 1992, p. 269).

During the interview, I frequently asked for clarification or elaboration where I thought necessary. My questions became more specific as the interview progressed and as I became aware of the relevant information the informant could provide. Again, a position of flexibility was extremely important during the interview, as I often needed to follow up promising areas of discussion, or return to an earlier point (Lincoln & Guba, 1985). I also used probes ("directed cues for more or extended information" [Lincoln & Guba, 1985, p. 271]) such as silence, sounds ("uh-huh" and "mmm-hmm"), encouraging body language (waves of the hand, nods), calls for more ("could you tell me more about that"), calls for examples, and other cues

which were more appropriate in Chamorro culture (a raising of the eyebrows). I made a conscious effort to assess the comfort level of the participants both through direct questions and observation of nonverbal cues, in order to insure that I did not impose upon them or inconvenience them.

When the interview ceased being productive, as assessed by redundancy of information or fatigue of the informant, I concluded the interview by asking if the informant had any questions or comments.

A second source of data was an interview with Joe V., a Chamorro mental health professional. Once the entire sample of informants had been interviewed, I articulated some tentative hypotheses from my notes taken during the interviews and requested an opportunity to meet with Joe V. at the Commonwealth Health Center in Saipan. During that meeting, I raised issues that had been brought up during the formal data collection phase of the study and asked for his interpretations. Extensive notes were taken during this interview and were written in an interview format.

A third source of data came from my role as a participant-observer in the Chamorro culture. Extensive notes were recorded in a personal journal, which were later written in a formal, organized fashion.

Data Management and Recording Procedures

An interview protocol (Creswell, 1994) was designed in advance to insure ease during the interviews, including key questions to be asked, and space to record comments and reflective notes. After its completion, each audiotaped interview was transcribed verbatim using Wordperfect 5.1 word processing software, saved on 3.5" disk, and printed. For ease of analysis, when audiotaping was declined by informants, extensive notes were taken, and

interviews were written in an interview format using the same style as the audiotaped interviews.

Methods for Verification: Reliability, Validity and Objectivity

Many post-positivist authors have provided comprehensive discussions on approaches to qualitative methodology. Guba and Lincoln (1989) have been instrumental in their application of reliability and validity criteria to qualitative data. As an in-depth examination of positivist versus post-positivist epistemologies is beyond the scope of the present paper, I will refer to their concepts and suggestions, and direct the reader to Guba and Lincoln (1989) for more information on the debate.

Several authors writing in the field of qualitative methodology (see Creswell, 1994; Marshall & Rossman, 1989) concur that Guba and Lincoln (1989) have suggested effective criteria for methodological rigor which parallel the criteria (i.e., reliability, internal validity, external validity, objectivity) used in conventional quantitative research. This section discusses these criteria, and suggests ways which the present study attempted to address them.

The first item to consider in establishing the rigor of a research project is reliability. Reliability may be defined as the consistency, or dependability of the inquiry, and is considered vital for establishing the validity of the data (Guba & Lincoln, 1989). In quantitative studies, for example, test-retest reliability may be assessed through repeated administrations of the assessment tool. However, according to Marshall and Rossman (1989), "qualitative research does not pretend to be replicable. The researcher purposefully avoids controlling the research conditions and concentrates on recording the complexity of situational contexts and interrelations as they occur" (p. 148). Several methodological steps suggested by Guba and Lincoln and others (Creswell, 1994; Marshall & Rossman, 1989) which increase the reliability

of data collection and interpretation were adopted into the present study: 1) by keeping thorough notes and a research diary, which is available for inspection by other researchers who may want to review the research process, I articulated any changes in methodology, and my decision-making processes; 2) by keeping all interview tapes, transcripts, notes, etc. in a well-organized, retrievable form, all data are easily available if my findings are challenged or another researcher wants to reanalyse data at a later date; and 3) by clearly articulating the data analysis and interpretation stages of the present study, as well as clearly supporting any conclusions with direct quotations from the informants themselves, other individuals reading this study will be able to trace the methods used for data collection, analysis and interpretation to determine whether the methods are reflective of the data.

The second criterion for methodological rigor is the issue of internal validity, or the accuracy of the data and how well they correspond to external reality (Creswell, 1994). Guba and Lincoln (1989) define internal validity for qualitative data as the agreement between the descriptions and interpretations of informants and those of researcher, and suggest several methods of maximizing this form of validity. First, in addition to the verbatim interview transcripts and observations, I discussed questions and hypotheses with the Cultural Consultants and Joe V., to determine their views on my data interpretation, and to ascertain whether or not their interpretations converged with mine.

Second, I attempted to elicit feedback from many of the informants on my descriptions and interpretations throughout the data collection process and asked whether they thought my conclusions were accurate; that is, I fed back to subsequent informants ideas which arose during previous interviews and analyses. According to Guba and Lincoln, these "member checks" (1989, p. 238) allow the researcher an opportunity to correct errors of interpretation,

to assess the intent of the informants, to obtain additional information, and to make the first steps towards data analysis.

A third contribution to the assessment of the internal validity of the present study is peer debriefing (Guba & Lincoln, 1989). This process involved several discussions of my findings, interpretations, and conclusions, with a faculty member from the Psychology Department at the University of Guam in order to examine my ongoing research processes with an individual who had also conducted qualitative mental health research in the Chamorro culture, and yet did not have a vested interest in research project or its findings. These discussions assisted me in an evaluation of own values and biases, and provided me with an opportunity to develop new steps in methodology or analysis.

To ensure internal validity, I attempted to evaluate my own interpretations to ensure that I was not giving certain views or ideas privilege over others. This technique, which Guba and Lincoln (1989) call progressive subjectivity, necessitates the documentation of my ideas before data collection begins, and the recording of subsequent interpretations at regular intervals throughout the study.

In conventional quantitative studies, the issue of external validity, or generalizability, assumes that the relationships found in the research can be generalized across other measures, individuals, settings, or time periods. Guba and Lincoln have defined the concept of external validity as the degree to which an individual in a similar situation could make use of the conclusions of your study. In order to maximize external validity, I have clearly articulated an extensive description of my research questions, sample characteristics, and the context of the present study. The purpose of providing such a complete data base and context description is to allow other individuals who may wish to apply the findings of the present study to situations of their own to evaluate the applicability of the present findings.

Finally, the criterion of objectivity is highly valued in conventional quantitative studies. The question of objectivity raises issues of whether particular findings are based more on the researcher's own biases, motivations, interests, values or prejudices than on the inquiry itself. The steps discussed earlier which intended to promote internal validity are also appropriate methods to minimize the impact of biases, values, etc. on the research findings and conclusions; that is, readers are provided with a complete series of quotations in the body of the paper which support interpretations, and the logic and rationales which dictated methodological decisions and interpretations. I also held several discussions with the Cultural Consultants, who questioned my interpretations and, at times, suggested rival hypotheses. However, as Kleinman (1995) states in his critique of current ethnographies, there needs to be a balance in objectivity and subjectivity of medical ethnographers. He criticizes some authors for being too objective in their accounts, and implies that, in addition to complex theoretical analyses, ethnographies should include more subjective accounts of the culture and phenomenon under study; for example, he criticizes one ethnography because its "analysis is impressive and would be even more convincing if the author let the ethnography roam outside the tight confines of the analytic framework" (p. 198); and "there is no local world in much of the book" (p. 214). In an attempt to address both the objective and subjective aspects of data collection and analysis, the present study includes formal interview data and analyses, and informal data collection and personal reflections on the culture, which offer the reader an account of the experiential aspects of the culture.

CHAPTER III

RESULTS AND DISCUSSION

The Results and Discussion sections of the present study have been combined into one chapter with several sections. The first section outlines the recommendations regarding the interview protocol made by the Cultural Consultants during our pre-interview discussion. The second section provides an overview of the data analysis strategies used to interpret the formal interviews. The third section contains an integration of the theory and findings from the literature discussed in the first chapter with the results from the three data sources: 1) an in-depth analysis of the formal interviews with Chamorro mental health clients; 2) the interview data from Joe V., a Chamorro mental health professional; and 3) the informal observations gained as a participant-observer in the Chamorro culture.

Pre-Interview Discussion

After several informal meetings with the Cultural Consultants in which we discussed the purpose and rationale for the present study, we met formally to discuss issues of appropriate dress, interview length and rapport, and wording of the consent form. I also chose to discuss these essential issues with Mr. Joseph Ruak, a Carolinian individual who had worked for the local mental health center, as he also had considerable experience with relating in both Western and Chamorro cultures.

Interview Dress

The Cultural Consultants and I discussed appropriate dress for myself for the interviews. Mr. Ruak informed me that, although there are not strict rules regarding dress in the Chamorro culture, in order to put the participants at ease, and to convey a sense of my position as a professional, my shoulders should be covered, and if wearing a skirt or dress, my knees should also be covered. There were no prescriptions regarding footwear.

Length of Interview and Rapport

Mr. Ruak expressed concern that it may be quite difficult to establish rapport with the potential informants. He stated that it may take an hour just to have the informant feel comfortable with me and the interview situation. However, if several interviews were needed, the data would quickly get unwieldy for purposes of analysis, and considering the needs of a doctoral dissertation, even 2 to 3 hour interviews would greatly extend data collection time. It was decided that I would conduct the first few interviews attempting to terminate after approximately one hour. However, this concern was unfounded, as most informants spoke at length about their experiences, and never was more than one hour necessary for an interview.

Consent Form Wording

I asked the Cultural Consultants and Mr. Ruak to examine the wording of the consent form, and to discuss the issue of "informed consent." Mr. Ruak stated that some of the wording of the consent form might be challenging for individuals with English as a second language, particularly those who had not attended post-secondary education. The consent form was revised to reflect more colloquial language, while retaining the original meaning (see Appendix E for the original and revised consent form). Mr. Ruak believed that, providing it was explained that having them sign a consent form was to protect their rights, the informants would not have difficulty understanding the concept of informed consent.

Data Analysis Strategies

Marshall and Rossman (1989) define data analysis as "the process of bringing order, structure, and meaning to the mass of collected data" (p. 112). One of the key elements of qualitative methodology is that the processes of data collection and data analysis are conducted simultaneously (Creswell, 1994); later data collection and interview questions are influenced by discoveries in the data analysis.

The data analysis strategies in the present study followed those recommendations outlined by Tesch (1990), with minor modifications which seemed appropriate for the present researcher's cognitive style - verbal rather than visual. The modifications to her method involved eliminating the graphic representations and illustrations which Tesch suggests, such as mapping out topics, or drawing connective lines between related topics. After the first several interviews had been completed, I conducted a careful reading of 4 transcripts selected at random, jotting down ideas or comments as they came to mind. The Cultural Consultants also followed this step. We then met as a group to discuss our reactions to the transcripts. The Consultants provided a written summary of each transcript (see Appendix H). I then made a tentative list of the categories the group had identified.

I then transcribed 8 more interviews with the categories from the first step available. During the transcription process, I noted when new categories arose and added them to the master list. Using the 12 transcribed interviews, I performed a second reading, where the task was to "de-contextualize" (Tesch, 1990) or separate relevant sections of data from their context. This process involved dividing the transcript into smaller parts, what Tesch calls "segments" - "a segment of text that is comprehensible by itself and contains one idea, episode, or piece of information" (p. 116). According to Tesch, these segments must be comprehensible outside of their context, and must have relevance to the research question. This was a particularly difficult step, due to the tangential nature of the speech of the informants, and there were often random segments which were not related to the rest of the section of dialogue. However, as an assumption of the present study is that schizophrenic speech is an expression of the individual's experience, an attempt was made to consider each segment separately.

As I identified these segments, I noted any thoughts about the underlying meaning or category in the margin of the transcript. I attempted to allow the topics to arise from the data themselves; however, as I have articulated certain research questions, I also had the following *a priori* major categories in mind: Psychotic Symptoms, Explanatory Models, Attitudes toward Traditional Beliefs, Attitudes toward Treatment, Attitudes towards Family, Descriptions of Chamorro Culture, and Attitudes Toward U.S. involvement. These categories were based upon the questions asked during the interview. Categories based upon Western conceptions of schizophrenia and its symptoms were also *a priori*: delusions and their structure (grandiose, paranoid, etc.), hallucinations, loose associations. Other categories and subcategories emerged exclusively from the informants. Therefore, as I read the transcripts, I maintained a position of flexibility, where I looked for evidence of my own categories, while at the same time searched for categories which I had not anticipated (see Appendix I for a table of Master Categories, Categories, Themes and Subthemes). I also determined whether or not each segment was relevant to my research questions. If it was not relevant, a general category name was noted on the transcript, but not included in the next step of analysis.

Once I completed this step for the 12 interviews, I made a list of the relevant categories I identified from each interview. I then transcribed the remaining interviews and completed segment identification and categorization with those transcripts. During this reading, the category names were revised to encompass the entire set of data. Official category headings were devised. Each of the 20 transcripts was then reread and each segment was placed in its appropriate category.

The next step involved a reading of the segments within each separate category, and the segments were grouped together based on their underlying theme. The purpose of this step was to identify and summarize the content in each category. At that point, I looked for

commonalities in content, uniqueness in content, confusions and contradictions in content, and missing information with regard to the research question. Category and theme headings were revised if, after a reading of the segments, a more accurate or descriptive name was required, and segments were moved to a different theme if a new grouping appeared. At this stage, notation of the demographic information provided by each informant was made using a grid system, with informant number across the top, and demographic information down the side of the grid (see Appendix J). Subcategories and their underlying themes were then added to the interpretive system after a rereading of the segments (see Appendix I).

Due to the nature of the research questions, the analysis of psychotic symptoms was more complicated than other categories. First, segments containing symptoms of schizophrenia as defined by the DSM-IV (APA, 1994), such as delusions (beliefs which did not correspond to my understanding of the culturally accepted view of reality), hallucinations (experiences which informants described as "hallucinations," "seeing or hearing things," or experiences where they described seeing a fantasy creature which was not consistent with their cultural beliefs, etc.), suicidal ideation (reports of attempting to harm themselves), were identified under the major category "Symptoms." Next, delusional thoughts were classified under the "delusions" category. At that point, each delusional segment was classified as to its type: grandiose, persecutory, etc. according to DSM-IV criteria. This was the subcategory of each segment. Then, various content themes were derived for each subcategory. The final step involved an in-depth analysis of the thematic content of the delusions, in order to identify further subthemes. A similar procedure was following for auditory and visual hallucinations.

The final stage in data analysis was to incorporate data from other sources into the organization from the formal interviews. First, the interview with Joe V. was transcribed and read, and segments were placed under each category, subcategory, and theme. Then, my

observations on the Chamorro culture, which had been noted during my stay on Saipan and Guam, were written in journal format. The data from the Joe V. interview and the informal observations were included in the analysis when they aided the interpretation of the information offered by the informants.

As stated earlier, the data analysis procedure described above yielded several major categories for discussion: Symptom Description, Explanatory Models, Attitudes toward Traditional Beliefs, Self Reflection, Attitudes toward Treatment, Attitudes toward Family, Descriptions of Chamorro Culture, Attitudes toward U.S. Involvement in the Chamorro Culture, Chamorro Attitudes toward Mental Health Problems, and Attitudes toward Interview. Within each major category, common subcategories, themes, and subthemes were identified. This section examines each major category separately, using direct quotations from informants wherever possible and appropriate for illustration. Some quotations are particularly short, and may not appear to add significantly to the content of other quotations, but are included in the paper to give voice to those informants who were more reluctant to describe their experiences and attitudes. Because of the nature of speech of many of the informants, an attempt was made to facilitate the understanding of the reader by editing verbalizations not integral to the statement, such as "uh-uh," "mmm-hmm," "you know," etc.; three dots (...) were used to indicate when such discourse was removed. It should be noted that each quotation used in this section is referenced by the informant's pseudonym and transcript number.

Formal Data Analysis

Description of Symptoms

As the first goal of the present study was to analyse the psychotic thought of Chamorro schizophrenics, this section describes the symptoms of the informants, with particular

emphasis on delusions and hallucinations; these symptoms include both those described as such by the informants, and those observed during the interview.

Delusional thought. Twelve individuals provided descriptions of their delusional thought. Delusional thought or experiences that appeared delusional fell into two main structural categories: persecutory and grandiose. These two types of delusions appeared together in two individuals who described systematized delusions where their paranoid ideation was accompanied by a grandiose delusion. This association of delusions of grandeur and persecution has been categorized by Kaplan and Sadock (1992) as paranoid delusions.

Esco (009), for example, reported that her husband was trying to poison her, but God gave her a message which saved her life:

> My husband, he wants me to die. He is trying to poison me so he can take all my property...With a needle in the hospital, and here in the house...he's still trying to poison me...I was eating, and I feel something. I asked God what it was. He said it was poisonous. That's why I'm still alive, because God told me. Before my husband poisoned me with a needle, I prayed to God. When I got the shot of poison in me, God helped me. I hear God's voice in my mind.

Another informant, also afraid of harm from a male figure, reported being protected by spirits:

> But I cannot leave the house because that man, he's gonna kill me. He's gonna come inside my house and kill me. He's gonna take the belt, the rope, and he gonna tie my neck and he gonna tie it tight and he gonna push me out...The man in the car, he's been following me for long time...He told me wherever I am he's gonna come. I'm very afraid...maybe that man, he's gonna hit me, he's gonna run after me and hit me...He says wherever I go, wherever I am, he gonna follow me...He just stays there...That not good. I'm crying. I cannot sleep...At night he says he gonna come but the spirits, they guard me. So if he gonna come they gonna be there. (Erica, 013)

Two individuals reported persecutory delusions without any grandiose elements. Joseph (003) believed that someone had poisoned his food: "I don't see why somebody got jealous of me and hypnotized me and put poison in my food and let me eat the food, so I

became mental from that." James (008) reported several experiences with a cult of men who attempted to harm him:

> ...one of the members of the group, the people in the town I lived in, was a very powerful man, and he was involved in this drug conflict, the drug war, among gangs and everything. He didn't like me. He didn't want me around, so I left...They told me that...if I was going to be involved in their community...I would have to be ready to kill on their orders. They told me I had to be able to kill when they wanted me to kill. I knew at that time, I would only get killed if I stayed around...I didn't know if she was my mother or if she was just someone they had killed or had around to, or if she was somebody they had tortured. They were ordered to induce thought control, to mind that I was paralyzed.

Roy (018) also described feeling like he was being conspired against:

> They sent me a note saying somebody's very sick. Maybe someone was trying to trap me, I don't know, like a trap or something. Like teasing me, like my mother's name was there, but when I came my mother wasn't here. So maybe it was a trick. Must have been somebody who wanted me or something like that. I swore by my blood that I would get even.

Two informants were able to describe their feelings of paranoia from a more detached perspective:

> I used to think that...people were talking about me. Like I was working once, and my friend was climbing into the tank, and she was meeting another friend, and I swear to God they were talking about me...just a little bump, and I thought they were trying to hit me...I got pissed off at my boss one night, I thought they were talking about me, plotting things against me...I got up and went outside, and I kicked the chair. (Francis, 005)

> I get paranoid at times, I'm scared...afraid of robberies or, when I'm by myself at home, I keep an eye out. I'm a light sleeper. I jump up real quick. I jump up real quick to find out what's happening in the house, you know. So, whenever I'm in the house I just feel paranoid...I was scared. I was thinking my sister-in-law, she was trying to kill me. She was always after me and she was picking on me too much...Like right now, I'm going home today, I'm going to be alone, so I'm going to relax myself...I'm tempted to go with my friend but I don't think I want to bother her. I'll just mind my own business. I'll work it out myself...It's like somebody's going to attack me. I'm paranoid that somebody's going to attack me. I feel it, you know, and it bothers my mind. (Marian, 011)

According to the sociopolitical model outlined in the previous chapter (see e.g., Harper, 1992), there may be a legitimate basis for paranoid beliefs within many individuals who hold a

powerless position in society. In addition, Mirowsky and Ross (1983) suggest that paranoia may develop when sociopolitically powerless individuals (i.e., those with low education, income and social status) learn that others have control over important aspects of their lives. Although not directly commented on by the informants, this is consistent with the Chamorro people who, as Underwood (1979, cited in Bretania-Shafer, 1989) reported, believe that they have limited control over their external environment. Cross-cultural research on paranoia has suggested that paranoia may be related to the stress of acculturation, and that perceived or actual rejection or discrimination may foster paranoid beliefs, delusions, and hallucinations (Jack, Nicassio, & West, 1984). In their study of 200 patients attending a general hospital psychiatric unit in India, Kala and Wig (1982) found that persecutory delusions were the most common type in their sample (82% of patients interviewed expressed delusions of persecution; 35% reported persecutory delusions in the current sample). The authors report that their findings confirm those of other studies, and suggest that many cultures structure their environment on the basis of aggression and fear, and that these symbols define interpersonal relationships and identity formation. They also offer as a secondary hypothesis that those individuals with persecutory delusions may be less tolerated in many cultures, and therefore more are likely to be brought in for treatment, compared to those with religious delusions. Both of these statements may explain the present findings. The cultural and historical context of the Chamorro people, still governed to some extent by Mainland Americans, may generate feelings of fear and powerlessness within their own society. This atmosphere of fear and paranoia may stem from a feeling of distrust of Americans, who had taken the most valuable land on Guam for their military bases, and who continue to provide financial aid with the threat of eventual withdrawal. The finding that many of the women's persecutory beliefs are about harm from male intimates or dangerous male strangers may

reflect their experience as women in the male-dominated Chamorro culture where domestic violence and sexual abuse are fairly common. It is also possible that Chamorro individuals who are expressing persecutory delusions are more likely to come into contact with the Western mental health system, as they may be more difficult to tolerate in the home environment. This issue might be clarified by conducting interviews with individuals who have not had contact with the mental health system and by investigating the prevalence of persecutory delusions within that sample. Five informants described grandiose delusions. Joaquin (001) believed himself to be the Governor of Saipan, who was responsible for giving "money to people to help them." John (012) believed himself to possess special powers:

> I used to have another life when I was a sorcerer...Maybe it's just getting some energy light from my brain and making sense of it. But ever since I met this small star one, star one, I made this wish and I was going to try to escape, escape forever. And when I made that wish it came true...I escaped the building. I was still a sorcerer, the gargoloid buildings.

Three informants reported having a special relationship with prominent religious figures:

> I used to pray a lot...straight to God. God gave me a message, it went really fast in my head, but he gave me a message...I thought God was helping me, like I'd ask God, "Are you sure this is right?" Then suddenly he says, like real far away, say uh, "Yeah I think that's right," talking to somebody else, and I would think God was talking to me. You know what I'm saying?...Somebody would just say something and I would think that God was the one that would make them say that. (Francis, 005)

> They say the Lord is dead, they say my Lord is dead, even when he appeared to me. But they are lying because he appeared to me...I saw it, I just keep looking from about here to here [makes directions with hands] about 10 feet above ground, and there's nothing to stay up, for your feet. He was just looking at me, going like this to me, then he told me to quit sinning, because I was a sinner. You know, I sinned a lot. I take drugs, and marriage, and everything, then after I saw those things I stopped. It really happened to me. He told me to quit sinning from then on. I quit what I was doing...Maybe two years later, I saw the Lord with that big cross, or something like that. (Roy, 018)

> So that's when I saw the devil, when I was about two years old. I think I was maybe a year old, I was just young...when I was possessed by the devil at that

> time in my life...They swore that they would do that to the Virgin Mary. And I'm fighting for the Virgin Mary, fighting for her side. (James, 008)

There were other types of delusions demonstrated by the informants. Francis (005), for example, expressed a delusion of thought broadcasting: "...but now my thoughts are talking out loud, talk talk talk all the time." In a delusion of reference, James (008) believed that music has special messages for him:

> ...it [music] sends messages...And that spreading messages like that would be like...telling the person that...listens to the message to say oh, since I'm a part of this music...that they're playing, like heavy metal...or very light music, could be a big monstrosity, and destroy everything that exists.

John (012) described a series of experiences involving aliens from outer space, robots, and other unusual events, which may be classified as a bizarre delusion:

> ...she's a small robot space ship above in space. She flies around without no wings...She looks like the ship Star Trek...I sense people that come here from another place, beyond this world, I mean, outside this world. I sense them coming around. I know who's who, and who's not who. But sometimes I don't know who's who and not who. Now I talk with Shanendora, and she's from another world...There was a rhino who shoots rocks out of his head and explode. There was a, you ever see those little bacterias, amoebas? Those things that can change shape? There was one this big and one that small, you know.

As is evident from the series of quotations above, there are several instances where, because of the nature of the delusions and cultural beliefs, a belief which would be considered delusional in Western psychiatry would not necessarily be delusional in Chamorro culture, such as a belief in witchcraft, receiving a message from God, or having spiritual protection against evil. This difficulty in diagnosing delusional thought in a culture different than that of the mental health clinician has been discussed by authors such as Chandrasena (1983). Chandrasena states that clinicians may mistake cultural beliefs for delusional beliefs which may lead to an incorrect diagnosis and unnecessary treatment when unfamiliar with a client's

cultural context. This emphasizes the need for mental health professionals to become acquainted with their clients' cultural beliefs before attempting to make such decisions.

The difficulty in distinguishing between cultural beliefs and delusional ideas is exemplified by the narratives offered by two informants who expressed a belief that their life difficulties were due in some part to witchcraft. Joseph (003) stated:

> I was hypnotised by voodoo before I became mental, before I became a schizophrenia...Because there was a person from a competing shop, my competitor. This guy had a wife from Pohnpei, so this guy from Pohnpei could make himself do that personal witchcraft or voodoo. That time, he knew what to do with this kind of medicine.

Marian (011) also believed that her problems were due to witchcraft:

> I have to blame my sister-in-law because she studied witchcraft. The reason why she hated my attitude is because I took one of her witchcraft books and I never returned it and she kind of cursed me out.

According to the DSM-IV (APA, 1994), based in North American psychiatry, a belief that witchcraft or other supernatural forces were responsible for life problems would be diagnosed as a bizarre delusion - one that involves phenomena which are considered implausible by the individual's culture or subculture. To classify a belief in witchcraft as a delusion, it would have to be considered implausible by the Chamorro people. Many informants and Chamorro students with whom I spoke expressed ambivalent views, recounting stories of witchcraft and spirit possession with both disbelief and acceptance. Therefore, it is possible that mental health difficulties precipitated by witchcraft may be a culturally accepted belief. However, this is not to say that Joseph (003) and Marian (011) were incorrectly diagnosed; they exhibited other behaviors which were indicative of mental health problems, such as loose associations, hallucinations, etc. It does emphasize the need to collect information on cultural beliefs and to determine whether other psychotic symptoms are present before making a diagnosis of schizophrenia.

Hallucinations. Eleven respondents reported during the interview that they had or were currently experiencing visual and/or auditory hallucinations. Although some informants were unable to describe the specific content of their hallucinations, others provided explicit details. For example:

> I got drunk, and then I heard voices...It said things against my family. It said about me not having a girlfriend. (Jesus, 004)
>
> ...it used to be devils, but I don't believe that...they don't say much. They used to call my name, 'cause they wanted me to go to hell with them. (Francis, 005)
>
> They say my mother's family's mutung. Mutung means stinky and smelly...It sounds like my mom's niece is saying it...She says things like "your family's mutung." (Carmen, 006)
>
> When I was a child I was hearing voices, when I was a young child, about a year or two years old. I saw something when I was alone. I saw a dinosaur. A big thing. (James, 008)
>
> ...the voices I hear are kids playing on the playground calling "mommy" you know, "come and play with me." (Marian, 011)
>
> I heard voices, walk down the road, like it was Mother Mary or something. Boy you should have seen my hallucinations, man, it was very dangerous...You see, when I was home long time ago, there was a dead stove that hadn't been used for three years...then all of a sudden, rats started coming in, some sort of rats started coming in my back, coming into my brain, eating it. Man, that felt weird. (John, 012)
>
> I was hearing voices already, yeah, I was hearing voices...it wasn't nice. I heard them before that, when I first got turned in. I used to go in the jungle and walk around the jungle, carrying trees...The priest took me, he took me and I said, I'm not seeing clearly, I'm seeing ghosts and things, I came to confess. And he said, you have no problem with God, and he took me over to Mental Health and turned me in. (Jack, 016)

Susan (014) reported experiences which may have been auditory and visual hallucinations, or delusions of thought broadcasting:

> So he'd turn the fan on and it seemed like whatever I'm thinking, that the sound is echoing back to me and saying the same thing, repeating over and over again, but it's what I'm thinking and then, when the noise of the fan moving around it sounds like it was recording, saying what I'm saying...Whatever the person was thinking about, my kids, my husband, I close my eyes, I can see

> them. When I open my eyes it's gone, then sometimes I'd be going to dinner and I'd close my eyes and you may not believe it but I could see the picture of the Holy Scriptures, the Madonna, the Blessed Virgin, Christ, and all that.

Two informants, Francis (005) and Susan (014), exhibited distortions in perception. Francis stated:

> ...my hand would be here right (holds hand by her face), but it would look all far away, or all close up. Or my voice would be tiny in my head. You could barely hear it.

Similarly, Susan reported:

> I feel like I'm way up high on the ceiling when I'm sitting on the couch. And if I got up I looked down I'd feel like it's very deep, you know, and I'd stumble even on the floor. I feel like it's so deep down there I can't reach it. I have to walk. And the window, when I look out the window when I'm sleeping or laying down, it was going this way, bouncing. And I feel like the house is turning over but it's not really. But I'm still in the house.

It is of interest to note that the content of the Chamorro mental health informants' delusional ideation, as well as the content of their hallucinations, were very similar to those found with North American schizophrenics, and that there were no delusions involving *taotaomona* or *surohanos*. However, there were two instances of primary delusional content which are less common in North American schizophrenics: witchcraft and poisoning (Kala & Wig, 1982). Two informants (Joseph, 003 and Marion, 011) used the term "witchcraft" to explain their mental health problems, and two other informants (Joseph, 003 and Esco, 009) described being poisoned. Although "spells" and "curses" may be common delusional content, the use of the term "witchcraft" has not been noted in the literature, with few exceptions. In his paper on the African world-view, Hammond-Tooke (1975) discusses the Bantu belief in witchcraft. However, the Bantu definition of sorcery fits more closely with the Chamorro definition of witchcraft. The author states: "sorcery is the use of medicine or magical substances to harm: witchcraft involves the manipulation of psychic powers" (p. 26). The Bantu's sorcery is similar to what Joseph (003) describes:

> Because there was a person from a competing shop, my competitor, competition both shop...this guy had a wife from Pohnpei, so this guy from Pohnpei could make himself do that personal witchcraft or voodoo. That time, he knew what to do with this kind of medicine.

Hammond-Tooke suggests that witchcraft accusations are indicators of stresses and social conflicts within a community, particularly when competing for scarce resources; in Joseph's case, there was competition for financial resources.

According to Kala and Wig (1982), primary delusions of being poisoned are rare in Western cultures. However, in their sample of schizophrenic individuals in India, poisoning occurred as a distinct theme. The authors suggest that in cultures where ceremonies and social interactions often take place around food, delusions of poisoning occur more frequently. This explanation would appear to fit with the Chamorro culture, as most of their rituals and family gatherings involve the mass preparation and consumption of food. It may also be that in less industrialized cultures, food poisoning is more common due to a lack of refrigeration, and therefore may occur more frequently in the general population.

In other respects, the delusional objects reported by the informants tended to be those found in most cultures: demons, devils, religious figures, etc. (Jahoda, 1995). The largely Western content, with the two exceptions noted above, is consistent with the assumptions of Western cultural psychiatry, which suggests that, while the biologically determined structure of delusions (e.g., persecutory, grandiose, erotomanic, etc.) remains constant across cultures, delusional content is influenced by cultural and social variables. There are several possible explanations for this finding. First, as Western culture has had such a significant impact on the Chamorro people, most traditional Chamorro concepts may be less influential than Western concepts. The influence of Western ideas may have been amplified by the informants' experience with treatment in the Western mental health system. These individuals, with more exposure to Western ideas in particular, and Western mental health

concepts in general, are likely more Westernized in their ideas and concepts than psychotic individuals who have never sought Western treatment, and therefore their delusions would be less likely to reflect traditional Chamorro cultural concepts. It is possible that individuals with no exposure to Western medicine are more traditional in their attitudes, beliefs, and values. Third, as a culture which has been ruled from outside for several hundred years, Chamorros may have lessened their adherence to traditional beliefs in *taotaomona* and witchcraft, particularly in interaction with Westerners. In addition, the role of reporting bias should not be ignored; the informants may have offered primarily Western concepts and ideas during the interviews because they were speaking with a Westerner. However, it is important to note that, with the exception of John's (012) delusions surrounding creatures from outer space, there were no accounts of technological delusions; that is, delusions involving radio or television waves, video games, computer chips, and the like. This may suggest that the Western phenomenon of computers and television cable in every home has not permeated Chamorro culture.

In general, there were several important underlying themes evident from a thorough examination of the entire set of delusional and hallucinatory content presented by informants. The primary theme which may be seen as a common thread running throughout the transcripts is powerlessness. Most delusions or hallucinations placed the informants themselves in a powerless position compared to others involved in the delusional system. For example, Francis (005), although receiving messages from God, was in a less powerful position, as she was asking "Are you sure this is right?" - asking for guidance from a powerful figure. James (008), who had several delusions revolving around devils, demons, monsters, and all-powerful cult members, saw himself as powerless against these forces: "They told me that...if I was going to be involved in their community...I would have to be ready to kill on their

orders." He also had resigned himself as powerless to change his life circumstances: "...when I was possessed by the devil at that time in my life, I would never really try to change that, I just accepted that I would live with that..."

When Roy (018) describes his visions of God, he reports feeling unworthy of such a great honor:

> I'm not God, I'm not Jesus, I'm nobody. I am nobody compared to Jesus and God. God is good, Jesus is the holy one that went to the cross, not me...Why me? There's a lot of people he could have talked to, could have talked to all those prophets...There's a lot of people that are dying, yet I'm still here, wondering how come you appeared to me.

There is also a theme of powerlessness underlying the persecutory delusions of many informants. Esco (009), for example, sounds paralyzed by fear of being poisoned by her husband. Erica (013) also appeared consumed by thoughts of being harmed by her male stalker. Both of these women were able to seek protection from powerful forces: God and spirits. Carmen (006) describes an event where she was powerless, which was apparently traumatic enough for her to ascribe her life difficulties to it:

> Because when I was working at my mom's school, this man comes in the bathroom 'cause he wanted to use it, and I was sitting down on the toilet and he didn't want to go out and I wanted him to go out because I was using it. He keeps standing there looking at me. So I said "if you don't get out, I'm going to tell my mother, and she runs the place, she's the principal, and the principal can boss you around"...But he didn't want to tell me his last name. 'Cause he said "you don't know me." But he knew me because he knew that my mom was the principal.

Although it is unclear whether or not this event is a reflection of delusional thought processes, the situation is certainly one where she is in a powerless position against this intruder who knows her but will not allow her to know him.

Three informants' reports of their auditory hallucinations reflect a theme of shame and derogation, with the effect being the informants reportedly feeling badly about themselves. The voice that Carmen (006) described hearing was a relative's voice saying her family was

"stinky." In a similar vein, Jesus reported that the voice he heard made derogatory comments against his family, and insulted him because he didn't have a girlfriend. Marian stated that the voices she heard were children calling her to come to them, and she said that she felt that was because her "illness" prevented her from being able to care for her children. This theme is reflective of the Chamorro cultural context, as shame is a very strong presence in Chamorro family life. Much of their childrearing strategies are based on shame. As many of my students related to me, a child is often made to feel ashamed by family members when she or he misbehaves or fails at something; shame which may translate to an individual's shame brought upon the family. The issue of shame is discussed further in the section on mental health stigma and family attitudes to mental health treatment.

Another theme, one which is very much related to feelings of powerlessness, is one of fear. Most informants who described their delusional system reported feeling very afraid of their delusional objects. These objects in many of the delusions and hallucinations were frightening creatures: devils, dinosaurs, demons, dragons, ghosts, rhinos, and other fantasy creatures. Other objects were human intruders who have intent to do serious harm.

Finally, Christian religious content was quite common in many of the grandiose delusional systems of the informants. As reported earlier, Francis (005), Roy (019) and Esco (009) stated that they had received messages from God; James (008) felt himself to be the protector of the Virgin Mary and apparently saw figures from the Bible; Susan (014) reported having visions of Biblical figures; and John (012) reported that the voice he heard was Mother Mary. In addition, for those who did have religious content in their delusions, the religious icons figured prominently throughout their narratives.

The reflection of strong religious values in the delusional content of the informants is also consistent with their cultural and historical context. Since 1668, when the Spanish

missionaries first began their conversion of the Chamorro people to Catholicism, Christian religion has maintained a central position in their cultural beliefs and values. From my own observations of the culture, the Chamorros appeared to be a very religious people. According to Stanley (1992), a significant majority of Chamorro people strongly identify themselves with the Catholic church. Most of their rituals and festivities centered around the Catholic religion. Family contact often took place during religious holidays, weddings, rosaries, and novenas. These gatherings involved as many family members as were on island at the time, and always offered a huge array of local food and social contact. Since Catholic values and beliefs are a large part of the Chamorro identity, it is not surprising that religious objects figure prominently in many of the informants delusions. This is also consistent with research on other strongly religious cultures, such as studies by Guarnaccia, Guevara-Ramos, Gonzales, Carino, and Bird (1992) and Brewerton (1994), that found religious content in Puerto Rican and Hawaiian psychotic individuals, respectively.

In general, these underlying themes found in the delusional and hallucinatory content of the informants are consistent with the cultural perspective, as well as the sociopolitical perspective, outlined in the first chapter. First, these themes are consistent with the cultural and historical context of the Chamorro people. As a culture, they have been powerless over the administration of their community, having to adapt or acculturate to several different governing cultures. Presently, the United States is a powerful influence on the Chamorros. Until recently, the U.S. military has been a strong and obvious presence. Both islands follow many U.S. laws and regulations, receive funding from U.S. sources, and look to Mainland Americans to fulfil many positions of power, particularly in professional arenas.

Second, the issue of power evident in the informants' delusional thought is also consistent with the sociopolitical approach. For example, Glass (1981, 1985, 1987) suggested

that the delusional content of schizophrenics contains themes based on power relationships in Western society - domination, devaluation, etc. He also stated that schizophrenic individuals connect themselves with powerful figures (e.g., God) to reduce their fear of domination. These individuals are excluded from society because the content of their delusional thought highlights the inequities in Western society. This may be what is occurring in Chamorro culture. Since historically the Chamorro people have had to adapt to external power sources, it might be threatening for many Chamorros to admit their resentment of their powerlessness. Labeling as 'crazy' the thoughts and behavior which emphasize power relations in Chamorro society may make it easier to maintain the status quo.

Mirowsky and Ross' (1983) sociopolitical model of the development of paranoia is also relevant to the present discussion. These authors hypothesized that paranoid ideas develop out of a belief in the external control of significant events and the threat of victimization. It is apparent from my observations of the culture that many Chamorros had a strong belief in external control; the island philosophy of sitting back and watching what happens. This belief may stem from both the historical and geographical context of the Chamorro people. Significant events have been controlled by outside forces: the Spanish, the Japanese, the Americans, as well as typhoons, earthquakes, volcanos. There have also been significant threats to the Chamorro population, beginning with physical threats from Magellan through the Second World War, to more economic and cultural threats from the Americans and Japanese. This interpretation supports the importance of vertical collectivism (Triandis 1995a, 1995b, 1996) in the Chamorro culture; that is, as a vertical collectivist culture, the Chamorro people may accept that authority figures direct and control the environment, and it is one's duty to abide by their direction and control, yet maintain an interdependent identity.

Thought disorder. Another category of symptoms discussed by three informants was the characteristic symptom of thought disorder (e.g., loose associations, disorganized speech, neologisms). They described the symptom as a difficulty in thinking or concentrating. For example:

> That's when I feeled that I was so sick, so everything makes me complicated. I feel many things are complicating for me. It was unusual that I could not make my mind steady. I think about weird things, important things. I know that I just don't see why my mind wasn't so pure. (Joseph, 003)

> I wasn't able to...accomplish...I wasn't able to think... (Rod, 007)

> ...if I shut myself down in a certain pattern of doing things, things I shouldn't do, my mind malfunctions. So, there's things I shouldn't do. There are things, sometimes, I'll simply see a spot and I will get troubled, and there it goes, my whole day, my whole month is gone, wasted... (James, 008)

> I talked to myself. That's how I knew I needed medication...I wasn't looking after myself, my personal hygiene...I wouldn't talk. I wasn't myself. (Sharon, 017)

In addition to delusions and hallucinations, every informant, to one degree or another, displayed the speech patterns characteristic of schizophrenia. As is apparent when reading the transcripts, and quotations from those transcripts, most showed evidence of loosening of associations, with their train of thought at times being difficult to follow. Rod (007) used neologisms, such as "gargoloid." Francis (005) complained of "tripping" during the interview, interrupting the flow of conversation with laughter and exclamations; "Wow, I just freaked out (laughs). Huh?...I freaked out. I'm ok."

Other psychiatric symptoms. John (012) poignantly describes the blunting of his affect, another characteristic symptom of schizophrenia:

> But, ever since my girlfriend broke my heart now I got hardly any emotions or any feelings...But now I still get this feeling like, my feelings are still like a robot...every time I get feelings I smoke to get rid of it. Because if you got more feelings you get emotional, and when you get emotional, you tend to get ill or something, that's why I just cut off the feelings when I smoke or do something else.

There was also evidence of other symptoms, not necessarily characteristic of schizophrenia, throughout the interviews. Five informants reported drug and/or alcohol abuse in their histories:

> I smoked marijuana, I used drugs. (Joseph, 003)
>
> I got drunk, and then I heard voices... (Jesus, 004)
>
> I had tried marijuana, it was new to me. I was 17 years old at that time. I had just come over from Viet Nam...So in my condition, my physical condition, my weakness, my addiction, I could not do without it, like when I was in Viet Nam, where we always had it. (James, 008)
>
> I used to be 250 pounds, all these drugs...I used to do things, hard things, shabu. (Elaine, 010)
>
> I was doing ice. (Jim, 015)

Four other informants provided tragic descriptions of their suicidal ideations and drastic attempts to end their own lives:

> I tried to kill myself. First, I drank some lysol. Then, I covered myself with gasoline and tried to set me on fire. (Mary, 000)
>
> I was suicidal. I had this thing in my head like, there's this depression or something. You know what I mean? Like there's this huge pressure and I don't know what it is. So I get depressed, and feel like killing myself...I'm always like that too. And I tried to pull it off several times. (Francis, 005)
>
> I tried to stab myself. Cover with a blanket and burn myself. I hung myself on a tree. I tried to cut myself, without my family understanding [cries]. (Elaine, 010)
>
> Did you know that I felt so sad and depressed I stopped my heart from beating, again. I really shut it down. I just killed my whole battery to my heart. And the only thing I'm moving around is air. I was just breathing. When I felt my pulse, it wasn't there. I wanted to die. (John, 012)

In general, the narratives provided by the informants showed several characteristic symptoms of schizophrenia: delusional thought, auditory and visual hallucinations, thought disorder, disturbance of affect, and other general psychiatric symptoms, such as substance abuse and suicidal ideation. These symptoms, and their descriptions, were all strikingly

similar to those one would observe in schizophrenic individuals in North America. However, as discussed earlier, there was evidence that the cultural context, being one of an amalgamation of Western and Chamorro influences, did have an impact on the content of delusional thought. These results are discussed in more detail in the final chapter of the paper.

Explanatory Models

Since a second goal of the present study was to investigate the explanatory models used by Chamorro individuals to explain their own life difficulties, this section examines the situations or characteristics to which informants attributed their symptoms. Kleinman (1978) defines explanatory models as those which "serve to organize those episodes [of sickness] as socially constituted 'clinical realities' (i.e., particular views of what is wrong, expectations about the type and style of treatment, and goals for what will be considered effective care)" (p. 428). It should be noted that many informants used a combination of models to explain their symptoms; an abusive history and substance abuse, for example. However, each theory is examined separately for ease of overall comprehension.

In general, of those individuals who expressed awareness of their mental health problems, eight individuals used labels such as "sick" or "ill" to describe their difficulties, and four informants used the label "schizophrenic" or "schizophrenia" to apply to themselves and/or others. These individuals appear to have adopted the explanatory model of the Western mental health system, one where they are sick or ill with the disease of schizophrenia.

The most frequently reported cause of mental health problems reported by the informants was external stress. Although the type of stress varied from informant to informant, eight individuals cited a particularly stressful event as the starting point of their

problems. In particular, the stress of abuse from family members was an attribution made by three informants:

> I have a brother who hurt me very much when I was young. He hurt me mentally, and it was a long time...I'm always such alone, because of my brothers. I'm always by myself when I walk along...'cause of the things they've done to me when I was younger, and it was hard for people to understand me. (James, 007)

> ...it's because of my first husband. I was married twice. So you know, my first husband was abusive to me. He'd give me black eyes, bruises, hitting me against the wall, he nearly killed my bones, my face and everything. He was abusing me bad. (Marian, 011)

> All the abuses in my family set me down, made me negative...when my girlfriend came over when I was 3 years old, 3½ years old, I just blacked out and my father found me and he whipped me. He whipped me 'til my, the muscles showed on my skin, 'til my muscles showed out on the edge of my skin. Boy, that made me upset... (John, 012)

In addition to abuse, several other stressful experiences were cited by informants. Elaine (010) and Jack (016) both spoke about the death of a close family member as being responsible for their difficulties:

> ...when my mother died, when I was seventeen, she died of a heart attack, I went to inpatient Mental Health and Substance Abuse for life, I was an inpatient for life. (Elaine, 010)

> ...she thought I was going crazy 'cause my mom died. I was having problems with that. I didn't have a mom around, you know what I mean. (Jack, 016)

Sharon (017) reported that school problems were responsible for her symptoms: "I had an F in school one time and I was brought to doctors and psychiatrists...I freaked out. I thought I was losing my mind." In addition to the stress of abuse mentioned earlier, John (012) had several other theories as to why he became "ill:"

> (a) I have so much fun of life when I was young, that I really think that life's responsible for this...(b) when you get emotional, you tend to get ill or something...(c) I had this girlfriend of mine that got me sick...I kept thinking of my girl, but she has another boyfriend...That's why I got jealous. That's why my temper got high...Then it just got me sick...Hanging around too much with women, that stressed my life...(d) there are things that we want to get and

> sometimes we get what we don't want and sometimes we get what we want and you want and you don't get. I think that's the reason why a lot of people end up in there, you know. Or maybe they're always straining themselves, stressing themselves, about something.

Therefore, John attributes his problems to a combination of stressors: too much fun when he was young, difficulties with women, emotional lability, and desire for things that are unattainable.

Two other informants described unusual events which happened to them in the past as causative agents. As described earlier, Carmen (006) reported an incident where she was the victim of unwelcome contact:

> Because when I was working at my mom's school, this man comes in the bathroom 'cause he wanted to use it, and I was sitting down on the toilet and he didn't want to go out and I wanted him to go out because I was using it.

James (008) also brought up a situation where he was visited by a person that could have done him harm:

> I think that when I was a child I was...was lying there, it wasn't evening, it was during the night. Suddenly, this man who wasn't a devil, he was really a wealthy man...was sent to me when I was just a baby boy. He told me I don't have any rights to be any where at all.

Although it is again unclear whether or not these two incidents are delusional in nature, it is important to note that these narratives were offered when asked for their theories of why they had been experiencing difficulties.

Joe V. suggested that the rapid social change from Western sources is a contributing factor to stress, and subsequent mental health problems and substance abuse in Chamorro culture. He stated:

> [Social change is]...great for people that have the ability to understand what having money means. It's sad to those who don't. People progress with development who would have progressed without it. There are always those who would have suffered anyway. But, instability can lead to mental illness and substance abuse.

In particular, he refers to the turbulent political history of the islands, where the Chamorro people have been governed from outside cultures for hundreds of years:

> Western thinking creates multiple personalities with all the different thinking. More than just religion too; the governments - Spanish, German, Japanese, U.S. The Chamorros have been sliced up four different ways. My parents are fluent in Japanese because they were taught Japanese during the War. My grandfather speaks German. All of this would be an insult to any system; it will create acting out. It can lead to mental illness. People need a safety valve, having nervous breakdowns...In the past, Micronesian community and culture favored equality and support within the community. Westerners encouraged individualism and accomplishment to distinguish themselves from other people. That can cause stress.

Joe V.'s position has been supported by the literature in various areas of study. First, research on acculturation has shown that rapid social change and the process of adapting to a new culture is extremely stressful. Berry (1995) reports that one of the most frequently cited consequences of acculturation is social disintegration and personal crisis. At the individual level, reactions such as depression, confusion, hostility, identity confusion, or anxiety may result. At the group level, social problems such as suicide, homicide, domestic violence and substance abuse may increase. Other authors have suggested that paranoia may be related to acculturation stress (see e.g., Copeland, 1968; Lucas, Sainsbury, & Collins, 1962; cited in Jack, Nicassio, & West, 1984). For example, Jack, Nicassio, and West (1984) present a case study of a Southeast Asian refugee in the United States who suffered from paranoid delusions potentially precipitated by acculturative stressors.

As Laing (1967) suggested, the process of socialization in Western capitalist society contributes to the generation of psychotic symptoms. He viewed the Western social context as a repressive form of social control which forces individuals to hold a particular world view so as to not upset the existing social order. In a culture such as the Chamorros, who are being confronted with having to adapt to Western ways of thinking, where there may be considerable pressure to conform to Western social order, this might be particularly stressful.

Corin and Lauzon (1994) also point to the North American social and cultural environment as complicating the course of schizophrenia. These authors claim that feelings of marginality and alienation may develop from the North American social context which does not reinforce or integrate the schizophrenic individuals' life-strategies. The exclusive focus on symptoms and skill development in Western mental health does nothing to foster a rearticulation of the schizophrenic's experience. Corin and Lauzon suggest that this hypothesis may be reflected in the WHO's Determinants of Outcome study findings that the more industrialized the society, the poorer the course and outcome of schizophrenia. WHO authors (Sartorius, Jablensky, & Shapiro, 1978; Sartorius, Jablensky, Korten, & Emberg, 1986) suggest that factors associated with industrialization may be stressful, thereby making it difficult for psychotic individuals to reestablish themselves after a psychotic episode.

Another common explanatory model of psychiatric difficulties offered by the informants was the use of drugs and alcohol. Six informants reported that their problems or those of other mental health clients began with the use of legal or illegal drugs, or alcohol:

> It also could be that I used too much drugs at that time. I smoked marijuana. I used drugs that time, those days. (Joseph, 003)
>
> [Why do people hear voices?] From drinking...They're probably drunk. (Jesus, 004)
>
> ...my experience is that uh, a drink or two, myself, I was cheating myself. I think probably from the alcohol too that was making me sick. (Marian, 011)
>
> I think I got that hallucination because I'd been drugged, and maybe that's why it's affecting me, you know, a long time ago...I wouldn't have had hallucinations if that wasn't so, because you know how there's side effects and all that after drugs, after LSD or something. (John, 012)
>
> I'm having children one right after the other, and every children they gave me a spinal injection...that's when I got sick but I was taking medication after I got rid of my medication...So, maybe it's from my kids, but I'm thinking maybe the medication too...Most of these clients, some of them drink. They go out at night and have a beer...I look at it from a logical way, like, maybe the drinking,

> smoking marijuana, and they've got those drugs, they can't sleep, they party all the time, and they have to lose control of their emotional senses. (Susan, 014)

> It's what they take, like drinks. Alcohol, for I don't care who, they call them alcoholics, I wasn't an alcoholic at all, I only drink sodapop. Some people take whiskey, take beer, man, all these people... (Roy, 018)

These informants viewed their difficulties, or the difficulties of others they know with similar problems, as having stemmed from some form of substance abuse.

Other less common explanatory models included witchcraft, biological factors, early childhood experiences, and an articulation of the diathesis-stress model of schizophrenia. As mentioned earlier in the section on delusional thought, Marian (011) reported that one of the causes of her problems was that her sister-in-law had put a curse on her. Jesus (004), although he did not believe witchcraft was responsible for his own problems, did report that others' difficulties might be due to witchcraft:

> ...a mystic...Like evil...Like maybe they got caught by a mystic with a spell...That's what I believe, even in the States.

Joseph (003) reportedly believed that all "schizophrenia" is caused by "voodoo" or "witchcraft:"

> I believe that the schizophrenia is causing them [people's problems], from the very beginning, was the witchcraft, because this is the only way to get schizophrenia, it's something on the brain, somebody who wants to do harm to you, there has to be harm to you, it has to be something that comes from somebody, that would cause you damage to your brain...I believe that the other patients are having the same sickness, the schizophrenia. I believe that their things are from the witchcraft...Of course I believe that it [mental illness] is caused by the witchcraft too. Yeah, because before it became civilized the witchcraft was studied all over the world. You find witchcraft all over, all over.

Two informants described biological factors which were responsible for psychiatric problems. Carmen (006) stated that she was not "normal" because of a birth trauma:

> But I wasn't normal because of the cord...They said I had a cord caught on my arm, that was the only thing that kept me from being normal. But if I didn't have the cord stuck on my leg or my arm, I would be normal. Then I wouldn't be in this place right now.

Referring to other mental health patients, Marian (011) believed psychological problems were a result of brain dysfunction:

> I think it's an illness that they have. It's a possibility of the brain and the nerves...You have to deal with the brain and the nerves, because without that it's not going to work.

Two other informants talked about childhood experiences as contributing factors in mental health problems. John (012) reported that exposure to media as a child can have an impact:

> I think also these problems of mental health, mental problems, it all starts when they were young. You know, can you see uh, a two years old boy or a one years old boy watching music TV, MTV, with all those colliding, all those different pictures, all those different images...And to me, I think that's one of the causes of mental illness...it's what they put in their minds, you know. But the little kid can't help that, you know, because he's not, he's not able to, he doesn't have the personality to test what's right and wrong. Maybe the same thing happened to me when I was young.

Susan (014) views early family experiences as creating mental health difficulties:

> ...how mental health starts, depression and different medications and the way we are now, I think if after birth and what we have to go through to grow up...There's so many kids now, from broken families, you know all about it, from different fathers, and then when they're grown up, and they reach their manhood, they get scared and say "oh my God, there's something wrong with me"...It's just how you grew up in life, I think it's to do with your family, and the experiences you had when you were young. If you were being ignored, you're losing something too, right?

Finally, two informants articulated the diathesis-stress model of psychopathology. Francis (005) reported that she learned this theory from a seminar at a psychiatric hospital in the U.S.:

> I think it [drugs] kicked it off, you know what I'm saying. I think it's hereditary, but the drugs just kicked it off...And probably, whether or not I took drugs I would have gotten sick because of stress. I had a horrible childhood. Some people might have the gene but they'll never get it. They're still susceptible to it, you know? It's just that it's in the family.

James (007), who did not recall any formal training in the theory, discusses brain chemistry in interaction with stress:

> You know, there's dopamine in the brain, and if you don't have enough of it, it wouldn't be more harmful in the future if you didn't have somebody be abusive, or you could see some other way of getting over it, around it...[so, if you're abused] you become incapable of overcoming it.

In summary, the Chamorro informants expressed a wide variety of explanatory models of their own and others' psychiatric difficulties. Many expressed these theories in combination, although not explicitly, as in the diathesis-stress model. For example, Joseph (003) and Jesus (004) cited both substance abuse and witchcraft; Marian (011) mentioned alcohol abuse, domestic violence, witchcraft, and brain dysfunction as playing a role; Carmen (006) discussed both stress and birth trauma; Susan (014) listed both substance abuse and early childhood experiences; John (012) cited several types of stress and substance abuse. Although few informants integrated these various factors into a coherent theory, each informant appeared aware of one or more influences on their mental health.

There are two important insights to be gained from the previous findings on Chamorro schizophrenics' understanding of their mental health difficulties. First, the level of complexity and awareness evident in the informants' responses to the question of what factors were responsible for their difficulties is highly notable. I had been warned by mental health professionals that I would have a challenge eliciting responses to those questions; the implication was that individuals diagnosed with schizophrenia are unable to reflect on their own experiences. Comments made by Joe V. reflected this belief. He portrayed schizophrenic individuals as people who do not have a full understanding of their life problems:

> They don't really have scientific knowledge. They believe the person did something to offend the spirits, or their parents did. Now they're the bearer of misfortune...Your testes may become enlarged, you may get lost, or go crazy.

This attitude was contradicted by the interviews. The informants offered very insightful explanations; most informants seemed to have a clear sense of the factors that contributed to their problems. This suggestion may have important implications for mental health treatment for schizophrenic individuals, perhaps regardless of culture. When one assumes that schizophrenic speech is meaningful, and that these individuals are often able to reflect on their own experiences, an insight-oriented approach to "talking" psychotherapy becomes a viable option. Suggestions for such an approach, along with a discussion of relevant literature, are outlined in the next chapter.

Second, similar to the findings on psychotic symptomatology, the explanatory models offered by the informants were remarkably similar to those one would expect to find from North American individuals. Most informants discussed theories that Western mental health professionals would use in a clear, insightful manner: diathesis-stress, stress (abuse and trauma, early childhood experiences), substance abuse, biological factors. This is consistent with Kleinman's (1978) suggestion that culture exerts a significant influence on the categories used to understand and respond to illness. The informants were members in the Chamorro culture, one which has been influenced by Western values and beliefs. In addition, the informants were members of the Western mental health culture, as they were receiving treatment from primarily Western or Western-trained mental health staff. Experience in both of these cultures likely changed their explanatory models from traditional Chamorro understandings to more Western ones. This finding also has implications for mental health professionals working with schizophrenic individuals. For example, since the most common attribution offered by the informants was external stress, the diathesis-stress model may be a helpful way to conceptualize their mental health difficulties. In particular, it might be beneficial for a therapist to help her or his schizophrenic client find a significant stressor to explain their

difficulties. According to Kleinman (1978), when there is conflict between the practitioner's and the client's explanatory models, where there are significant differences between conceptions of what is wrong, and expectations for and goals of treatment, the client may refuse to comply with treatment recommendations, and treatment may be ineffective or inappropriate.

However, it is important to note that there were few references to any culturally-specific explanatory models of mental health problems; there were only three references to witchcraft as partially responsible, and no mention of other cultural concepts such as *taotaomona*. There are several possible reasons for this finding. First, it may be that informants did not wish to express belief in cultural concepts such as witchcraft and *taotaomona* to a Western mental health professional. It is possible that, since they knew they were being interviewed by a Western mental health researcher, they offered responses with which they thought I would be familiar and comfortable. Second, it may be that Western mental health models have replaced the traditional explanatory models of psychotic behavior, especially in those individuals who have also been exposed to Western mental health services. Therefore, the next section examines the informants' attitudes towards these traditional Chamorro concepts.

Attitudes toward Traditional Beliefs

The focus of this section is attitudes toward three traditional Chamorro beliefs: witchcraft; the *taotaomona*, or ancestral spirits; and the *surohanos*, or traditional healers.

As stated earlier, three informants believed strongly in the efficacy of witchcraft, and stated that their mental health problems were a result of curses or spells. When others were asked their attitudes towards witchcraft, there was variation in their responses. Jack (016) stated he believed in the power of witchcraft: "it is true, eh, that it can be done. Folks who

don't like you can put a spell on you." Two individuals, however, Sharon (017) and Roy (018) stated that they did not believe in witchcraft:

> That's make believe. That isn't reality. (Sharon, 017)

> That's not real...I don't believe in that. The Lord is the one provider for us. (Roy, 018)

Rod (007), however, expressed a conflicted opinion. He saw a belief in witchcraft as delusional, yet also admitted to sometimes believing in it himself:

> ...right there is the delusionary nature of the person who may have been through problems in the past that causes them to do harm to themself...and I have those feelings too, and sometimes they're hard to overcome. You think it's for real...Sometimes I get angry at Jesus...but I say, "man, Jesus, I don't get you, you know,"...but then I think it over and I think that they use that sort of way of witchcraft because...they just hang up themself...I don't think that [curses] even works. I don't think it really works but the person who thinks that way really needs help. He really needs help, you know, because that person could be mentally stuck.

Attitudes towards the *taotaomona* were similar to those of witchcraft. Four informants expressed strong beliefs in these ancestral spirits, one did not, and three were unsure. Three informants provided excellent descriptions of *taotaomona* as spirits of ancient Chamorros:

> A lot bigger than you or me or anyone. And they cut their neck off with a machete. If people bother them they just, cut it off...They cut their own necks. But you make them mad and they'll cut your own neck off too. My mom says they don't like to be bothered...That was when the ancient Chamorro people were here...She said two thousand years ago the ancient Chamorro people were our people because we speak their language...These are ancient Chamorro people who lived in their home almost that long. They called them *taotaomona*, because *taotaomonas* are not here anymore but they still have a little bit because they're trying to tell their people that other people shouldn't be in our home because they're telling us how to run our home, not their home. (Carmen, 006)

> The *taotaomona* are just a beast...that...people want to make themselves disappear, or in every way possible want to make him do one of your things in so many ways...that's just a legend going back...You know what a legend is, just a game...but that's not the true *taotaomona* here...The true tradition is that *taotaomona* are souls, they were just from ancestors from way back. (Rod, 007)

> If you do some things you're not supposed to do in the jungle, like go the bathroom, because that's their place, and they don't want nobody doing that in their place. So if you go through there, they can put a curse on you. If you pass by there, that's their own place, and they like their own place, and if they see you there and they don't like you, they will do some things to you, or do you a favor. It all depends...because they might let you go inside, or they might not. It's better to ask than to not ask. (Jack, 016)

Jack's comment also illustrates the attitude of 'playing it safe;' not quite believing but not wanting to risk angering the *taotaomona* by not believing. Two other informants expressed this attitude:

> They want to believe in the *taotaomona*, they want to believe in witchcraft, or something like that, I mean, sure...I believe in those things sometimes myself. Sometimes they have the same interpretation I do, because actually what you're thinking is from other people's knowledge. (Rod, 007)

> I don't know. It's kind of funny, but maybe, I don't know. I don't know, it's kind of funny 'cause I sort of thought I saw a tall man when I was a little girl (laughs)...[some kind of spirit?] Yeah. But, I don't know if that's true or not. I don't believe in that. (Francis, 005)

Despite her confusion, however, Francis goes on to recount a story of her relative having contact with the *taotaomona*:

> ...my niece, when I was living with my sister, every night at twelve o'clock you'd hear knock, knock, knock, on the second story, look out on the balcony, nobody up, nobody down. Open the door and no one was there. So I don't know. It happened every night. I don't believe in that.

Susan (014) was the only informant who clearly stated that she did not believe in *taotaomona*:

> I don't really believe in that. I don't know how to say that. I don't believe in *taotaomona* either. *Taotaomona* could be just a shadow of a tree standing there or the sun shining, making things look very shiny.

Esco, on the other hand, was very adamant about her belief in the spirits: "the *taotaomona* wants me, but I didn't listen to him. When I'm sleeping, they surround me."

Attitudes toward *surohanos* were also similar in their variation. Two informants, both Saipanese, had used the services of a *surohano* and found them helpful with their symptoms:

> I had gone to four witchdoctors. I paid them, I spent around fifty thousand dollars just to get them to cure me. And it happened that they died before they could cure my sickness. All four of my witchdoctors had died...They did help me, but not as much as they could. (Joseph, 003)

> Yeah [I found them helpful]...They gave me medicine. (Jesus, 004)

Erica (013) and Sharon (017) reported that they believed in the powers of a *surohano*, although they had not used their services to aid in their mental health problems. Erica stated: "I know some you go to for make you pregnant, with Chamorro medicine." However, although her father was apparently a *surohano*, Sharon maintained that most people, except those in poverty, seek Western medical treatment for most physical ailments:

> A *surohano* is a doctor in ancient times. They use it now especially to get pregnant. But now everybody goes to the hospital. Even the *surohanos* go to doctors. If there's a dangerous delivery, they go to the hospital. For me, there's not much use for it....Some people go to *surohanos* because they can't afford the hospital. But it depends on each person you meet.

Two other informants reported having sought the services of a *surohano*, but were unsure as to whether or not they were helped:

> I don't really remember...they gave me a massage...But, I don't know. I don't know why. It's kind of weird. I went for something else but I forget what. (Francis, 005)

> ...they tried to cure me but they were scared because I went to a *surohano* since that I have a different uh, different life before...How could they? Because, if they did that, a lot of things would come out of me. (John, 012)

Francis appears to have some belief in the *surohano's* power. John's statement, however, may reflect some delusional thinking, and so is more difficult to interpret.

Marian (011) expressed her opinion that *surohanos*, or as she called them, witchdoctors, did not have healing powers. However, she had reported earlier that her mental health problems had been caused by the witchcraft of her sister-in-law. She stated:

> I don't believe on that. A witchdoctor, they call it. I don't believe in witchcraft and witchdoctors. You know what? For my opinion, for what I believe, that the

> good Lord will help me out, and will protect me...I don't believe on that. If something's wrong with me then I go to the doctor, the medical doctor.

In summary, attitudes towards traditional Chamorro beliefs were conflicted, with some informants conveying strong acceptance of these phenomena, others expressing disbelief, and others remaining confused in whether or not to believe. There also did not seem to be any consistencies across these three categories of beliefs; for example, those informants who expressed a belief in *taotaomona* did not necessarily express a belief in witchcraft. It appears that, according to these informants, one is able to believe in some traditional concepts, and yet be sceptical of others. Again, this lack of consistency and considerable ambivalence toward traditional concepts may be reflective of the acculturation process which the Chamorros have undergone over the past 300 years. The strong presence of and control from other cultures has led to this being a particular example of the "two truths" (Penningroth & Penningroth, 1977). Although they have retained the traditional concepts, the belief in these concepts, for many Chamorros, has weakened over time to the point of superstition, similar to many North Americans who refuse to walk under ladders, despite acknowledging that such an act does not cause bad luck.

Self Reflection

Since an understanding of the factors contributing to one's mental health problems requires a certain degree of self-awareness, this section offers a brief discussion of the reflections of some of the informants on their symptoms or their life difficulties. These informants not only offer insight into their own difficulties, but also provide the reader with an understanding of how they experience themselves and their symptoms.

Some informants shared their pain and frustration at having had some of the experiences they did. Marian (011) talked about the continuing cycle of problems; that despite her high level of functioning, she still experiences considerable distress:

> I'm still having problems. It doesn't go away. I don't know. I don't know how to explain this but my illness, I'm not mental, I have good common sense and uh, I could explain and I could talk about things, but I'm not mentally ill...But from there it carried on, off and on, it went on and on, off and on, off and on, on and off, you know what I mean. It goes back and forth, you know. It comes back, back and forth, on and off, you know.

Rod (007) shares his feelings of not being "normal" and his anger at his brother for the abuse he perpetrated:

> ...I feel like nothing in my whole aspect of life, you know. I feel like this monstrosity...it's like a monstrosity my brother put on me...it's very dirty what a person can do to you. It can ruin your outlook, I can't understand it.

He also describes the loneliness and alienation he feels as someone who has difficulty connecting with others:

> ...when I was living with my sister I was always running away from, a person has nothing going for them, they don't have much in common with the outside world....I isolated myself from the rest of the world. I'm not saying I'm antisocial...I just had a problem with my brother...He's a negative influence...I had injuries in my mind.

John (012) also shares, very vividly, the pain of having been subject to the delusions and hallucinations he experienced:

> ...what I went through is very painful. It's worse than being shot in the chest, worse than being shot with, on the lawnmower on the back, or something, it's worse than your tooth being removed without any painkillers, you know. Oh man, that's painful, the things I went through.

Two other informants revealed insights they had had about their symptoms, and their reactions to them. Rod (007) talked about what happens when he hears voices:

> ...if you have a monster thing...going on in your brain, you can't actually remember what they're saying, it's in you indirectly. A lot of it is something that you just listen to and feel that, you hear the voices saying, "you better watch out" or something like that. It's saying something like what you're saying in your mind...what you're thinking, talking about. I think it's only talking in your brain, the talking belongs in your mind...I don't know exactly, I can't read minds.

John (012) shared his insight into why he occasionally experienced hallucinations:

> ...sometimes I get this feeling like I'm going to go back into hallucinations because nothing much is happening, you know. I just talk to myself.

In summary, several informants offered vivid images in their narratives about their experience; their affect and alienation, and how they understand their symptoms. As mentioned previously in the discussion of the informants' explanatory models, their degree of insight, and their ability to so profoundly reflect upon their experiences was remarkable. These findings provide support for Western-trained psychotherapists conducting insight-oriented therapy with schizophrenic individuals, as they suggest that there may be some benefit to this type of approach.

Attitudes toward Treatment

Another goal of the present study was to explore the Chamorro schizophrenics' recommendations for useful mental health interventions. Since all of the informants were involved in the mental health system in some way, themes began to emerge about their attitudes to these interventions. In general, there were mixed reviews about the various forms of psychiatric treatment they had received: inpatient care, day treatment, and medication. This section examines each form of treatment separately, outlining positive and negative attitudes to each.

Inpatient hospitalization. All but one informant reported having been hospitalized at some time in their life. Four informants reported that they found inpatient services helpful. Joseph (003) believed that being in hospital relieved him of his symptoms:

> ...it was helpful because...the way I talk now and the way I was before they're so different, quite different...now I believe that I am cured. I cured myself in the hospital by cooperating with others to make my life well.

Francis (005) did not like being confined, but realized that it provided her with the rest that she needed in order to feel better: "Yeah [it helped]. But I hate being admitted. I hate being locked up. But it's worth the rest." Jack (016) also reported that inpatient services helped

him, despite a reluctance to be admitted, as it kept him away from a stressful home environment:

> I didn't want to go into the hospital. I didn't want to but he turned me in...[it helped because]...Staying away from my parents and my brothers and sisters. (Jack, 016)

Other informants were vehement in their dislike of inpatient hospital services:

> No, I don't like it. (Joaquin, 001)

> When I came to inpatient they treated me very rough. Everything was third degree under orders and commands...They were pushing me around, and telling me what to do...I hated the nurse and doctor for their administration. So I just couldn't do any better than that. I had a terrible time...Those clients, they were all begging, and they were all yelling, and screaming. It was abuse of the patients. (James, 008)

> It's not really helpful because the things that I was doing before, like working, I need to work, and I get a lot of money just for helping. It's not really helping, it's working, doing things that need to be done...How come they admit me and put me to bed and everything and tell me how I should run my life, like I can run my life better than them...I don't like them knowing my business... (Roy, 018)

Although Joaquin was noncommittal about reasons for his dislike, James and Roy were quite specific. James did not like the degree of control exerted by the hospital staff, whereas Roy believed that by being hospitalized, he was missing out on valuable work activities. Roy also raised a point about staff confidentiality. This appears to be a valid concern for individuals in the mental health system in small communities such as Guam or Saipan, where one is bound to encounter a relative at some point in her or his involvement.

Carmen (006) expressed conflicting attitudes toward hospitalization. When asked about her experience in inpatient treatment, she stated:

> Not too good either. You can't get out until they let you get out. It's like a prison...It's a scary place. They might punch you or hurt you or something. I didn't like that. That's why I told my social worker that I wanted out.

However, she did say that the food during hospitalization was helpful; "[was there anything that helped?] Well, just getting fat. They feed you lots of food."

Day treatment services. Day treatment services received a much more favourable response from informants. Six individuals believed that the day treatment program was helpful because it kept them occupied during the day:

> It's more helpful than pacing at home and thinking about...dwelling on, putting yourself down in some way, keeping things inside. (Rod, 007)
>
> It's very nice for people that are taking medication that they do not have anything to do, instead of just staying home and taking your medication...If they stay home you'll get all those things in your mind, what happened in the past, bring it back. If it makes you mad in the past it will still make you mad in the present if it comes back. And that's not good...It keeps your mind occupied. (Susan, 014)
>
> Stops me going out and partying. (Jim, 015)
>
> I don't get in trouble. (Jack, 016)
>
> It gave me something to do, something to occupy my time. (Sharon, 017)
>
> ...it's better than nothing, yeah 'cause you get to have something to do. (Roy, 018)

Five informants appreciated day treatment because they were able to work and generate an income which would not interfere with their social security payments:

> I like it...I've got a good job...You got a job and some money for your plans. (Elaine, 010)
>
> I like to work. I like to make money. (Erica, 013)
>
> ...to me it's like coming to a job every morning. I look forward for these things to do every day of the week, five days a week. (Susan, 014)
>
> It's alright. I mop. I clean. At first I don't know what to do but when they told me what to do then that's what I kept on doing. (Jack, 016)
>
> ...here is helpful because, yeah I could work outside but I'll stick to this thing in here. (Roy, 018)

This finding supports the literature which suggests that one factor in a less industrialized culture which contributes to a better course and outcome for schizophrenic individuals is occupational support. Authors such as Cooper and Sartorius (1977) (see also Lin & Kleinman, 1988; Warner, 1994) suggest that employment in less industrialized cultures tends to be less stressful for schizophrenic individuals; work roles tend to be assigned rather than awarded based upon performance, and work duties are integrated with daily life. In general, this may be more true of Saipan than Guam, since on Saipan, farming is a more widespread industry, and family members may return to work on the family farm. In particular, the work environment described by the attendants of the day treatment program appears to fit with this description.

Two informants revealed that they enjoyed being able to eat at day treatment:

> Sometimes I like a soda, or an ice tea. I need that, sugar and ice tea, because I put ice in it to fix it and make it nice. I like that. (Erica, 013)

> I think day treatment is good for me, we have fried chicken and rice, and spinach, and some cantaloupes, milk and juice. (Susan, 014)

Francis (005) reported that she enjoyed both the socializing and the work aspects of day treatment:

> Oh, it's ok. It's kind of crazy in there but (laughs), it's entertaining...They're funny (laughs)...socializing, and therapy. I just come here for the money, and entertainment. That's all I come here for...'Cause I'm on social security so I can't work outside the hospital. I could work, but that's going to affect my cheque and everything...Then I won't be making money at all...But I also got this thing about being stressed out...I've tried it [working outside the hospital]. I got sick. I got stressed out.

James (008) stated that he found both the staff members and the stability of day treatment helpful:

> That keeps up the, what I would say right now is when I stay here long time, because you have a whole regular sense of self, which I need...but I have a very strange thought about my case manager. He's obviously superior...He's superior. And if I do something really mean, he can tell me to go home and I

> will. I am confident in him, he is kind, he is kind...But my case manager is superior and he helps...He's a good person, he stands out above them all.

Marian (011) also enjoyed the work aspect of day treatment, but also mentioned therapy as being helpful:

> ...the day treatment program is a very good, uh, influence because, it's a very good...therapy, that...keeps our mind occupied, it gives us a job...it's like a family you know. We have our group therapy, and all these types of things, job programs.

Esco (009), who did not attend day treatment but visited regularly with her case manager, said that she found it beneficial to have these meetings because "she helps me, tells me things."

Two informants stated that they did not find day treatment very helpful. Carmen (006) reported that she did not like day treatment because it prevented her from being with her family:

> I want to get out of here but I've been breaking my treatment plan and I can't do it. When I cannot do it I break it 'cause I don't like to stay here. I just like to be with my family, and my brother's family, and my brothers and sisters.

Sharon (017) did not come to day treatment, but was unclear about why: "now I don't come for day treatment anymore. I have a hard time coming. I feel really ill and sick sometimes. I like to feel good a lot. I enjoy feeling good."

Elaine (010) and John (012) were ambivalent about day treatment. Elaine stated, "it's helpful but, they get mad. They keep sending me for one to get better. I can't understand why." John appreciated having a person to talk to, but did not like putting himself in a position where others know information about him:

> It hasn't helped me a lot. I just stayed the same. Maybe talking to somebody helps a lot. Talking can do a lot of help, eh, being pushed or being forced, you know...to my social worker...it's not that they help or something, then I get frightened about people getting violent, talking about me when it's none of their business whatever I do or whatever I think.

Along with Roy (018), as mentioned previously, John raises a concern which had been echoed by other Chamorros with whom I came in contact. A student of mine conducted a survey asking Chamorros who they would rather have as a therapist: a Chamorro or a Mainland American. Almost half of her sample reported a preference for a Mainland American, because that individual would be less likely to know their family. Maintaining confidentiality in communities as small and close-knit as Saipan and Guam is apparently a difficult prospect. It is a strong likelihood that when someone seeks mental health or substance abuse treatment, she or he will come into contact with a relative or friend - therapist, administrative or maintenance staff, fellow client, etc. It is also likely that, even if one's therapist is not known personally, she or he knows the client's family. In addition, confidentiality of session notes is difficult to ensure. According to a mental health professional on Saipan, while therapists may be responsible in maintaining confidentiality, hospital forms circulate through many departments, past many staff members, who may not be as responsible. This finding suggests that when conducting psychotherapy with individuals in a close community, issues of confidentiality should be addressed in order for trust and rapport to be established.

When asked about what improvements they would like to see in the day treatment program, eight informants had suggestions. Three individuals recommended more 'talking' therapy:

> What could help me? I'd like to talk to somebody, somebody, a compassionate person, somebody I want...What you need is somebody special in your life, something like that. (Rod, 007)

> I may have problems but we do all have problems but, you know, I'm trying to solve it and I'm trying to talk about it because you get it out of your system, you know, because every time it comes to your mind, the memory you're having, the problem that you went through, you know, sometimes, you feel depressed, you don't want to eat, you don't want to drink, you don't want, you know, you just want to smoke your life away if you're a smoker... (Marian, 011)

> Observation. Staff observe patients...They could come to me and listen to me. (Sharon, 017)

Two other informants mentioned a lack of transportation for many mental health clients as being a problem:

> ...that's a problem, I don't have transportation. Last time there was a meeting and I happened to participate in the meeting 'cause I had a car. (Joseph, 003)

> I don't always get to go because I don't always have a ride...Every day I come here, before, but now if I don't have ride, I can't come. So I just stay home. (Erica, 013)

There were also other suggestions. Joseph (003), who was a member of the Mental Health Planning Council on Saipan, talked about the need for supportive housing for mental health clients where they can learn daily living skills:

> ...there's places for the patients to stay when they release themselves...and learn how to like it...When they leave, the patients want a quiet place. It's good for them to live by themselves so they can learn how to live, how to eat, how to cook, how to clean themselves.

John (012) spoke of difficulties in finding a job outside the hospital for former psychiatric patients.

> ...but you know why I never go out and look for a job? I read a lot of books and I'm very intelligent and above average kind of mind, and when I go out there and look for a job, they say don't call us, we'll call you. You know, I don't like that kind of attitude. When I go there, and they fire you before they hire you. I don't like that.

Francis (005), who stated earlier that she enjoyed the social aspect of day treatment, wished there were more "high functioning" people with whom she could socialize.

Psychotropic medication. Since all informants were involved in the mental health system, all informants were on psychotropic medication. All but two informants found that medication was helpful in reducing their symptoms:

> I decided that it was because I kept feeling the solution from the medication. (Joseph, 003)

> I went off of it before and I got real sick. Almost the same way as when I first got sick. (Francis, 005)
>
> It helps me clear my mind up. (Carmen, 006)
>
> I find release on this medication. It makes a good day. It plans out a whole day for yourself. It allows you see what is real, but only what is safe. It helps you to sleep whenever you need to sleep. (James, 008)
>
> It helps me standing, and sometimes thinking. (Esco, 009)
>
> ..because I just come here to take my medicine...It's very good. When I do things, I'm shaking too. The medication, it stops it. (Erica, 013)
>
> ...it's helpful. If I didn't take the medication to help balance my whole system. (Susan, 014)
>
> ...[the medication is] stopping the voices. (Jim, 015)
>
> ...it relaxes me, makes my body relaxed. Not like before, I'd be tight, glued tight. (Jack, 016)
>
> It helps me become better...It helps me to talk. It helps me to feel better. At first it didn't help, but gradually it made me feel better. (Sharon, 017)
>
> ...it was helpful because it got me under control... (Roy, 018)

Marian (011) and Roy (018) expressed ambivalent attitudes towards medication. Marian believed it helped her control herself, but found the side effects disturbing:

> ...it really made my brain, like it was going to blow up, you know. So, over time, for the first time in history that I've took, you know, it really changed me to some kind of uh, hard person that can't think too good...It got me bloated, like 300 pounds, I couldn't get up in bed.

Roy, as well, thought that the medication "got [him] under control," but later said he was not sure why he was taking it. He also pointed out the contradiction between taking prescription medication but being told not to take illegal drugs:

> I need it, but I don't know why I need those things. But now, I know now why I need those things, I don't really need it, to be honest with you. I don't want them messing with my body. I always carry that piece of paper, "drug free" right, I'm a drug free person, right? But yet they make me take their drugs. They force me to take it...I don't know how it's going to help me, when I think about it.

In general, the informants expressed a positive attitude toward the treatment they were being offered. They seemed to particularly enjoy having a place to go where they could work, and where they could get their minds off their problems. However, it does appear that at times, some informants wish they had a person with whom they could talk in depth about their problems. This finding again supports the potential of "talking" therapy for individuals with schizophrenia. However, the possibility that these responses were, in some part, due to social desirability must be considered. It may be that the informants, when asked about their attitudes toward treatment, offered responses which they thought were appropriate, particularly as they were speaking to a Western mental health professional. Given the existence of the "two truths," it is possible that the informants held two truths about treatment: the Western truth is that medication, day treatment, and psychotherapy are helpful, whereas the Chamorro truth is that medication, day treatment, and psychotherapy are necessary because the mental health system says they are. It is also possible that the "two truths" phenomenon was less influential than "false consciousness" (Lather, 1991) - that experience in the mental health system has convinced the informants that the treatment they are offered is beneficial to them. At this stage in the research, the effects of social desirability are difficult to assess, although they may have been reduced had the interviews been conducted by a Chamorro individual with no mental health affiliation. However, given that there were some negative attitudes offered to which I conveyed a belief and respect for their expressed views, and that I was presented to the informants as someone from Canada conducting research with no connection to the local mental health system, it is hoped that informants were being as honest as they could be in their responses.

Attitudes toward Family

One of the purposes of the present study was to investigate whether the Chamorro culture offered variables, such as extended family support, which had been shown to ameliorate the course of schizophrenia. One of the characteristics immediately evident in any discussion with Chamorro people about their culture is their emphasis on the extended family system. The Chamorro population on Saipan and Guam is relatively small, so most Chamorros know each other, and it appears, at least to an outsider, that many are related.

There are several large, prominent families who hold positions of power on the islands, and people with particular surnames are treated with respect, although this respect is sometimes not genuine. For example, on Saipan, there is one particularly powerful Chamorro family: there are family members in the local government, and many stores and businesses are owned by this family. It is accepted by most people with whom I came in contact that one should be very careful in dealing with members of this family. One of my students was the daughter of a powerful politician, and when I had to make the decision to give her a failing grade due to lack of attendance and incomplete course requirements, I had to seek the advice of the Chair of my department on how to proceed. He agreed that to fail the student was a risky proposition; if the student had had a different last name, neither of us would have been concerned. The bottom line was always, "you don't want to alienate someone from that family." We agreed to give her a failing grade, with the understanding that it would be changed to an "Incomplete" should she contact myself or the Chair.

This emphasis on family name also contributes to an atmosphere of what North American's might call nepotism; however, from a Chamorro perspective, preferential treatment of members of certain families is not considered a negative act; rather, this perspective holds that when people reach a position of power in the Chamorro culture, they want to surround

themselves with others they know they can trust and who will be loyal. Chamorros often seem to rely on their powerful family members for favors and inside information. My prospective supervisor at the Division of Mental Health often spoke of his brother in the Commonwealth Legislature when we discussed immigration and labor laws under consideration by the government, the Division's budget concerns, etc. One of the Cultural Consultants was related to the Governor of Saipan, and offered to contact him on my behalf regarding my work visa difficulties. I even found myself asking people if they had any connections in the various organizations I became involved in if I needed some information or clarification.

The importance of family was also evident from casual interactions with Chamorro people. Connections, that is, who you know and who your family is, were a very important aspect of introduction. Stating who your relatives are was a way of orienting the other person to your social, political, and economic standing. This reference to family name is also a way of establishing trust in a new relationship; if I know your father and your cousin, and you know my brother, then I know that I can trust you. This presented some difficulties for me as an alien with no relatives on island. People were far more trusting when I could mention that I knew someone who was their family member or friend. For example, when I met with the Director of Labor, I mentioned that I had spoken previously with his cousin, who referred me to the Director himself. At other times, particularly when I recognized a last name of someone I was meeting for the first time, I attempted to ascertain whether they were a relative of someone I knew. In such a small, family-oriented community, this is an acceptable behavior. In my experience, there was almost always some family tie between people with the same last name.

There were other ways which the importance of the family was evident in my interactions with Chamorro people. These people appear to place their family above all else in their lives, even their jobs or school. One Chamorro man told me that he had had conflicts with his White supervisor because he left work early one day because his relative was in a car accident. Another woman told me that her partner placed his family and their relationship above his work duties; there were occasions when he would miss work because he was asked to do something for his family, or something was needed at home. When I taught the psychology courses for Master's students, many of them complained of the workload, stating that once they came home they needed to spend time with their families, particularly their children.

The boundaries of the family unit appeared very different from the typical North American family. There were often siblings, step or half siblings, cousins, aunties and uncles, all living in the same house, with all adults assuming care for the children. In fact, one individual told me that his brother gave his sister their newborn son, since the sister had all girls and had wanted a boy. Often, if a young girl has a child out of wedlock, the child will be cared for by grandparents, aunties, etc. The child may go to live with other relatives for either a definite or indefinite amount of time. According to some of my students, there is really little need for a formal adoption service, as children may be sent to live with various relatives, rather than being adopted by strangers.

The importance of extended family was reflected in the nature and quantity of rituals and celebrations, where attendance is expected for all family members. At Christmas, for example, Chamorro families participate in *novenas*, which take place each night for nine days either before or after Christmas day. I attended several such novenas given by my landlord

and his family, where the entire family gathered at my landlord's brother's house. There were at least 15-20 children present at these novenas, and usually as many adults.

Therefore, the Chamorro people, although undergoing a period of rapid social change, appear to have the characteristic emphasis on extended family that is evident in many nonindustrialized cultures. However, there are signs that this is changing somewhat in the Chamorro culture. Many students leave the islands to study at American universities; many Chamorro individuals marry people from other cultures and may leave island. Some of my students reflected to me that the younger children and adolescents are less interested in the large family gatherings.

This view of the solidarity of the Chamorro extended family unit was at times in conflict with the reports from the Chamorro schizophrenic informants. Although many reported that their family had been supportive and encouraging throughout their experience with the mental health system, others reported abuse and rejection.

For many informants, there were several different types of support offered by family members. A few individuals stated that their family gave them financial support:

> They give me money. (Joaquin, 001)

> They've given me a lot of money. Before I was put on welfare and medicaid, my brother had to pay all my bills. In less than one month, I owed the hospital $9,000, and my brother went ahead and paid it. (James, 008)

> All they do is get me welfare, get welfare and food stamps...she gives me money. Sometimes when I got a lot of money and I don't know what to do with it I give it to her to pay the electric bill and water bill. (John, 012)

Others stated that their family provided them with emotional and practical support:

> ...they were actually impressed with my reaction, when I first had the mental problems...they weren't worried. They weren't worried because they knew I'm doing ok. I'm doing fine...When I came back they cooked food for me, washing my clothes...they were very supportive...they cook, they wash my clothes, put things out...My family...admires me that I've found a place for me to hang around. (Joseph, 003)

> ...they always encouraged me to stay away from drugs, to stay away from those people...They do support me...And my mother and my brother every time I see them, there was this terrible look on their faces. They would be crying in their faces. (James, 008)

> ...they don't treat me like a retarded person, they don't treat me as an ill person. They treat me as a normal person, regular person and uh, they treat me as a special person...my family never let me down, my family never, no they never did. They never hurt my feelings. They always asked me, do you need anything at the store, do you need anything, do you need help, do you want this and that, do you want us to find you an apartment... (Marian, 011)

> Me and my sister, we'd help each other out. If we need money, we'd help out each other...They say it's up to me right now, because I'm on my own. It's not like they don't care, but they want it to be up to me. My sister, she just says, be good work and don't be stupid and get fired or whatever. (Jack, 016)

Other informants revealed that they found their family to be unsupportive. Jesus (004) reported that his family reacted in anger, as well as set limits on his behavior:

> They got mad...just my brothers. I'm against my father. Even my mum too...We usually fight...I can't stay with them...[they did] not let me drink beer.

Some informants stated that they felt rejected and mistreated by their parents:

> My family treats me like shit...when I was really really sick, mom and dad were talking, and I did something and he said, "that's your daughter" and she said, "no that's your daughter." Like they were disowning me. (Francis, 005)

> They think I'm the crazy one. That God did this to me, all my kids think that. And they say "Mama the crazy one," I take that one to heart. (Elaine, 010)

Jack (016) described feeling both mistreated by his parents and betrayed by his sister for admitting him into inpatient services:

> ...he'd get pissed off, my dad. He'd find a way to get at me. I'd have to stand still and go with my mom, because my mom protects me more than my dad. If I'm bad and my dad shows up for dinner, I hide behind my mom, because he knows I did something bad, and whenever I did something wrong he finds a way to get to me, before, my dad...my sister admit me because my mom just died and my dad. They thought I was gonna get at her daughter, because she just gave birth. So she wanted me away from the daughter...because she was just newborn. So she took me up there and I stayed for two weeks. She admitted me out...she turned me in 'cause she thought I was gonna do something.

Others revealed that their family was supportive in some ways, yet unsupportive in others. Rod (007) found that some family members tried to be supportive, but found it difficult:

> ...when I was in Guam, we had...family members who...weren't like they were your flesh and blood...they wanted to make things like, but they weren't able to complete what they were trying to emphasize, you know. Because it's hard for them too, and then, they tried it out but then, it didn't work. And that's probably what happened to me, I'm just a complete joke to this family member who hurt me very much, you know, the family...Like my sister...when she got the wrong interpretation about me, you see, and she was...too fast for me to even understand why she was considering me this way...then all of a sudden, she found out that I'd been abused, it made her realize something, she never really knew about that...They [my parents] got upset [when I was put in hospital]...They take everything, they weren't there for me anymore. They don't care what I have to say. And that made them feel that they weren't a part of me anymore.

Elaine (010) displayed considerable anger towards her brother, and yet found them encouraging at one of her accomplishments:

> I don't want to interfere with my brother's family [gets angry]. They don't want me to fucking visit them or what. When I visited them one time, he took the gun and pulled the gun. He started to look for me, I hid in his shed...They're proud of myself 'cause I got a certificate, for three years.

Several informants discussed their history of abusive family experiences during the interviews. Four individuals reported being abused by their extended family:

> They beat the crap out of me when I was growing up...They never had patience with me when I was growing up, so I didn't have patience with nobody. (Francis, 005)

> My sister had long nails, like Diana Ross and the Supremes, not twisty like hers but long, and she went and scratched my face and there was blood running down and they had to bandage me. (Carmen, 006)

> Because my brother would actually attack me, you know. He would actually attack me when I was a kid. You know, you would just be like, he was giving you suffering, but instead he made you live, and say "ha ha ha, I made you like this." (Rod, 007)

> My uncle, he had a bad temper because he has an ulcer. I used to stay with him in 1988 through 1990, I used to stay with him then I had to move out...But,

> he had a bad temper. He punched me one time, right there, he took a strike at me and I almost turned him in to the police...we always fight sometimes. You don't know what your brother's up to, sometimes he'll strike in the back, because you're not doing your job, you're playing around. (Jack, 016)

Two female informants revealed that they had been the victims of domestic violence. Mary (000) stated, "my husband used to beat me up all the time. My children aren't his so he used to abuse me." As mentioned earlier, Marian (011) also complained of physical abuse from her husband:

> ...he tried to shoot me, with a gun, not shoot me, but he stabbed my back with a knife, and then he uh, and I had him put in jail, you know, I pressed charges on him...he threatened me with a gun, he choked my neck with a gun.

In addition to a lack of support and even abuse, a few informants spoke of the shame on the family of a mental health client. Francis (005) reported that she was aware of the shame she brought to her family, and how she avoided seeking treatment because of that shame:

> I think they could care less. They thought I would embarrass them. But I did embarrass them...that's how they feel, and I feel. But they feel that way so it makes me feel that way. That's why I didn't go for treatment for four years, until it got real bad.

Rod (007) revealed his shame for having the problems that he does, and his shame for the abuse his brother perpetrated:

> I like living very useful in many ways, but...I don't want to face up to a lot of things in life...Because of the shame that I feel...I cannot face the way how I'm supposed to face a person honestly and straight and forward and respected. It's very hard for me...It's like a monstrosity my brother put on me. Things like that, "oh, you're so sick in the head,"...but, you think, "you're not so sick in the head, you're better than that." You know, you think that but it's very dirty, it's very dirty, what a person can do to you. It can ruin your outlook, I can't understand it.

John (012) also reported feeling ashamed of himself for having had the experiences he did:

> ...when I found out I was so young knowing about everything I got ashamed, you know, feel guilty. I was ashamed about myself because I was so young

> and I wonder how could that be, you know. The one thing that's normal about it is that it almost killed me.

A sense of shame of mental health difficulties has been shown to be prevalent in nonWestern cultures. According to Gaw (1993), a label of mental illness in the Chinese American community brings shame upon the entire family, and raises concern about family members and their children. Shame is, therefore, a factor which often leads Chinese Americans to attempt to manage a family member's disturbing behavior within the home. Often home management includes such as measures as isolation or seclusion in her or his room. This reaction has also been found in Japanese Americans (Fujii, Fukushima, & Yamamoto, 1993), and Filipino Americans (Araneta, Jr., 1993); these are groups which maintain their ethnocultural values while acculturating to American society. Joe V. suggested that because of family shame, the process by which Chamorro individuals come to seek Westernized mental health treatment in Saipan is complicated:

> Most people seek local healers. Not as many people seek psychiatric help, just local healers. Many people with mental illness are kept in the house at the back, after many times of seeking help with a surohano. Then they're given to us so we'll take care of it. Then they see the psychiatrist, only if the person's violent.

In general, there was considerable variation in how informants perceived the reactions of their families to their mental health problems. Although many reportedly received financial, emotional, and/or practical support from extended family members, others reported feeling unsupported, abused, betrayed, and ashamed. It would appear that although there are many positive aspects to a culture with a powerful extended family base, there are also potential negative aspects. While the family may provide support in many ways, it may also function to shame and pressure the individual and protect more powerful family members, particularly with respect to incest and physical abuse.

Chamorro Attitudes toward Mental Illness

As several studies (see e.g., Sartorius, Jablensky, & Shapiro, 1978) report that less industrialized cultures appear to have more favorable attitudes towards individuals exhibiting bizarre behavior, it was of interest to explore the stigma toward people seeking mental health services in the Chamorro culture. This section outlines several comments made by informants on Chamorro attitudes toward mental illness and mental health clients. Although not every informant shared her or his views on the topic, there are several quotes which are particularly relevant.

Francis (005), who spent considerable time on the U.S. mainland and offers several insightful comments on mental health issues, describes the stigma which accompanies a diagnosis of schizophrenia. She states:

> ...the people here think mental sickness only happens to the lower classes, you know what I mean?...I said to my father..."do you know there's a guy in the States who is a lawyer and is mentally ill?" And he said, "then what is he doing in mental health?"...They really look down on you in Guam, they really do...they don't look down on me until they find out that I'm mentally ill...They think you're crazy, and you're kind of put down there, you know what I mean?...I start looking down on myself when I find someone that I feel I can be friends with to go out with, but I have an inferiority complex, so I feel like I'm not as good as them, you know what I mean?...being crazy here on Guam is a lower class disease. So when they say it's hereditary, it's a lower class disease, and that means you come from a lower class family, you know what I'm saying?

Rod (007) also expressed perhaps an internalized sense of stigma as he explains his feelings about being a mental health patient, and his regret at being in his current situation:

> I'm not saying that I should put myself down in any way, because I'm really in a situation that is so undesirable...you don't realize that I couldn't interview someone like you in another place and time, but I tell you what, that doesn't mean anything, that doesn't mean that I want to take your tape, but that's an example where I would have been with myself in another place and time.

Joe V. describes the problems with labeling someone as mentally ill in the Chamorro culture, although there may be fewer behaviors that contribute to the label than in Western cultures:

> It's disturbing for someone in a spiritual community that they are sick. Labeling is a problem...That is the most difficult part of Western thinking and here, but here, bizarre ways of thinking are more acceptable because it's not labeled.

Francis (005) discusses what she sees to be the difference between American and Chamorro views of mental illness:

> In the States if you say you're crazy because you took drugs they look down on you, but if it's hereditary they have more pity. But here in Guam, if you're crazy because of heredity they look down on you, and if you're crazy because you took drugs they have pity.

Joe V. was asked to comment on Francis's conceptualization of the mental illness-substance abuse distinction in the two cultures. He supported her comments, saying:

> Yeah, that's true. With drugs, you're taking it, it's a choice thing. If mental illness is heredity, then your parents must have done something bad, you're paying for it. It's a choice issue. It's easier to say "stop doing drugs, then the craziness will go away." That means something can be done. But if it's heredity, then nothing can be done, there's a lack of power to do something, except separation from these people, like maybe you can catch it, maybe it's in your family...if it was drugs, then it could be addressed. It was psychological, then they have no control over the person.

The suggestion made here that the substance abuser is less stigmatized that the mental health client raises an interesting point, as it is contrary to hypotheses in the literature. Lin and Kleinman (1988) argued that less industrialized countries attribute less stigma to individuals with mental health problems, because these cultures tend to use explanations which reduce personal responsibility. Industrialized countries, on the other hand, attribute more stigma to these individuals, as these cultures use explanations which emphasize personal responsibility. Chamorro culture, whose explanations of mental health difficulties do reduce personal responsibility, stigmatizes mental health clients for precisely this reason; if

there is little personal responsibility for symptoms (and perhaps greater family responsibility), there is nothing one can do to change the behavior. It is possible that this partially explains why some researchers (e.g., Hughes, 1993) suggest that less industrialized cultures do stigmatize their mental health clients; since they use explanations which point to family characteristics (such as angering ancestral spirits or genetics), the presence of a family member exhibiting bizarre behavior invokes the community's negative attitudes toward the entire family.

Lin and Lin (1981), in their study of Chinese Canadians, support this hypothesis. They offer several Chinese explanations of mental illness which reduce personal responsibility and therefore contribute to the development of stigma. These explanations are similar to those of Chamorros. In particular, Chinese Canadians believe that mental illness is a sign that the ancestral spirits have been angered by family members not following family rituals of ancestor worship; they also believe that mental illness is caused by genetic defects. According to Gaw (1993), "the stigma implies that misconduct and/or deficiency has occurred in the family and that family members have failed to guide, exhort, educate, manage, or provide for the patient--and, therefore, that they are deserving of shame" (p. 254).

Francis (005) offers suggestions to reduce the stigma associated with mental health problems:

> More education. But you know, I tell you one thing, I could go out there and preach that mentally ill people are less violent than you know, you know what I'm saying? But then I could turn around and stab somebody (laughs).

Joe V., however, cautioned against taking a strictly Western approach to public education on mental health issues in his culture. In order to change current attitudes towards individuals with mental health difficulties, he emphasized the need for a culturally sensitive approach:

> You need to do this without giving up the cultural perspective on mental illness, present mental illness as a disease as well as spirit possession, make it more clinical so it is viewed as an illness, so there will be less stigma.

When asked about support groups for families of mental health clients, he responded:

> That wouldn't work out here. There is the feeling that you don't air your dirty laundry in public. AA is a haolie [Mainland American] group. Groups here, if they are going to work, have to be completely local, no haolies or they won't come.

He recommended one particular culturally appropriate approach to public education:

> I was suggesting trying something that the politicians do during elections, called pocket meetings. They take a section of every village, then invite their neighbours and give them the opportunity to discuss issues, usually political issues. This may work also for mental health issues. It's less threatening because its in their homes. The environment is for them, and they're in power. They still may not accept it, but it's worth it to try a different format.

Therefore, according to two informants, there is a certain degree of stigma attached to being a mental health client. However, we cannot assume that all mental health clients hold the same attitudes as Francis and Rod, since these were the only two informants to directly address the issue.

Descriptions of Chamorro Culture

As the present study was also an examination of Chamorro cultural beliefs and values, it was of interest to ask for the informants' perspectives on what made Chamorros unique. There were several themes that were evident.

Normative values. The most common response to this question was an attempt from informants to conceptualize the Chamorro personality style. The Chamorro people were described:

> ...we're nice people, we're friendly, we entertain ourselves to the people who come to our country, to our island. We give them respect...Just that the people are so practical. (Joseph, 003)

> We're just gentle, kind. (Jesus, 004)

> They're funny people. They have the funniest thoughts. But I'll tell you one thing, they have more common sense than a lot of people, in some ways. Socially. (Francis, 005)
>
> They're good people. They're hard-working people. (Carmen, 006)
>
> Chamorros are sometimes shy, when their feelings were hurt...they want to be very sensitive in many ways, that's what they want to be, they want respect in many ways. (Rod, 007)

James (008) and Roy (018) comment on the dividedness of the Chamorro people. They both stated that they did not believe themselves to be "real Chamorro[s]," and expressed considerable hostility to those that did:

> I don't think I'm considered pure Chamorro, I'm not considered part of the lingo. I am a very poor man. I am considered a heathen or a mange. I think they're a very cruel and lonely people. And they have their language, they have their culture. And their dress, half naked and everything...They only want money and land and houses. If the Americans hadn't preserved that line they wouldn't have wasted it right now. Those people didn't know what they were doing. I've never seen such a, what do you call it, a terrible destiny. (James, 008)
>
> A Chamorro is the one like on a ranch. Those even, having sugar, having coffee, those are real Chamorros. They don't care about the life or the people outside the lights...They stay on the ranches and whatever food they got they say ok, not like the others who complain about food then you look in the background and see the banana trees, they say they have nothing. That's baloney. How can you not have food when that's what banana tree's for. (Roy, 018)

Language. Many informants mentioned the language as a distinguishing and important feature of Chamorro culture:

> If you are interested to know about our language then you have to know first the bad words (laughs)...If you want to learn how to speak Chamorro you have to speak Chamorro and learn the bad words. (Joseph, 003)
>
> But they [Statesiders] want you to speak English but here they want you to speak Chamorro 'cause they don't know how to understand English. (Carmen, 006)
>
> The language. (Elaine, 010)

> Maybe you could talk Chamorro, the language?...But if you learn Chamorro you can speak it to people. With Guamanians, you have to ask them to teach you the Chamorro language. (Erica, 013)

> I also think we need to remember our language...I understand it a little bit. I can talk a bit to my aunties and uncles. But English is my first language. (Sharon, 017)

> I went two years to speak the language. I went to University of Guam. A couple years. But in one year and a half already I know a lot...I just wanted to learn the language. (Roy, 018)

According to many Mainland Americans with whom I came in contact, the language is the only aspect of Chamorro culture which is truly unique, as many of the cultural artifacts (Hughes, 1993) such as dance, art, and architecture are similar to American and Hawaiian artifacts. For example, the Chamorro cultural dance shows put on by hotels and cultural groups often involve young women in Polynesian costumes dancing to Don Ho, a Hawaiian musician.

Traditions and rituals. Several individuals spoke of the local traditions and rituals of the Chamorro culture:

> ...we entertain them [visitors] as to what are their needs, and what do they want to see. We entertain them by arts and cultural fairs, we show them all the costumes that we have, all the culture we have. (Joseph, 003)

> Chamorro people have their food, too. Like kelaguen, red rice, chicken, red hot pepper with coconut milk and spinach and put it together with pepper, the red Chamorro pepper. I eat that with my mom when I go to the fiestas. (Carmen, 006)

> ...we have fiestas, and it's not only about the food, but it's about the beliefs you know, and the legends we have in Guam, like Magellan, and Two Lovers' Point, and the Chamorro culture is a good culture because we get together as a family and we cooperate and participate. (Marian, 011)

> Then, in the Chamorro cultures they used to have a lot of religious ceremonies, like a walk and Good Friday, following the cross where Jesus walked, or was carried, every day. And most of the time before Christmas the Chamorro cultures too they have rosaries every twenty five days before Christmas, every day they have rosaries. And that's the custom they used to have. (John, 012)

We barbecue food. We like to barbecue. (Jim, 015)

Again, although there are many legends which are of Chamorro origin, the traditions and rituals of the Chamorro culture are frequently Catholic ceremonies. This illustrates the amalgamation of cultural influences evident in the Chamorro culture. This point will be addressed further later in the paper.

Chamorro historical context. A few informants made mention of the history of the Chamorro people in their descriptions. Rod (007) discussed the impact of the Second World War on the Chamorro culture:

> It's because of the war...when Japan ruled the war, after the Japanese taught us things, they wanted us to make things...take them to their belief in God, you know. Because that's what Chamorros want, that's what they want to do. Chamorros have a belief towards God. If they don't have that...then that weighs on them.

Susan (014) talked about the influence of American culture on the Chamorro people, and made a comparison between Chamorros and Mainland Americans. She reported:

> ...the Chamorro people are learning to trust the American people, and living that way...But they're living in modern homes now, they do their studies, they're working, driving, travelling back and forth to the States...they're living like in American ways which is just normal for Guam, because they are American citizens. And we all have school, English school. We spoke Chamorro at home and with our friends but at school we speak English. So it's just like school in the States, our reading, our mathematics, English grammar, and our history...there's not too many differences. Only their lifestyle, they are wild, the Chamorros.

Sharon (017) appears to concur with Susan's assessment of Chamorro people: "Chamorros are just like American people."

In general, the informants described the Chamorro people as kind, good, gentle people, who have their traditions of language, food, and festivals which make them different from Mainland Americans, although this may be where the differences end. In other respects,

Chamorros were presented as no different from Mainland Americans. These findings are consistent with the earlier discussion of mental health symptoms and explanatory models.

Attitudes toward U.S. Involvement

In order to further explore the impact of industrialization on the Chamorro culture, informants were asked about the effects of Americanization on the Chamorro people. There were those informants who were very supportive and appreciative of U.S. influence. Rod (003) sees Chamorro people being very closely tied to the U.S. mainland culture:

> ...we have grown up from English people, the American people. We have survived from the American people, during and after the war...so we are learning more about American ways, the culture, the language, their minds, all those things. We need the local people to learn the culture of the American people...like we're unified...to America, we decided to become an America place, so, we chose the American life, American living, American standard of living, and all that. We educate ourselves from the American. We learn many things from the Americans...We are very much in favor of the American people.

Other informants also valued the Americanization of their culture:

> I like it. I like it a lot. I wish the buses would run more (laughs), 'cause I always have to take the bus. (Francis, 005)

> Technology is good. Technology is very good. It's helpful, every aspect I know available. (Rod, 007)

> It's ok. The Americans bring good things, like the technology, the economy. If you have to go to the doctor. But there's still poor people. (Sharon, 017)

Roy (018), however, did not agree that the Chamorro people have truly adopted American ways. He states:

> I know they go by American laws and everything but they're not really American laws. They're just doing their thing. And they don't want to give back Uncle Sam what they owe him. They don't want to give back the tax, they don't want to give back...They want to keep the money and not continue to give it back to Uncle Sam...They're good to them. Whatever they ask for, the government back in the States gives it, everything. Why give it, it's a lousy island. They can take it and knock it down, we don't need you. But the Americans are so convenient to them.

The influence of U.S. mainland culture on the Chamorros culture was immediately evident from my observations. However, it should be noted that there were considerable differences in the extent of this influence between more industrialized Guam, and less industrialized Saipan.

In many ways, Guam resembled a North American city: fast food restaurants lined the seven-lane highway; 20-story plus apartment buildings and hotels towered above pedestrians; several shopping malls offered locals and tourists considerable selection. Saipan, on the other hand, was clearly 10 or 15 years behind Guam in terms of economic and industrial development. One of the striking differences between these two islands was the variety of products and services, and the degree of selection one had, with Saipanese individuals having considerably less choice. Guam had considerably more American fast food chains than Saipan. Whereas Guam supermarkets may offer you choice of 10 kinds of cereal, Saipan may only offer you two. Many Saipanese flew to Guam especially to visit the new K-Mart, which offered items in variety and price that was rivalled by no other store in any of the islands. Therefore, the more Westernized the culture, the more that 'freedom of choice' was available and valued.

There was a difference in clothing styles across the two islands. The Guamanian Chamorros on the University of Guam campus appeared to be dressed no differently than those at the University of Windsor. Guamanians wore the same, if not more, American and European designer-wear. However, on Saipan, although there were certainly those individuals who appeared in the latest fashions, more traditional apparel (multi-colored print clothing and "zorries," or what North Americans might call "flip-flops") and hair styles (long hair on both men and women, with women wearing their hair in buns on top of their heads and men wearing pony-tails) was evident.

On both Guam and Saipan, an interesting effect of Westernization on Chamorro culture was the apparent increase in body image awareness. During a lecture on anorexia and bulimia, my students discussed the prevalence of these types of disturbances. From their experience, students from the adult generation had a different perspective from the youth. The parents in the class stated that there was not an emphasis on thinness as there was in Western culture. One Chamorro woman recounted that when she started exercising, her husband told her not to lose weight because if she became too thin, others would think he was not providing adequately for his family. Other local women in the class agreed. However, they did state that they are seeing more of a preoccupation with weight in the young girls in high school. According to the Chamorro students, the youth are raised with more exposure to Western media, a media which values thinness as beauty rather than heaviness as prosperity. From Kleinman's (1978) perspective, this phenomenon illustrates how cultural beliefs and values influence what is defined as "sickness," and how individuals in that culture are expected to respond to it. In the Chamorro culture, particularly the adult generation, a state of being too thin is considered deviant, based upon a belief that individuals who are too thin live in a family too poor to provide adequate nourishment; in the North American culture, thinness is an ideal, perhaps based upon a belief that individuals who are too heavy are lazy or have no self-control. However, in North American culture, an irrational obsession with thinness, as is the case with eating disorders, is also considered deviant, and has been labeled a psychiatric disorder. For traditional Chamorros, the concept of an eating disorder is not a relevant or useful category. As the influx of North American values continues, the youth are beginning to value Western beliefs over traditional Chamorro beliefs, and so the concept of eating disorders may become more applicable.

Westernization has also appeared to have had an impact of the extended family system. As stated previously, a remarkable aspect of Chamorro culture is the emphasis on taking care of one's kin. However, an influx of Western values of individuality and self-sufficiency have put younger generations of family members in difficult, confusing positions. For example, a Chamorro described to me a Guamanian family who were angered at the expectation that because they were financially successful, they should give money to the husband's relation, who was continuously out of work. The wife in the family felt that this was unfair; they had worked hard for their money and should be able to spend it how they saw fit. However, there was considerable pressure from the husband's family to help out others. This apparently had caused some conflict in the marriage.

Carmen (006) perhaps uses a tale of *taotaomona* to describe her negative feelings towards American influence:

> ...*taotaomonas* are not here anymore but they still have a little bit because they're trying to tell their people that other people shouldn't be in our home because they're telling us how to run our home, not their home...

She also describes how Chamorros and Americans are dependent on each other for employment, and expresses her resentment at those who see Guam as too American:

> ...there's woman...says that we're running the place but they come here [Guam] to look for a job. Now they call it Guam U.S.A. 'cause it's part of the States. She says "we're [Mainland Americans] running the place now because there's only a little bit of Chamorros." But I said "no, there's more Chamorros here than there are other people." They [Mainland Americans] should go back to their home 'cause they're not from here. But the Chamorro people always stay here. But they [Chamorros] go there [to the U.S. mainland] because they want to be smart and go to school or have a place to work or something. 'Cause sometimes you don't have jobs here either. And you have to go back there [to the U.S.] and come here [to Guam].

Rod (007) appears to agree with Carmen in her description of the relationship between Americans and Chamorros:

> I was born in the States. I'm supposed to be Stateside, you know, instead of here in Guam. It's like...I'm back there, but all the time I'm turning my cheek, and saying, "hey, I want to stay in Guam, but there's no opportunity for me here, there's no nothing...It's like being oppressed...you can't really open up your mind and throw out the rest. It's like a difference in the person's viewpoint.

He also expresses the inherent contradiction in being both Chamorro and American:

> If...you come from some sort of heritage from back then, but actually you're Chamorro, but you're also a U.S. American, you know, belonging to the mainland...It's like we're trying to make ourselves more competitive, so we can overcome our problems...because we have so many people from different cultures with different ways, you know, they are different, and we can't even realize why we treat each other in a different respect.

In summary, there appears to be many conflicting attitudes towards American involvement in the Chamorro culture. On the one hand, Americanization brings with it many improvements in daily living. On the other hand, it brings conflict and confusion about cultural identity. A poem by Fred Cordova, quoted by Evangelista (1988), about a similar conflict in the Filipino culture articulates the confusion perhaps experienced by Chamorros:

> We say we are Filipino; we say we are American, so, who are we; more so, what are we; brown or white; or are we still "other?"...We are then marginal man, marginal woman, better yet, margarine, because we are being burnt, toasted, singed, braised, scorched, always to our detriment for someone else's benefit; thus, we party, dance, banquet, and, happy in our delusions of grandeur, we do not hurt as much with the pain of exploitation. (p. 52)

As expected from a reading of the history and development of the Chamorro culture, there was considerable evidence of the amalgamation of several other cultures with Chamorro and North American culture. For example, the impact of Spanish rule on Chamorro culture was reflected in several ways. First, the predominance of Catholicism on both islands is a remnant of Spanish missionaries. The architecture of the Catholic churches is also reminiscent of Spanish times. Most rituals and festivities were those centered on the Catholic church. Second, the language has adopted many Spanish words, although the Malaysian influence on the language was clearly evident. Third, one of the most popular types of dance

music traces its origins to Latin America. Every band at every bar or restaurant that I visited played several cha-chas, sambas, mambos, and lambadas. In order to "fit in" with the local people with whom I worked, I quickly had to learn how to cha-cha with a degree of both skill and nonchalance, as was the custom of the Chamorros. The "bar scene" was an extremely popular social environment among Chamorros, according to many Chamorros with whom I spoke, and according to my observations of coworkers and their friends. The "bar" was the environment where my role as teacher was relegated to a secondary position, and I was able to realize my role as participant-observer in the culture. In general, bars, nightclubs and alcohol played a large part in social behavior (Saipan is the largest per capita consumer of Budweiser beer in the world), and the accompanying social problems of domestic violence and child abuse. There were more permissive attitudes toward drinking and driving and having open containers of alcohol in a motor vehicle than is typical of North America. All social events and family gatherings I attended or heard about included the consumption of alcohol, specifically beer. Although this observation may be based, in part, on my orientation toward social activities, the importance of alcohol in the social aspects of the culture was also conveyed to me by many Chamorros who reportedly did not endorse that orientation.

There were also examples of Asian influence on Chamorro culture. On Guam and Saipan, storefront signs were in either English, Japanese, Chamorro, or all of the above. Government documents, media communications and signs were in both English and Chamorro, which reflects the Western emphasis and bilingual nature of the culture. The Japanese language was included wherever tourists were likely to venture. In some tourist areas, it was uncommon to find someone who was able to communicate to you in English; however, if you spoke Japanese, or more recently, Korean, you would be able to communicate with ease. Because of the large Filipino alien contract worker population on

Saipan, many businesses, restaurants, and other service industries were staffed by Filipinos who often spoke little English. I found that the Chamorro people on Saipan were more likely to use Chamorro as their first language, and most children I met spoke both languages fluently. In fact, during some group work in the classes I taught in Saipan, the Chamorro students would form a group of their own and complete the group project in Chamorro, speaking English only when presenting information to the rest of the class. On Guam, however, Chamorro appears much less as a first language, particularly among the young people. When I asked some college students if they could speak Chamorro, many reported that they could speak some Chamorro, as I would imagine most of my peers are able to speak French.

This amalgamation of language, tradition, and values has often led many North Americans I encountered, particularly professional individuals in education and law, to state the opinion that Chamorros have 'no culture.' I would assert, however, that this perhaps somewhat biased sample of individuals defined culture strictly from the artifacts of the culture, not its behavior and values. The Chamorros I encountered professed a strong cultural identity, complete with t-shirts and bumper stickers expressing Chamorro sentiments. In fact, "Taotao i Redondo" - people of the circle - is a cultural group whose interests are to celebrate Chamorro history and culture. There are also new history books written by local authors, glorifying the Chamorro chiefs who conflicted with the Spanish. For example, the mainstream account of Chief Matapang's assassination of Father Diego Luis de San Vitores because the missionary had baptized the Chief's child against his will, emphasizes the courage of the Missionary, whereas the Chamorro version praises the bravery of the Chief.

This cultural amalgamation was not without its difficulties. Given the historical and cultural context of the island, it is no surprise that there is considerable racial conflict,

particularly on Saipan. The culture has experienced both Japanese and American rule, which has engendered underlying resentment. Older Chamorros remember the concentration camps and torture of the Japanese occupation, which makes the current Japanese tourist boom a bitter pill to swallow. The American influence appears to be a double-edged sword, bringing with it technology and progress, yet a dilution of traditional culture and an absence of autonomy. For example, local attitudes towards Mainland American professionals on the island were contradictory. In general, the perspective I inferred was: while the local people of Saipan need and value Western professionals, particularly medical and educational staff, they also hold resentment toward people who do not know the Chamorro culture's values, attitudes and beliefs. When I was first negotiating employment at the mental health center, some local staff members were hesitant to hire another "haolie female" who didn't know the culture. I had to work very hard to prove myself to these individuals; to show that I did not fall into the stereotype of an aggressive, know-it-all female who held Western ways above all else. I accomplished this by meeting individually with the staff for an informal lunch to give them an opportunity to get to know me. On the other hand, the staff realized that there were no other professionals on island at that time, let alone any local professionals, who had the training and experience to fulfil the requirements of the job.

This tension between the local Chamorros and Mainland Americans was a complex interaction of race and nationality. One the one hand, the tension was clearly racial. The term for a White person independent of country of origin is "haolie," a derogatory reference originating from the Hawaiian language (although all White individuals I knew used the term to refer to themselves, without acknowledging the underlying put-down). The Chamorro people seemed to group all White people together in one category; Canadians, Mainland Americans, Australians, New Zealanders. Even Whites who were born on Saipan or Guam were haolies.

I once heard the expression - you can marry a local, you can have children with a local, but if you're White, you can never be local. One was unable to refer to White Americans as "Americans," as Chamorros also consider themselves Americans. Americans from other racial groups, such as African-Americans, or Pakistani-Americans, apparently did not receive as much negative sentiment. One friend who was an Indian, born in Africa, stated that he felt great relief coming to Guam as a "brown man." He said that he experienced much less racial prejudice from Chamorros than from U.S. Mainlanders. However, other people of color were most definitely the victims of racism.

The large alien labor force from the Philippines working on Saipan has created a great deal of racial tension. The minimum wage of Saipan was $2.75 per hour; compared to Western standards, a ridiculously low wage. The majority of people who worked for this wage were Filipinos working in construction, the tourist/service industry, and the entertainment industry. However, there was resentment against the Filipinos from the local people because, according to some of the more vocal Chamorros, they were taking away jobs from locals. The Filipinos, from my experience, were individuals who had been living in poverty in the Philippines and had left their spouses and children to come to Saipan to make enough money to send back to their families. Poverty on Saipan, therefore, appeared to be racially divided, with the Filipinos living in deplorable conditions - in barracks, tin houses, etc. As I became friendly with a Filipino, my local and American friends were unsupportive of our relationship. I received many warnings - to make sure he knew I was not American and could not, therefore, get him a "green card," to make sure if he had a wife or children in the Philippines, to not lend him money. Their attitude was one of distrust and suspicion, as if I was becoming friendly with someone who was definitely below my social standing, and who would possibly have ulterior motives for becoming my friend.

Other racial tensions appeared to exist between the Chamorro and Carolinian cultures. According to some, there was some dispute as to which culture had arrived on the island of Saipan first. There was also some conflict around the political and economic power of each culture. Carolinians appeared to be, in general, in less powerful positions than the Chamorros, a fact which angered the few Carolinians with whom I spoke. In addition, negative stereotypes of the Carolinian culture were held by some Chamorros. I had heard stories where a Chamorro might make a comment such as, "You're being Carolinian today," meaning you were being lazy, the stereotype of a Carolinian. However, this tension was not obvious to the casual observer of interactions between Carolinians and Chamorros, and I was only privy to it through my friendship with a Carolinian individual.

According to one of my Cultural Consultants, there were also tensions between Chamorros from the CNMI (Saipan, Rota, and Tinian) and Chamorros from Guam. Some Guamanian Chamorros apparently viewed their CNMI counterparts as less sophisticated than themselves, much as city dwellers in North American might view their rural cousins as "country bumpkins." On the other hand, CNMI Chamorros saw the Guamanian Chamorros as thinking a little too highly of themselves. One of the Cultural Consultants was from Rota, and was attending school on Guam. She reported to me that she often perceived negative attitudes from some of the Guamanian Chamorros she encountered. There is also a historical basis for some of this animosity. Apparently, during the Second World War, the Japanese were more firmly entrenched on Saipan, and often used Saipanese Chamorros as interpreters when they went to Guam. According to a Chamorra with whom I spoke, there is a belief that there were some Guamanians killed because of miscommunications through the Saipanese interpreters. The accuracy of this information is unknown, since it did come from an informal

source, but if this is a widely held belief, it may have contributed to some of the ill-feelings between Saipanese and Guamanian Chamorros.

Attitudes toward the Interview

This brief section is included to describe the attitudes of some of the informants to the interview situation. There were a few clients who appeared uncomfortable with the interview process; they were quiet and appeared reluctant to speak about their issues. However, the majority of informants appeared to enjoy the experience and to be eager to engage in conversation with me. Many informants who saw me after their interview greeted me warmly, asked about the progress of the research or asked for feedback. Others, who had apparently heard about the interview process, offered to be interviewed themselves. A few informants, Jesus (004) and Roy (018) for example, attempted to engage me in a more personal conversation about myself. Others, such as James (008) and Marian (011) expressed their appreciation directly for being given the chance to speak their minds:

> Because in this part of my life, I'm 43 years old, and I'm happy to at least present something to my fellow clients and the staff here, to be very black and white, and to present something to the government. (James, 008)

> I hope I'm not jumping to conclusions, because I've been talking about it to get it out of my system. Like I said, I've went through a lot of experiences and until now I'm still, you know, still kicking [laughs]...Well, obviously you're a very good person, the way I look at you. You're nice, you're friendly, and I appreciate all the conversation. (Marian, 011)

James, however, did appear to be somewhat concerned about what my reaction to his thoughts and ideas would be:

> Well, I've been speaking mainly about how this goes, maybe you think I'm a dickhead...But I'm still a dickhead...But I wanted to entertain you. I wish you'd forget this when I get out of here.

John (012), whose delusions centered around aliens from outer space about whom he expressed a certain amount of comfort, on the day following his interview, shouted at me cordially across the day treatment room, "Hey, you're from another planet!"

In my interview with Joe V., I discussed my perception of the positive response of informants to the interview process. I recounted a conversation with a Chamorra teacher who informed me that oral traditions are very important in the culture, as Chamorro has been a written language for only the past hundred years. Joe V. responded:

> It helps that in working the field, you're not just an outsider. it helps when you come across as nonjudgemental. They need acceptance of the voices and what they tell them. They need to put a face to the voice, this is a great pressure reliever. You're not judgemental, you're a person discussing this who wants to know about the stuff they're going through. By empowering people with mental illness with their own story, each one of us takes on our own story.

These anecdotes are included to support my observation that the majority of these informants found the interview a pleasant experience, and were glad they had participated in the research. It is hoped that their attitudes also reflect a desire to be honest with their thoughts, feelings, and ideas; however, it also may be that since they enjoyed the interview experience, they wanted to please me and therefore tell me what they thought I wanted to hear.

CHAPTER IV

CONCLUSIONS

This section serves five purposes: first, the primary goals and research questions of the present study are reviewed, with brief summaries of the conclusions for each; second, recommendations for treatment with schizophrenic individuals are provided; third, the limitations of the present study are presented; fourth, suggestions for future research are outlined; and fifth, the cultural theoretical perspective outlined in the first chapter of the paper is evaluated with respect to the present study.

Summary of Findings

Delusional thinking and culture. The first two goals were to present a description of the structure and content of delusional thought in Chamorro schizophrenic individuals, and to relate the content to the Chamorro cultural and historical context. In general, the delusional content was reflective of the Chamorro culture. First, there were two instances of culturally-specific content: witchcraft and poisoning. Second, with the exception of witchcraft and poisoning, there were no remarkable differences in delusional thought content between Chamorro and North American schizophrenics. This amalgamation of cultural content reflects the Chamorro history of colonization; as a result, the Chamorro people have integrated a wide variety of Western elements into their own cultural framework. Currently, the Chamorro people are experiencing considerable cultural change and acculturation by the United States and other cultures. While many traditional Chamorro concepts exist, there appears to be less unconditional acceptance of these concepts. When compared to Osburn's (1977) study, these results suggest that the process of acculturation has impacted upon the psychotic thought of Chamorro schizophrenics. Consistent with the present study, Osburn found that the two most common forms of delusional thought were delusions of grandeur and delusions of persecution.

However, Osburn also found particular Chamorro content (e.g., *taotaomona*) mixed with Christian religious content (Joan of Arc). It may be that 20 years ago, delusions of *taotaomona* and witchcraft were more prevalent than they are in the present study, which would suggest that as the Chamorro culture is increasingly exposed to Western concepts, the delusional content also becomes more Western.

Another possible factor in the similarity of delusional thought between Chamorro and North American schizophrenics is the common history of Christianity in general and Catholicism in particular in both cultures. There has been a strong influence of the Catholic church on the values and belief systems in these and other cultural groups. This would possibly explain the strong Catholic religious content of the Chamorro informants' delusional thought, which was similar to delusions expected in North American mental health clients. Brewerton (1994), for example, found significant religious themes and content in his study of psychotic individuals in Hawaii: auditory hallucinations included references to God, spirits or saints, devils or demons; paranoid delusions included possession by devils or demons; grandiose delusions consisted largely of beliefs that the informant was a religious savior, such as Christ or Buddha, or that she was pregnant with such a savior. The author concludes that the specific religious content was influenced by the participants' religious upbringing or culture. The delusions reported by Brewerton are very similar to those reported by the Chamorro informants; the participants in this study described messages from God, visions of religious figures such as God and the Virgin Mary, etc.

Other studies of nonWestern cultures have also found cultural content in the delusions of schizophrenic individuals. As discussed previously, Kala and Wig (1982) found a definite relationship between types of delusions and cultural context in Indian schizophrenic participants. As mentioned earlier, in an investigation of psychotic symptoms in Puerto

Ricans, Guarnaccia and his colleagues (Guarnaccia, et al., 1992) conducted 1,500 interviews, identifying 146 individuals reporting at least one psychotic symptom. The most frequent symptoms were "visual experiences; paranoid features; auditory illusions or hallucinations; and tactile perceptions" (p. 104), with many symptoms containing strong religious themes, as well as deceased ancestors and clairvoyance. These delusions fit well within the Puerto Rican cultural context, as religious experiences in the Catholic and Pentecostal churches play an important role for many Puerto Ricans in their daily life. In a study of the New Zealand Maori, Sachdev (1990) also found considerable cultural content: delusional themes included involvement of Maori spirits and persecution by *pakeha* (individuals of European descent). The Maori people are a nonChristian culture who, similar to the Chamorros, have suffered from the effects of colonization: significant reduction in population due to warfare and disease, industrialization, urbanization, a transformation of the sociopolitical system, and the introduction of modern medicine and science. Torrey (1981), in a review of the literature on paranoia in various cultures, cites several older studies whose results indicate the cultural content of delusions. Tooth (1950, cited in Torrey, 1981) found that schizophrenic delusions centered around the fetish system in less industrialized northern Ghana, while in more technologized southern Ghana, delusions included objects such as televisions, radios, and electricity. Lambo (1965, cited in Torrey) reported that delusions in rural, non-literate Nigerians contained references to supernaturalism and ancestral cults, while literate Nigerians described hypochondriacal delusions. Torrey also suggests that the content of delusional thought may change according to the changing historical context, citing a study by Asai (1964) that found delusions in pre-World War II Japanese schizophrenics centered around the Japanese Emperor, whereas post-World War II delusions focused on the United States, Communism, radio, and television.

Third, the underlying themes of powerlessness, fear, and shame are also reflective of the cultural and historical context of the Chamorro culture. The experience of powerlessness over their geography and social organization for hundreds of years may have influenced the beliefs and values, and ethos of the Chamorro culture. For example, according to many Chamorros with whom I spoke, their culture is shame-based; that is, shame is used as a means of social control, particularly in childrearing practices. According to Underwood (1979, cited in Bretania-Shafer, 1989), a sense of shame governs daily behavior in the Chamorro culture. As a collectivist culture, any behavior which shames the group is considered a most serious social violation. It is not surprising, then, that the concept of shame was also raised during discussions of Chamorro attitudes toward mental health problems. The importance of the role of shame in Chamorro culture is consistent with the cross-cultural literature. "Shame cultures" (Wallbott & Scherer, 1995) regulate behavior and ensure compliance with social rules through external sanctions and pressure on the individual; collectivist, nonWestern cultures have typically been identified as shame cultures. In "guilt cultures," on the other hand, the individual internalizes these external sanctions, so that guilt may be experienced when no others are present. Individualist, Western cultures tend to be guilt cultures.

However, it should be noted that the schizophrenic role in general is often a powerless one, even in North American society. Individuals displaying psychotic symptoms are often disenfranchised people whose experience has been negated by society. Only in cultures where bizarre or unusual behavior is valued by the majority is the experience different. As stated by Benedict (1934):

> ...if it [culture] chooses to treat their peculiarities as the most valued variants of human behaviour, the individuals in question will rise to the occasion and perform their social roles without reference to our usual ideas of the types who can make social adjustments and those who cannot. (p. 270)

Cultural characteristics. The third goal was to investigate which, if any, factors characteristic of less industrialized societies were present in Chamorro culture which might help to ameliorate the course of schizophrenia. The literature identified five such factors: extended family support, more permissive work environment, reduced stigma, reduced social isolation and support, and the lower survival rate of vulnerable individuals. In general, the findings were ambiguous regarding the presence of these factors in the Chamorro culture. The values of the Chamorro culture did strongly emphasize the extended family system; however, the power of the extended family was not always a positive influence. Often family membership was used to conceal abuse, or to shame individuals with mental health problems. The informants in the present study reported certain benefits from their employment, although this employment was obtained through the Department of Mental Health's day treatment program, and so may be more likely a function of good programming than the Chamorro culture's approach to work. The present findings also indicated the stigmatization of mental health clients, rather than acceptance. This may be a function of how the culture conceptualizes the nature of mental health problems. It appears that the Chamorros view these problems as permanent conditions, and so stigmatization would be greater than cultures which see mental health problems as transitory, such as the Inuit culture who reported less stigma on these individuals (Kirmayer, Fletcher, Corin & Boothroyd, 1994). However, it would appear that the Chamorro culture does offer many opportunities for social relationships, and it is very unusual to find a Chamorro with no social contacts on island. This may be a function of living in such a small community, rather than a function of the characteristics of the culture. Finally, although the survival of vulnerable individuals was unable to be directly assessed, the Westernized medical system on both Saipan and Guam, with access to advances in medical technology which may identify perinatal or neonatal trauma or defects, would reduce the infant

and childhood mortality rates. This would likely not be a factor in the better course and outcome of schizophrenia on Guam and Saipan.

Explanatory models. The fourth goal of the present study was to explore the explanatory models used by the informants to understand their psychotic symptoms and their recommendations for treatment. The results indicate that many of the Chamorro schizophrenic individuals interviewed had clear ideas on the factors which contributed to their mental health difficulties: stress, substance abuse, witchcraft, biological factors, early childhood experiences, and genetic predispositions. With the exception of witchcraft, these models appeared similar to those used in Western mental health settings.

These findings are consistent with other ethnographic research on conceptions of mental illness. For example, Kirmayer et al. (1994), in their study of Inuit concepts of mental health and illness, found that their Inuit informants recognized four causes of mental health problems: 1) physical and environmental (e.g., substance abuse during pregnancy, biological variability); 2) psychological or emotional (e.g., emotional trauma from family conflict, physical and sexual abuse); 3) demon or spirit possession; and 4) social and cultural changes (e.g., changes in the figure and scale of the community). These authors also described their informants as holding similar theories of causation to those of North American mental health professionals; "most informants were very 'psychologically minded' by the standards of mental health practitioners in psychiatry" (p. 84).

It is important to remember, however, that all informants in the present study were fluent in the English language, and therefore, were acquainted with English terms and concepts for their experience: schizophrenia, mental illness or sickness, stress, stigma, psychology and psychiatry, etc. The influence of language on thought has been described by numerous authors. Specifically, the Whorf hypothesis of linguistic relativity (1956; see also

Hunt & Agnoli, 1991) states that language shapes the perception of reality as much as the perception of reality shapes language. Therefore, individuals whose language provides several terms for distinguishing subtypes within a category will perceive their world differently than individuals whose language has one or no terms. Since the Chamorro informants in the present study had been involved with the Western mental health system, they had Western, psychiatric terms to describe their experiences, and would perceive those experiences differently than if they did not.

Evaluation of qualitative methodology. The final goal of the present study was to investigate the usefulness of a qualitative approach to understanding schizophrenia specifically, and cultural psychology and psychiatry in general. The qualitative approach proved to be extremely useful, given the nature of the research questions and the thoughts and experiences of the informants. Using an unstructured interview format allowed "thick description" where the data were my own "constructions of other people's constructions of what they and their compatriots are up to" (Geertz, 1973, p. 9). The informants were given the opportunity to tell their own story using their own structure. The richness of information gained as a result permitted detailed interpretation, and provided a deeper understanding of the experiential world of the schizophrenic. As stated by Corin and Lauzon (1992): "the [phenomenological] investigation of the [informants'] vantage point reveals a much more complex picture" (p. 276). A quantitative approach using paper-and-pencil measures would have constrained the informants' responses, and therefore would not have provided access to the complexity of their delusional thinking, their experiences, and their recommendations. In addition, participation might have been more difficult to obtain had questionnaires been used; since English was a second language for most participants, results gained from such a method might have had questionable validity. However, it should be noted that the qualitative

interpretive analysis conducted here was subjective; other researchers using different models might develop different sets of categories with different interpretations and recommendations. Although attempts were made in the present study to illustrate interpretations with data from various sources, it is inevitable that the final product is unique. The goal was to offer one way of understanding the experiences of Chamorro schizophrenic individuals, which would have some benefit to those who consented to participate, as well as other mental health clients. According to Corin and Lauzon (1994), this type of interpretative analysis is never exact; it merely presents individual experience that is always open to another complementary reading.

The inclusion of three sources of data - Chamorro schizophrenic individuals, a Chamorro mental health professional, and observations as a participant-observer in the culture - provided access to data from different sources to support or discredit hypotheses and interpretations. The informant interviews allowed me to ask specific questions; the interview with Joe V. allowed me to discuss possible interpretations after the interviews were complete; and the informal observations served to explicate aspects of the culture which were not accessible through interviews or published accounts.

An additional benefit of ethnography and the role of participant-observer is the exploration of my own "unstated assumptions" which occurred while exploring the assumptions of the Chamorro culture. As mentioned earlier, Triandis (1995a) states that a culture's unstated basic assumptions are "so fundamental that we are unaware of them. It is not until we come into contact with people from another culture that we realize our assumptions are not universal" (p. 5).

To delineate my own cultural context, before living in Saipan, I had little experience with other, nonWestern cultures. I had been raised with a great deal of U.S. media, and living on the border of Canada and the U.S. for the past 6 years, saw very little difference between

Canadians and Americans. However, one of the personal reasons for my choice of conducting my dissertation on Chamorro culture was to gain exposure to nonWestern ways of thinking; to challenge my current world view.

During the nine months I spent on Saipan and Guam, I worked with, lived with, and befriended individuals from different cultures: Chamorro, Filipino, Carolinian, Samoan, and American. Encountering people with different cultural values forced me to identify and solidify my own definition of culture in general, and my definition of Canadian culture specifically. I had traditionally viewed North Americans as lacking a specific cultural identity; individuals from other countries had much 'more' culture. My experience changed this view. Before living on Saipan, the concepts of individualism and collectivism were theoretical. By the time I had lived on Saipan for a few months, I knew experientially what those concepts entailed. I noticed myself struggle to maintain my individuality and identity by cherishing those things which made me different from others. I clung strongly to my sense of being Canadian, **not** American, and corrected those who assumed I was American. Through this experience, I articulated to myself and others what these differences were: our political system, our health care system, our welfare system, our restricted access to firearms (see Lipset, 1990 for a discussion of the differences between Canadian and U.S. values and ideology). I engaged in political discussions with Americans regarding our differences in value systems, which fostered the development of my cultural and personal identity.

In addition to the Canadian-American comparison, the Western-nonWestern comparison was also integral to the solidification of my world view. I befriended individuals whose life experiences were completely different from my own. These encounters emphasized the importance of cultural context defining and shaping one's identity and concept

of the self. Again, although I was aware of cultural relativity in an intellectual sense, exposure to different values and beliefs brought this awareness into an experiential realm.

Through interaction with other cultural groups, in some ways I became more critical of Western culture. I lived within a small community that valued extended family. I admired the security of having an extended family system you can turn to for support. The smallness of the island fostered the sense of a small community, of knowing everybody. I rarely had the experience of going anywhere without seeing someone I knew. However, I also learned of the difficulties of being an outsider in such a small, tightly knit community. In addition, the island culture was a more relaxed way of living. I rarely drove above 45 m.p.h. Time became less important, less a defining factor of activities. Having a reduced number of choices, whether it be in groceries, music and nightlife, or other diversions, seemed to reduce the stress of daily living. I experienced culture shock upon my return to North America, particularly in these lifestyle issues. The speed and pressure of daily life, the experience of choice, were all overwhelming in comparison to the previous nine months.

In general, I came to my own definition of culture, cultural context, cultural identity. Experientially, I discovered that culture is your values - what you think is important in life, your priorities; your political views - who should take care of who, who has a right to what; your activities - how you make a living, how you relax, how and what you eat, how you celebrate life and family. I revised and rediscovered these values in my own Canadian culture, through an experiential examination of another.

Suggestions for Treatment

The informants' suggestions for useful treatment approaches included psychological interventions such as talking therapy, practical interventions such as access to transportation,

supportive living environments, and employment opportunities, and societal interventions such as public education to reduce the stigma associated with mental health problems.

There were three areas of evidence from the interviews which support the use of supportive psychotherapy with schizophrenic individuals. First, the informants appeared to enjoy having someone with whom to talk, who would not criticize or judge the veracity or rationality of their statements. Second, a few informants mentioned wanting someone with whom to talk about their problems, to "get it out of [their] system." Third, the interview process indicated that the informants were able to reflect on their experiences, share their thoughts and feelings, and were capable of insight into the causes of their difficulties. This recommendation is not new in psychiatry and psychology; numerous authors such as Selzer, Sullivan, Carsky, and Terkelsen (1989) and Gunderson and Carol (1983) suggest that schizophrenic individuals may benefit from individual psychotherapy. Selzer et al. (1989) state that few mental health professionals are aware of the life difficulties of their schizophrenic clients, and outline a method of talking with these clients which would provide access to rewarding interactions. In particular, these authors suggest that mental health clinicians need an understanding of the individual's experience of schizophrenia, of what she or he has lost, and what she or he hopes for in the future. According to Gunderson and Carol (1983), schizophrenic individuals who are largely asymptomatic and who are aware of having serious psychiatric problems may benefit from attending individual psychotherapy, provided that it is provided in a supportive psychosocial context.

With particular reference to cultural issues and mental health treatment, Kirmayer et al. (1994) report that the Inuit informants in their study widely recognized that talking with others was a positive way to prevent and/or resolve mental health problems. Similar to those concerns outlined by Chamorro informants, the need for confidentiality is paramount. The

authors report that their informants valued confiding in others, but tended to prefer talking with family members or friends, unless the issue was shameful or embarrassing, in which case, mental health workers were preferred.

According to Corin and Lauzon (1992), individuals with mental health problems in nonWestern cultures often initiate questioning that involves the larger social group, thereby providing an opportunity to question the social and cultural order. These authors suggest that the critical insights offered by schizophrenic individuals be treated seriously and incorporated into psychotherapy, as "this would better sustain the patients' attempt to find a place within a real world whose contradictions they perceive, rather than purporting to reintegrate them within an ideal society that they will hardly find around them" (p. 277). Corin and Lauzon (1992) also recommend that mental health professionals need to understand and accept the strategies and meaning systems that schizophrenic individuals use to construct their experience, despite the fact that entrance into the lifeworld of these individuals may be disturbing.

Kleinman (1978) makes several suggestions for working in a cross-cultural health system which are also of relevance. He states that ideally, in addition to biomedical explanatory models, the clinician should employ ethnomedical models which address the effects of culture on the perception, labeling and expression of symptoms. He recommends five practical methodological steps for assessing and treating illness in a cross-cultural setting. First, the clinician should seek out the client's own explanatory model, and if possible, the explanatory model of family members. The clinician may accomplish this by asking open-ended questions about the client's beliefs concerning the cause, reason for onset of symptoms at that particular time, pathophysiology, course and treatment, including client's goals and criteria for assessing outcome. The responses to these questions will provide the clinician with insight into the meaning of the symptoms for the client. Second, the clinician

should present her or his own explanatory model in layperson's terms, and provide sufficient time to respond to the client's questions. Third, a comparison of the clinician's and client's explanatory models should be undertaken to elucidate any differences. Fourth, the clinician should develop a list of illness problems - the experiential, interpersonal, family, economic and occupational problems created by the disease (see Chapter I for Kleinman's distinction between illness and disease). Finally, the clinician should develop specific recommendations for interventions for each illness problem, with specified criteria in order to evaluate the effect of the interventions. These five steps should be implemented while assessing the influence of cultural factors on help-seeking behaviors, the labeling of symptoms, the definition of the sick role, and the use of culture-specific treatments. As Westermeyer (1988) and others have stated, practitioners should enter a new cultural context with an intent to learn about the cultural beliefs and values in order to avoid imposing their own cultural concepts on their clients.

The practical interventions suggested by the informants would necessitate a case management system which would provide resources such as a transportation system to help clients get to appointments and to day treatment, and supportive aftercare housing where clients are taught daily living skills. These services may already be in place in many mental health systems, and should be seen as priorities in helping mental health clients lead full lives.

Public education to reduce stigma is a more challenging intervention to perform. As mentioned by Joe V., Western approaches to educating families and the general public on mental health, such as support groups, are at the present time, less likely to succeed in the Chamorro culture, as there is still considerable shame attached to discussing family problems in public, or with strangers. Therefore, a first step might be to solicit recommendations from the Chamorro people as to how to convey information to the public. Second, although

Mainland Americans and other cultural groups may be involved in the planning and design stages, the implementation of public education programs may be more successful if conducted by Chamorros, since there remains some distrust of Mainland Americans for many Chamorros, who may believe that a "haolie" is unable to understand their problems.

Limitations of the Present Study

There are five main limitations in the present study. First, as mentioned previously, Chamorro individuals experiencing delusional thought who had not been involved with the Western mental health system were not interviewed. Including these individuals would have permitted a comparison between those, presumably more Westernized, informants who had knowledge of psychiatric concepts and experience with psychiatric treatment with those individuals who did not. It is also possible that psychotic individuals with no treatment experience would have exhibited delusional thought containing more references to nonWestern concepts.

Second, a limitation according to a Kleinman psychiatric anthropology orientation is that the present research began with an assumption of the existence of delusions in the Chamorro cultural context, without first exploring whether the Chamorro people have a parallel concept, or whether the concept of delusions has validity in their understanding of mental health difficulties; in essence, the researcher committed a "category fallacy" (Kleinman, 1988b). From this perspective, the conclusions from the present study are potentially invalid, as I entered the research situation with Western psychiatric concepts, and subsequently found little difference between Chamorro and North American schizophrenics. However, the impact of this is hopefully reduced, as the individuals interviewed had undergone treatment in the Western mental health system. This would have, perhaps, been more problematic had individuals who had never engaged in Western psychiatric treatment been interviewed.

Third, medical records and treatment histories were not accessed for the Chamorro informants. This source of data was not accessed for two reasons: 1) the Guam Department of Mental Health and Substance Abuse was extremely reluctant to provide access to medical records, as previously they had been under litigation from mental health clients for using records in other research; and 2) the narratives of the informants were of primary concern, and I did not want to be influenced by reports from mental health staff. However, accessing these data would have provided information on the family, psychiatric, and social history of each informant, and may have provided additional information on her or his delusional thought content and structure.

Fourth, the small number of informants interviewed on Saipan prevented any cross-island analysis of delusional thought. It might have been interesting to compare the delusional thoughts and beliefs of Saipanese Chamorros and Guamanian Chamorros; the Saipanese may have had more references to traditional Chamorro content. It would also have been informative to interview Chamorro schizophrenic individuals from Rota and Tinian, islands considerably smaller and less industrialized than Saipan, for similar comparisons.

Finally, it is inevitable that my own biases, assumptions and values influenced the data collection, analysis and interpretation of the present study. Although I attempted to make these biases as explicit as possible, and to modulate them by discussing interpretations with the Cultural Consultants and mental health professionals, another researcher with different biases, assumptions and values may have developed different interpretations and come to different conclusions. Therefore, it is important to acknowledge the assumptions and context of the researcher articulated in the Method chapter of the present paper when reading the results and conclusions.

Recommendations for Future Research

Since a limitation of the present study was the absence of schizophrenic individuals who had not previously come into contact with the Westernized mental health system, an important next step would be to conduct similar research with these individuals. It is possible that more culturally specific delusions and explanatory models, and less ambivalent attitudes towards traditional Chamorro concepts would have been found had these individuals been interviewed. It is likely that individuals who had exhibited bizarre behavior but had not sought Western mental health treatment would have different ideas and experiences than those interviewed here.

Although consent to speak with individuals who were not associated with the mental health system was impossible to obtain in the present study, there are suggestions for making contact with this population. First, it would be necessary to spend considerable time with the culture in an established capacity in order to gain the trust and acceptance of the local people. This would facilitate introductions between acquaintances and potential informants. Second, recruitment strategies such as those employed by Hezel and Wylie (1992) would enable the researcher to come into contact with individuals who were not currently in treatment. In their study of the prevalence of schizophrenia in the Micronesian islands, these authors approached several individuals in each village and asked them if they knew of anyone who exhibited various types of bizarre behavior. Using this approach, the individuals could then ask the potential informant if she or he would be willing to talk to the researcher. However, this method would, again, be difficult without first taking the first step of gaining trust and respect in the community.

Ideally, this type of study could be conducted using methodology suggested by Kleinman (see e.g., Kleinman, 1977). As mentioned earlier, Kleinman (1977) describes an

"ideal" cross-cultural study of schizophrenia as one where indigenous people are asked for their own detailed phenomenological descriptions of deviant behaviors, where local and professional symptom terms and labels could be compared. Therefore, a goal for future research would be to determine the current local Chamorro cultural categories of mental illness, and investigate whether the concept of schizophrenia and its symptoms of delusions, hallucinations, etc. are culturally relevant categories. This may be achieved by first interviewing laypeople about what behaviors are considered deviant in the culture, and what are the expected responses from the person and her or his family members. Then individuals solicited by the method outlined above would also be interviewed about their life experiences. This methodology would enable the researcher to make interpretations about the appropriateness of Western mental health treatment for the Chamorro people.

With respect to pursuing further research into the cultural content of delusional thought without Western influence, one would be advised to shift away from a focus on small pockets of nonWesternized individuals who have been isolated from Western contact. It appears that these types of cultures are relatively rare; the "global village" phenomenon is quickly becoming a reality. Colonization of the South Pacific and Africa has been widespread, and so the chances of finding a nonindustrialized, nonWesternized culture such as the Ifaluk (Lutz, 1988) are few. Although Lutz's (1988) work is viewed by many to be representative of all Micronesian cultures, the present study of Guam and Saipan would indicate that there is wide variation in the degree of industrialization in the Micronesian islands. Instead, it might be beneficial to look to cultures without the history of Christian missionaries and colonization; for example, Southeast Asia, major areas in China, some areas of the Middle East. Conducting a study with similar goals and methodology to the present study in such cultures might provide

access to schizophrenic individuals with delusional thought that reflects the cultural context, without the conflation of Western influences.

Another area of future research would be the exploration of the explanatory models of mental health professionals in the Chamorro culture in detail. Given the results of the present study, it would be of interest to investigate how Chamorro mental health professionals conceptualize mental illness, how they approach treatment, and how they communicate both of these ideas to their clients. In a similar vein, it would be interesting to interview traditional healers who were known to treat Chamorro people for mental health difficulties - to explore their mental health models and approaches to treatment.

Evaluation of Theoretical Models

It should be noted that the information gained from the formal interviews with Chamorro mental health clients could have been interpreted through any of the models discussed in the introductory chapter of this paper. Had the genetic family history or biomedical test results been available and accessed, the delusional thought content could have been interpreted as symptoms resulting from biological factors. Had the personal history of each informant been available and accessed, the psychodynamic model or the existential model may have been used to interpret their delusional thought content. Had family members been available and accessed, the phenomenological theory of R. D. Laing may have been appropriate.

However, given the design and goals of the present study, the sociopolitical and cultural models of schizophrenia and psychotic thought were most effective in facilitating an understanding of the influence of cultural, social, and historical context on mental health issues. Both models hold similar assumptions in that they look to the larger context for explanations and interventions for mental health problems.

As the major conclusion of the present paper was that the Chamorro cultural, social, and historical context was reflected in the delusional thought of Chamorro individuals with schizophrenia, it is then appropriate to discuss how this reflection is actualized. As stated earlier, Berry et al. (1992) suggests three modes of cultural transmission: vertical (parent to child), oblique (other adults to child), and horizontal (peer to peer). All three modes are likely to be at work in the Chamorro culture. In particular, the public and private school systems often employ Mainland Americans teachers who teach U.S.-based curricula, so it is inevitable that Western values and beliefs are transmitted in this fashion. Also, there are several private Catholic schools on the islands, and so many children are taught Catholic religious beliefs from an early age. The media is another significant source of Western exposure. There are few local television stations which play Chamorro programming, but the majority of stations are from the United States. Similarly, the radio stations play primarily Western music.

In addition, culture affects an individual's view of the self, which is a locus of disturbance in schizophrenia (Fabrega, 1989). According to Markus and Kitayama (1991; see also Kitayama & Markus, 1995; Kitayama, Markus, & Matsumoto, 1995; Kleinman, 1988a), individuals in different cultures have strikingly different constructions of the self, others, and the interrelationship of the two. The Western, or independent, view of the self, holds that the self is an "independent, self-contained, autonomous entity who (a) comprises a unique configuration of internal attributes (e.g., traits, abilities, motives, and values) and (b) behaves primarily as a consequence of these internal attributes" (Markus & Kitayama, 1991, p. 224). Responding to the social environment stems from the need to express or assert the self's internal attributes, and behavior is regulated by these attributes. This sense of self is related to individualistic values. In contrast, the interdependent view of the self, common in Japanese and other Asian cultures, is constructed as interdependent with the context, and others or the

relationship between self and others are the focal point of experience. Individuals with an interdependent sense of self see themselves as one part of interconnected social relationships, and their behavior is determined by what they believe the thoughts, feelings, and actions of others in the social environment will be. Although the interdependent self also contains internal attributes, these attributes are less likely to be the determinants of behavior, and to be considered diagnostic of the self. This sense of self is related to collectivist values.

These different construals of the self influence the expression of emotions. For an interdependent self, private feelings, such as anger, which may interfere with interpersonal harmony, are likely to be controlled or de-emphasized; whereas for the independent self, inner feelings are expressed and acted upon, as they are seen as being diagnostic of the self. Therefore, according to Kitayama, Markus and Matsumoto (1995), Western cultures tend to emphasize independence in their dominant ideology (e.g., individualism), social customs and practices (e.g., personal choice), and institutions (e.g., a merit-based pay system). Many Asian cultures, on the other hand, emphasize interdependence in their dominant ideology (e.g., collectivism), social customs and practices (e.g., divining what others want and behaving accordingly), and institutions (e.g., seniority-based pay system). However, it should be noted that each culture contains elements of both interdependent and independent self constructs. For example, the Maori of New Zealand have two selves; a group or familial self and an individual self, where the group self has priority (Sachdev, 1990).

The construal of the self is affected or distorted by the process of schizophrenia. Fabrega (1989) states that schizophrenia is a disturbance in self-functioning involving self-definition, self-regulation, and self-awareness. The self connects to others in the social environment, so that the self or any disorder affecting the self is shaped and modified by the

cultural context. Therefore, schizophrenia affects the composition and functioning of the self, and results in a dysfunction in the productions and appearance of the self. He states:

> ...in this cultural framework, selfhood cannot be viewed as similar cross-culturally, and insofar as schizophrenic illness disturbs the integrity of the self, its manifestations and course can be expected to bear the impact of distinctive cultural influences on the self. (p. 280).

Therefore, according to the observations of and literature on the Chamorro culture, it would appear that the Chamorros construct an interdependent sense of self, with increasing frequency of independent elements. However, as discussed earlier, as the influence of Western and industrialized culture increases, the Chamorro sense of self and culture is transforming. Certainly before colonialism, and likely until the past 10 to 15 years, the Chamorros were a tight, simple, collectivist culture (see Triandis, 1996). As the islands become more multicultural, populated, and industrialized, the culture is shifting to a more loose, individualistic orientation. However, this shift is made easier when people are separated by geographical distances, since it is easier to tolerate deviations when in a larger community. So it is possible that this increase in multiculturalism, population, and industrialization is a contributing factor to the racial and ethnic tensions outlined previously, and to confusion in identity of the Chamorro people.

Kleinman (1988a) also describes how culture shapes the perception of illness in general. He describes the illness experience as the process by which people explain distress caused by pathophysiological factors in their own terms, and their conceptualization of how to cope with the distress and the problems in daily living the illness creates. According to Kleinman (1988a), the experience of illness is culturally shaped in several ways. First, culture shapes the experience of illness by defining what is "normal" or "natural;" what is defined as natural depends on shared understandings and commonsense knowledge in the culture. This knowledge also contributes to an understanding of what is "sick," and what is meant when a

person expresses their sickness experience through gestures, facial expressions, and language.

Second, Kleinman (1988a) asserts that the cultural and historical context influences the significance of particular symptoms or disorders; that is, expressions of distress have different meanings in different cultures, and in the same culture in different historical time periods. As the historical context or cultural values change, so does illness experience and culturally expected ways of dealing with distress. Even symptoms themselves have cultural significance, and may be related to the ideology of the culture. Therefore, in the Chamorro culture, the Chamorros have an accepted definition of what is normal, what is tolerated, and what is abnormal and worthy of seeking outside interventions. It is likely that, traditionally, these cultural models included the idea of body, mind, and spirit as interconnected, and led to seeking help from spiritual healers. As Western ideas gain more influence, there has been a change in the beliefs about normal and abnormal behavior, and on the relationship between the mind and body. In addition, Western ideas have impacted on the Chamorros' lay understandings of mental illness, and have given them a language to communicate about it. These ideas have also shaped Chamorro reactions to distress and abnormal behavior. Now that people are aware of mental health and substance abuse issues, and of the use of medical professionals when they are experiencing emotional or psychological distress, they may be less likely to seek out the services of a traditional, spiritual healer, and more likely to visit the local mental health center.

Cognitive anthropologists, such as Quinn and Holland (1987), also describe how culture influences how individuals see the world in general, which may be applied to the process by which mental health models are shaped. These authors use the term "cultural models" (p. 4) to refer to the information individuals need to know in order to act as they do,

and to interpret their experiences in the distinctive ways they do. These models are widely shared by individuals from each particular culture, and play a significant role in their understanding of their world and their behavior in it.

One way in which cultural models influence behavior is through an association with authority and expertise; for example, cultural models of health and illness are explanatory systems developed by a group of culturally designated experts like psychologists or psychiatrists (Quinn & Holland, 1987). Once certain people have been identified as experts by the culture, their ideas are transformed into cultural models and gain force through their identification with expert knowledge and cultural wisdom.

However, individuals also have tacit, unexamined models of what they understand as typical or normal based upon observations of others. They seek confirmation for their own views in the beliefs and actions of others, and in the historically dominant cultural models of the time. Cultural models from experts are also tested against each individual's experience. This may lead to conflicting ideas about the world. However, models are held with more conviction when they are most closely bound up with the sense that individuals have about themselves and their life experiences, including culturally provided understandings of the self and one's place in life. Therefore, socialization experiences also influence how strongly a particular cultural model motivates behavior.

Quinn and Holland (1987) caution that personal experience is necessary but not sufficient for individuals to learn all cultural models. Cultural knowledge also comes indirectly from language, particularly through discussions of abstract ideas; knowledge is acquired through intermittent advice and occasional correction, rather than from explicit instruction (Quinn & Holland, 1987). The ways in which language is used provide keys to understanding

underlying cultural models. According to cultural anthropologists such as Lutz (1987), the role of language is central for the storage and structuring of cultural knowledge.

With respect to the present study, the role of authority, language and socialization experiences are primary means by which cultural models of mental health are transmitted, both directly and indirectly. On Guam and Saipan, mental health professionals are actively engaged in public education on how to identify mental health problems and where to seek treatment for emotional distress and substance abuse problems. Revisions of cultural models of mental health are also influenced through other education experiences such as having instructors like myself teach courses in Western models of mental health and treatment. In many ways, I contributed to the process of influencing my students' cultural models of mental health. I provided them with a language and concepts to understand the difficulties they have seen in their own lives, the lives of their friends and family members, and their students.

The cultural approach to mental health put forth by Kleinman (1977, 1987, 1988b) and others discussed in this paper was instrumental in the understanding of the Chamorro schizophrenics' experience. Clearly, the cultural and historical context of the Chamorro people - the collectivist, interdependent values, the rapid social change and Westernization - influenced not only their delusional content, but their presentation of symptoms and recommendations for treatment. The need for a sensitivity to cultural issues and context, and for a focus not on a "cure" for the schizophrenic "disease" (medical interventions) but for a "healing" of the "illness" (psychosocial interventions) (Kleinman, 1977) were made salient by this type of interpretive analysis. These suggestions hold true for mental health clinicians and researchers working with other cultural groups, including North American individuals. In order to understand the schizophrenic experience, one must first seek to understand the cultural ethos and ideology, the conceptions of mental health and illness in the culture, the illness

problems and behavior present in the culture, and each individual's interpretation of her or his experience.

ENDNOTES

[1]There has been considerable discussion on the use of terms such as "developing", "nonindustrialized", and the like, to describe nonWestern societies (see e.g., German, 1984). For the purpose of the present study, I will use the term "industrialized" to refer to those societies which tend to be more individualist in nature, and rely on technology and industry to sustain their economy; I will use the term "nonindustrialized" to refer to those societies which tend to be more collectivist in nature, and rely on nontechnological and nonindustrial means of existence. Although "Western/nonWestern" may appear synonymous with "industrialized/nonindustrialized," the present study's emphasis on the impact of industrialization from Western (American) and nonWestern (Japanese) sources necessitates the consideration of these terms separately. It should also be noted that these concepts fall on a continuum, rather than existing as discrete entities.

[2]The format for the Method section of the present study will deviate somewhat from the traditional format generally used in quantitative studies (i.e., Participants, Materials, Procedure, Analysis). I have used the method outline for qualitative studies suggested by Creswell (1994), and incorporated suggestions from other qualitative methodologists such as Marshall and Rossman (1989) and Tesch (1990).

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APPENDIX A

AUTOBIOGRAPHICAL DESCRIPTIONS OF CULTURAL CONSULTANTS

Biographical Data for Percelleia Boddy, Cultural Consultant

Ms. Boddy is a 21 year old self-identified Chamorro. She was born on Kosrae, in the Federated States of Micronesia (FSM). Her mother is Chamorro, and her father is Caucasian. She has lived in several different geographic locations: Arizona, Utah, Hawaii, Chuuk (FSM), Saipan, Rota, and Guam. From elementary school to her second year of high school, Ms. Boddy lived on the island of Rota, in the Commonwealth of the Northern Marianas (CNMI). From there, she finished her high school diploma on Saipan, CNMI. After attending Northern Marianas College on Saipan, Ms. Boddy moved to Guam, where she is pursuing her B.A. in psychology at the University of Guam. She states that, although her father is Caucasian, she was raised in the Chamorro culture, and is able to speak, understand, read, and write the Chamorro language. In addition, she has taken classes on Chamorro history.

When asked why she was interested in participating in this research project on mental health in the Chamorro culture, Ms. Boddy replied, "I am a psychology major (senior), and I'm taking the Research Seminar class. I am helping Lisa Keith with her research basically to gain more experience in the research aspect of psychology; to become aware of how research is done, and actually participate in it. I feel that my contribution to Lisa's research may be beneficial as I am familiar with the basic traits in the Chamorro culture. I can help her find underlying themes, perspectives, explanations, and interpret Chamorro terms (vocabulary) when needed."

Biographical Data for Rodney San Nicholas Smith, Cultural Consultant

Mr. Smith was born on the island of Guam, and lived there until early adolescence. He also spent considerable time on the Mainland U.S. He was born to a Chamorro mother and Caucasian father, who raised him in the Chamorro culture with Chamorro values. He is able to read, write, speak, and understand the Chamorro language. He is currently a psychology senior at the University of Guam.

In reference to his participation in this research project, he states, "I registered for this class to gain more of an understanding of Chamorro psychology, general perceptions in the populace, and become familiar with research methodology. I feel as though I am equipped to interpret Chamorro verbal exchanges as I have lived and experienced them."

APPENDIX B

CORRESPONDENCE REGARDING ENTRY INTO

THE GUAM DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE

September 12, 1994

Marilyn Wingfield, Ph.D., Director
Nory R. Santz, M.D., Deputy Director
Department of Mental Health and Substance Abuse
790 Gov. Carlos G. Camacho Road
Tamuning, Guam, U.S.A. 96911

Dear Dr. Wingfield and Dr. Santz:

I am a doctoral student in clinical psychology at the University of Windsor in Windsor, Ontario, Canada, and a Limited License Psychologist in the state of Michigan, U.S.A. I am extremely interested in conducting my dissertation research at the Guam Department of Mental Health and Substance Abuse. I am therefore, writing to you to request your approval to do so.

First, let me tell you about myself. I am in the proposal stages of my doctoral dissertation. My partner, Dr. Iain Twaddle, recently joined the psychology faculty at the University of Guam, and so I spent the month of August investigating the possibility of collecting my research data on-island. It is my intention to submit the formal proposal to my dissertation committee in Windsor, and return to Guam in January, 1995 to complete the project. Once I have graduated, I fully intend to seek employment as a clinical psychologist on Guam.

The working title of my research project is An investigation of psychosis in Chamorro culture: Relating delusional thought to cultural context. The purpose of the study is twofold: to present an in-depth description of the delusional thought content found in Chamorro individuals with serious mental illness; and to explore how the Chamorro culture (that is, the history, values, and beliefs of the Chamorro people) are related to their delusional ideas. I believe that the information gained from such a study would provide a deeper understanding of Chamorro mental health clients and their experiences, and therefore enhance our ability to effectively treat these individuals.

In order to achieve this purpose, I would like to interview approximately 30-40 Chamorro individuals who have experienced or are currently experiencing delusions. I intend to work very closely with Department staff, who would recommend and introduce to me individuals whom they believe would be willing and able to participate in the study. Every attempt would be made to be sensitive to the rights and needs of the participants, including their rights to informed consent and confidentiality. Potential participants would be asked to sign a consent form outlining the purpose and requirements of the study, and given a copy of the consent form for their records. If there is any doubt as to whether an individual is able to give informed consent, the interview would be terminated and possibly rescheduled for a later date. I would then explain to participants in detail the following steps taken to ensure their anonymity: I would assign each participant a number which would be used to identify him or her from that point on - no other identifying information would be attached to any materials;

his or her consent form would be stored in a separate location with no way to match the consent form to any interview or questionnaire data.

Interviews would be conducted in a open-ended, semi-structured format to obtain each participant's opinions regarding her or his experiences with psychotic thought processes. Provided the participant has given permission, each interview would be audiotaped. Participants would be given the opportunity to switch off the tape recorder at any point, and to request to have portions of or the entire interview erased. I intend to conduct the interviews with the help of an undergraduate student who is fluent in the Chamorro language and culture and who may act as an interpreter during and after the interview. Throughout the interview process, I intend to make a conscious effort to assess the comfort level of the participants through direct questions and observation of nonverbal cues, in order to ensure that I do not impose upon them or inconvenience them in any way.

The interview itself would have two stages. First, I would attempt to gain a broad sense of the participant's experiences with psychotic thinking. Second, I would attempt to elicit from the participant his or her own understanding of those experiences. Participants would also be encouraged to bring up any topic that they find relevant to the discussion and would be given the opportunity to add topics to the interview which they believe have not been addressed.

After data collection and interpretation is complete, a document would be prepared for and distributed to all participants and to staff at the Department. This document would include a summary of general conclusions, a brief discussion of the implications of the results of the study, and a means to contact me should they have any questions about the results.

The research proposal will be passed through a committee of University of Windsor faculty. My committee consists of Michael Kral, Ph.D., Associate Professor of Psychology, Charlene Senn, Ph.D., Assistant Professor of Psychology, Brian Burke, M.D., psychiatrist and adjunct Psychology faculty, and Eleanor Maticka-Tyndale, Ph.D., Assistant Professor of Sociology. The proposal will also be reviewed and approved by the Psychology Department's Ethics Committee to ensure that the study does not infringe upon the rights of the participants.

During my stay on Guam, I spent a great deal of time with two former Department of Mental Health and Substance Abuse staff members, Lilli Perez-Ten Fingers and Carlos Diaz, who were instrumental in acquainting me with Chamorro culture and introducing me to Department staff. With their help, I met with a number of your staff (Maimie Belajadia, Patrick McMakin, Joaquin Guerrero, Daniel Duenas, and many others) who have been extremely supportive and enthusiastic about the project. I also met with Mary Spencer, who has appointed me to the position of Research Affiliate at the Micronesian Language Institute, University of Guam. I have been consistently impressed with each individual's generosity and willingness to help me get my project off the ground. Should you have any questions about myself or the research project, please feel free to contact Mary Spencer, who has kindly offered her assistance as my "on-island representative". In addition, Pamina Hofer, Ph.D., at the University of Guam, has offered to follow-up this letter and address any questions or concerns. Of course, you may contact me at the University of Windsor by telephone (519) 253-4232, extension 2217, by fax (519) 973-7021, or at home (519) 256-6645.

I have enclosed a copy of my curriculum vitae for your information. As you can see, I have a great deal of clinical experience working with mental health clients, particularly those individuals with chronic mental health problems. I am more than happy to send to you a copy of the detailed research proposal as soon as it is complete, and welcome any suggestions you may have. In the meantime, I would greatly appreciate it if you would consider my research project as soon as possible, as I need formal approval before I can write the proposal based on the Chamorro culture.
Thank you in advance for your consideration.

Sincerely,

Lisa S. Keith, M.A., L.L.P.
Principal Investigator

cc. Mary L. Spencer, Ph.D.
Micronesian Language Institute
University of Guam

Pamina Hofer, Ph.D.
Division of Social/Behavioral Sciences and Social Work
University of Guam

UNIVERSITY OF
WINDSOR

Department of Psychology
University of Windsor
401 Sunset Avenue
Windsor, Ontario, Canada N9B 2T6
Fax: (519) 973-7021

November 14, 1994

Nory R. Santz, M.D., Acting Director
Department of Mental Health and Substance Abuse
790 Gov. Carlos G. Camacho Road
Tamuning, Guam, U.S.A. 96911

Dear Dr. Santz:

I am writing to enquire about the status of my application to conduct my research entitled, An investigation of psychosis in Chamorro culture: Relating delusional thought to cultural context at the Department of Mental Health and Substance Abuse. You and I met this past August with Lili Perez-Ten Fingers, and I recently sent a detailed outline of my study to you and Dr. Wingfield. As per my conversation with Dr. Wingfield a few weeks ago, I understand that you are now responsible for giving approval to the project, and that you are intending to contact me by fax to give formal approval. I have also received a message from Dr. Pamina Hofer at the University of Guam who informed me that the project would also need approval from your Quality Assurance office.

I would, therefore, greatly appreciate it if you would consider my research project as soon as possible, and let me know of your decision, and any other steps I might need to take. As I stated in my previous letter, I am unable to continue with the formal research proposal until I am sure I have approval from the Department. It has been my experience that fax is the most efficient mode of communication, as mail delivery and time zone differences make other modes more difficult. My fax number is (519) 973-7021, and you may contact me at the University of Windsor by telephone (519) 253-4232, extension 2217, or at home (519) 256-6645.

In addition, I am applying for financial support from a Canadian agency which sponsors Canadian health sciences students and post-graduate candidates intending to work overseas. The application requires a letter from the institution at which I'll be conducting the data study. I would greatly appreciate it if you write a brief letter of acceptance indicating your approval of the project to the following address:

International Health Education Program
Canadian Society for International Health
170 Laurier Avenue West, Suite 902
Ottawa, Ontario, Canada K1P 5V5

Thank you in advance for considering my proposal. I will be happy to discuss any questions or concerns you may have about the project, and look forward to hearing from you soon.

Sincerely,

Lisa S. Keith, M.A., L.L.P.
Prinicpal Investigator

November 25, 1994

Department of Psychology
University of Windsor
401 Sunset Avenue
Windsor, Ontario, Canada N9B 3P4
Fax: (519) 973-7021

Ms. Carol O'Donnell, M.S.W.
Quality Assurance Coordinator
Department of Mental Health and Substance Abuse
790 Gov. Carlos G. Camacho Road
Tamuning, Guam, U.S.A. 96911
Fax: (671) 649-6948

Dear Ms. O'Donnell:

Thank you very much for your reply of November 22, 1994 regarding my research project. It sounds like things have been rather hectic at the Department given such drastic personnel changes in such a short amount of time.

Accompanying this fax is the original outline and curriculum vitae I faxed to Drs. Wingfield and Santz in early September. Should you need additional information, please do not hesitate to contact me. Unfortunately, although I received your letter, I did not receive the copy of your Policy on Research. Please fax me (another?) copy of this document, as no doubt it will provide vital information.

Thank you again for your help and cooperation in this matter. I am sorry that I didn't get a chance to meet you while I was in Guam this past August, but I am looking forward to meeting you in 1995.

Sincerely,

Lisa S. Keith, M.A., L.L.P.
Principal Investigator

DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE
GOVERNMENT OF GUAM
790 GOV. CARLOS G. CAMACHO ROAD
TAMUNING, GUAM 96911
Fax: (671) 649-6948
Tel: (671) 647-5445

F A X C O V E R S H E E T

DATE: 12-13-94

Please deliver to: Lisa S. Keith MA LIP
Dept. of Psychology, U. of Windsor
401 Sunset Ave. Windsor Ontario, Canada
N9B 3P6

FAX #: 519-973-7021

FROM: Carol Donnell MSW

TITLE: Quality Assurance Coordinator

DIVISION:
Admin

Total number of pages including this page: _____

Instructions and Comments:

Your letter of 9-12-94 has been found. We have mailed this letter to the I H E P and are mailing you a copy. Sorry for the long delay. Did not receive your Nov 25 fax.

Transmitted By

Document Name

UNIVERSITY OF
WINDSOR

April 27, 1995

Department of Psychology
University of Windsor
401 Sunset Avenue
Windsor, Ontario N9B 3P4
Canada
Fax: (519) 973-7021

Director
Department of Mental Health and Substance Abuse
790 Gov. Carlos G. Camacho Road
Tamuning, Guam, U.S.A. 96911

Dear Director of Department of Mental Health and Substance Abuse:

I am a doctoral student in clinical psychology at the University of Windsor in Windsor, Ontario, Canada, and a Limited License Psychologist in the state of Michigan, U.S.A. I was in contact several times during the fall with Dr. Nory Santz, Acting Director, and Carol O'Donnell, Quality Assurance Coordinator, regarding my conducting my doctoral dissertation research at the Guam Department of Mental Health and Substance Abuse. I received a letter from Carol in November, 1994 indicating permission to conduct my study with your agency. I am, therefore, writing to introduce myself to you as the new Director and acquaint you with my research.

I have completed all of the requirements for my Ph.D. degree in clinical psychology at the University of Windsor in Windsor, Ontario, Canada, with the exception of the doctoral dissertation. In May 1995, I intend to travel to Guam to collect data for my dissertation on cultural aspects of schizophrenia. After completion of the project, I expect to defend my doctoral dissertation by spring 1996, at which time I intend to return to the Micronesian region to pursue a career in teaching and clinical practice.

In the summer of 1994, I spent 5 weeks on Guam making arrangements for data collection and investigating potential employment opportunities. During my stay, I spent a great deal of time with professionals from the Guam Department of Mental Health and Substance Abuse and the University of Guam who were

instrumental in acquainting me with Chamorro culture and their mental health system. I have been consistently impressed with everyone's enthusiasm about the research, and their generosity and willingness to help me get my project off the ground.

The title of my research project is An investigation of psychosis in Chamorro culture: Relating delusional thought to cultural context. The purpose of the study is twofold: to present an in-depth description of the delusional thought content found in Chamorro individuals with serious mental illness; and to explore how the Chamorro culture (that is, the history, values, and beliefs of the Chamorro people) are related to their delusional ideas. I believe that the information gained from such a study would provide a deeper understanding of Chamorro mental health clients and their experiences, and therefore enhance our ability to effectively treat these individuals.

In order to achieve this purpose, I would like to interview approximately 20-30 Chamorro individuals who have experienced or are currently experiencing delusions. I intend to work very closely with Department staff, who would recommend and introduce to me individuals whom they believe would be willing and able to participate in the study. Every attempt would be made to be sensitive to the rights and needs of the participants, including their rights to informed consent and confidentiality. Potential participants would be asked to sign a consent form outlining the purpose and requirements of the study, and given a copy of the consent form for their records. If there is any doubt as to whether an individual is able to give informed consent, the interview would be terminated and possibly rescheduled for a later date. I would then explain to participants in detail the following steps taken to ensure their anonymity: I would assign each participant a number which would be used to identify him or her from that point on - no other identifying information would be attached to any materials; his or her consent form would be stored in a separate location with no way to match the consent form to any interview or questionnaire data.

As of May 4, 1995, the research proposal will be passed by a committee of University of Windsor faculty. My committee consists of Michael Kral, Ph,D., Assosiate Professor of Psychology, Charlene Senn, Ph.D., Assistant Professor of Psychology, Brian Burke, M.D., psychiatrist and adjunct Psychology faculty, and Eleanor Maticka-Tyndale, Ph.D., Assistant Professor of Sociology. The proposal will also be reviewed and approved by the Psychology Department's Ethics Committee to ensure that the study does not infringe upon the rights of the participants.

During my stay on Guam, I spent a great deal of time with two former Department of Mental Health and Substance Abuse staff members, Lilli Perez-Ten Fingers and Carlos Diaz, who were instrumental in acquainting me with Chamorro culture and introducing me to Department staff. With their help, I met with a

APPENDIX C

INFORMANTS' DEMOGRAPHIC DATA

Table 1

Demographic Characteristics

Characteristic	Frequency n[a] (%)
Island of Residence:	
Saipan	5 (20)
Guam	15 (75)
Gender:	
Female	10 (50)
Male	10 (50)
Living Arrangements:	
Alone	6 (30)
With Spouse	1 (5)
With Extended Family	6 (30)
Inpatient/Group Home Resident	5 (20)
Did not say	7 (35)
Marital Status:	
Married	2 (10)
Divorced	6 (30)
Did not say	12 (60)
Children:	
Yes	9 (45)
No	10 (50)
Did not say	1 (5)
Uses "sick" or "ill"	8 (40)
Uses "schizophrenic"	4 (20)
Travelled Abroad	2 (10)
Lived in U.S. Mainland	8 (40)

Note: [a]n=20.

APPENDIX D

JOE V., CHAMORRO MENTAL HEALTH CONSULTANT:

BIOGRAPHICAL DATA

Biographical Data on Joe V., Chamorro Mental Health Professional

Joe V., a Chamorro mental health professional from Saipan, was born and raised on Saipan until grade 10, when he attended private boarding school on Guam. He received his B.A. in Psychology at Washington State University, completed 3 years of medical school at University of Hawaii, when he decided to pursue his M.A. degree at Harvard. After working in the U.S., he returned to Saipan in 1992 to become a substance abuse specialist. In 1995, after a reorganization of mental health services, he became the director of the Division of Mental Health at the Commonwealth Health Center in Saipan.

APPENDIX E

CONSENT FORMS: ORIGINAL AND REVISED

Consent Form - Original

The purpose of this document is to inform you of the nature of this study and to obtain your written consent to participate. Please read the following statements and, if you wish to participate, sign and date below.

I understand that this study is being conducted by Lisa Keith from the University of Windsor, from Windsor, Ontario, Canada, as part of her doctoral program requirements. The purpose of this study is to attempt to explore the thought patterns and experiences of Chamorro people who may have had contact with the Guam Department of Mental Health and Substance Abuse, and how these experiences relate to Chamorro culture.

I understand that I will be interviewed and asked about my opinions, thoughts, and feelings about my life and experiences. I understand that this and any future interviews will be audiotaped for transcription purposes and subsequently erased. I understand that there will be no way to identify me from my responses to the interview. It is Lisa Keith's responsibility to keep my identity and opinions strictly confidential.

I understand that this study has been approved by the University of Windsor Psychology Department Ethics Committee (Dr. Roland Engelhart, Chair, (519-253-4232, extension 2222), whose purpose is to protect my rights and welfare. Any concerns I have about this study may be addressed to Lisa Keith at the University of Guam (734-9155), or Dr. Michael Kral, at the University of Windsor, Windsor, Ontario, Canada, N9B 3P4.

I also agree to permit excerpts of my responses to be used in research publications or for teaching purposes.

I have read and understand this form and I willingly consent to participate in this study. I have been given a copy of this form for my records. I realize that I can terminate the interview, stop the audiotape, or withdraw from the study at any time for any reason.

Signature: _____

Date: _____

Witness: _____

Consent Form - Revised

The purpose of this letter is to tell you about this research to get your written consent to participate. This form is to ensure that your rights as a research participant are protected. Please read the following statements and, if you wish to participate, sign and date below.

I understand that this study is being conducted by Lisa Keith from the University of Windsor, from Windsor, Ontario, Canada, as part of her doctoral degree. The purpose of this study is to explore the thoughts and experiences of Chamorro people who may have had contact with mental health professionals or local healers, and how these experiences relate to Chamorro culture.

I understand that I will be interviewed and asked about my opinions, thoughts, and feelings about my life and experiences. I understand that this and any future interviews will be tape-recorded so they may be typed at a later date. These tapes will then be erased. I understand that there will be no way to identify me from my responses to the interview. It is Lisa Keith's responsibility to keep my name and opinions strictly confidential.

I understand that this study has been approved by the University of Windsor Psychology Department Ethics Committee (Dr. Roland Engelhart, Chair, (519-253-4232, extension 2222), whose purpose is to protect my rights and welfare. Any concerns I have about this study may be addressed to Lisa Keith at the Northern Marianas College (670-234-0758, extension 1230), the University of Guam (671-735-2882), or Dr. Michael Kral, at the University of Windsor, Windsor, Ontario, Canada, N9B 3P4.

I also agree to let parts of my answers to be used in research publications or for teaching purposes.

I have read and understand this form and I willingly consent to participate in this study. I have been given a copy of this form for my records. I realize that I can end the interview, stop the tape-recorder, refuse to answer certain questions, or decide not to participate at any time for any reason.

Signature: _____

Date: _____

Witness: _____

APPENDIX F

GUAM DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE

RELEASE OF INFORMATION FORMS

DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE

"People Caring For People"

JK [illegible] CAMACHO
Director

T. MARY B. SANTZ
Deputy Director

CONSENT FOR RELEASE OF INFORMATION

I, _____, HEREBY GIVE PERMISSION TO
Client's Name (Print)

_____ TO CONTACT THE FOLLOWING
Staff's Name (Print)

INDIVIDUAL'S/AGENCIES INDICATED BELOW. I UNDERSTAND THAT THE PURPOSE FOR SUCH CONTACTS IS TOHELP IN THE EVALUATION AND SERVICES PROVIDED IN MY BEHALF.

Initial the boxes of those individual's/agencies to be contacted:

[ ] Family member(s): (name/relationship)_____

_____

[ ] Medical doctor/psychiatrist/psychologist: (name/address)_____

_____

[ ] Lawyer: (name/address)_____

_____

[ ] Probation/Parole Officer: (name/address)_____

_____

[ ] Employer/Supervisor: (name/address)_____

_____

[ ] Other(s): (name/address) _____

_____

_____ _____
(Signature of client, parent, guardian/Date) (Signature of Staff/Date)

I also understand that I can revoke this consent at any time to any of the parties indicated above.

Revoked this consent on: _____.
Date Signature

APPENDIX G

INTERVIEW SCHEDULE

Interview Schedule

ID Number:	Interview Date:
Location: Guam	Saipan
Gender: Female	Male
Age:	Education Level:
Marital Status:	
Village of Residence:	
Treatment:	
CHC Inpatient	CHC Outpatient
DMH Inpatient	DMH Day Treatment
DMH Case Management	

PART I: BACKGROUND CHARACTERISTICS

- How far did you get in school?
- Are you working right now?
- Tell me about your family. Siblings, parents, partner, children.
- Where were you born? Have you travelled off-island? Lived off-island?
- What activities do you enjoy?
- Do you live alone? With family?

PART II: DELUSIONAL THOUGHT

- How did you first come to the mental health center? What was happening at your life at the time?

PART III: INFORMANT'S OWN UNDERSTANDING

- Why do you think [symptom] happened? What do you think it means?
- Did you ever think that there were other reasons for [symptom]?
- Have you ever talked to people who had other reasons for these thoughts?
- Do you think this is different for different people? Would someone like Bill Clinton from the United States think differently?

PART IV: AMELIORATING FACTORS

- How did your family react to what was happening (mental health problems)?
- Extent of family involvement in treatment.
- What do you think other people could do to help you if you have these [symptoms] again?
- Do you think your experiences would be different in you had more support from family/community?
- What helped you most? What didn't help you at all?

PART V: ISSUES RAISED BY OTHER INFORMANTS

- Other people we've talked to have said that...does that make sense to you given your experiences?

PART VI: OTHER TOPICS OF INTEREST

- Tell me about the a) surohano; b) taotaomona; c) witchcraft; d) Chamorro culture; d) influence of Western culture.

PART VII: ANYTHING ELSE INFORMANT WISHES TO ADD

- Anything else you'd like to raise that we haven't talked about?

APPENDIX H

SUMMARY INTERPRETATIONS BY

THE CULTURAL CONSULTANTS

Interpretation - Transcript #003: Smith

From a disordered frame of reference, the informant struck me, from the very beginning, as an insincere individual who claims to have been poisoned, this affecting his mental state. First, he claims to be a mental health official, but then goes on to say that he has a problem with transportation - an inconsistency. The claims of great earnings were quite outlandish. His being "done in" by the hospitality of Pohnpeian competitors was quite cheap. Might there have been another reason why he chose to quit the business. It did not seem to be stress; in fact, the only stress he mentions happens to be what he experiences after he becomes disordered. In some ways, I get the impression that this man is somewhat opportunistic. Reasons for this include siring (production) of numerous children, the attitude that his children do not enjoy themselves because they are working, the easy paycheck with which to "have fun."

Interpretation - Transcript #003: Boddy

He blames his illness from being hypnotized by voodoo; someone poisoned his food. A competitor had his Pohnpeian wife cast spell on him. Competition is a big thing among Chamorro people. Just as long ago, there was ranking system based on family name as to which family had more property, more animals for raising. Same as today, who has biggest house, most cars, etc. Ranking is based on wealth, ancient times on most property and assets, today most valuable property and assets money wise. There is competition in society; to identify which families are seen as well off financially. Witchcraft is gone now because the Pohnpeian lady died. Witchcraft only way to get schizophrenia.

"I've seen my production" regarding his children. Long ago in Chamorro culture, children were seen as assets. He views his children as his creatures who will later produce for him. Assets in that they will contribute to family growth. They help in the household chores, participate in providing necessities for the family, and other contributions. Claims importance of Chamorro people is their customs and culture, for example, respect.

"Learn by hearing:" oral culture, pass on their knowledge - stories, traditions, etc. from generation to generation.

Interpretation - Transcript #005: Smith

The informant, thirty-three year old female, has been bothered by voices and hallucinations, depression, feelings of inferiority, mistreatment by family, a "horrible" childhood. She reported that she was able to endure four years without medication, so as not to bring the family embarrassment. Apparently, the informant is intelligent with a considerable degree of insight.

When the informant speaks about the positive and negative of life, she alludes to the parallel inner and outer life, realms where devils and God reside. In these places, attitudes and insight merge to result in whoever she happens to be at the moment.

The informant realizes the causes of her illness, heredity and stress, and claims that the trigger for the hallucinations she experiences was the drugs she had taken earlier. Interesting to note, when she talks about "being stressed out," she speaks about "it happen[ing] years ago now." Was the stressor a single event or factor contributing to the disorder? Also, when the interviewer asked a question about suicide, taotaomona, and Day Treatment, the informant would "freak out." What connection between the two might there be here?

The informant claims that Westerners have a frame of mind that complains, whereas Chamorros "take things as they come;" this may well be a reason she is schizophrenic.

Interpretation - Transcript #005: Boddy

The informant classifies mental illness to be a lower class disease, happening only to lower class people. She suggests that people with their illness are looked down upon in Guam. In addition, the informant believes that such an illness is caused by drugs, and can be hereditary in a family, just as she claims she would have become ill, even if she did not take drugs, as a result of stress which runs in her family.

When asked about taotaomona, the informant states that she is unsure if she believes in it, though she claims to have seen a "tall man" when she was a little girl, and had experienced visiting a local healer.

In addition, the informant talks about little support from her family, and how she felt as if she were being disowned once her family were aware of her illness. This was her reason for not wanting to be admitted into mental health to begin with, until her illness became severe. The informant also mentions how she feels inferior (looks down on herself) whenever she meets people who have a similar illness, as she does, and how she is uncomfortable having her family meet these friends of hers.

I believe that the basic theme of this interview revolves about "family." As in the Chamorro culture, embarrassing the family name is a very crucial matter to deal with. The idea is to keep the family name clean and pure in the eyes of society. This all reflects back to the informant's actions of holding back from being placed in mental health, and the little support her family offers. The informant also makes a comparison of how on Guam if illness is hereditary, people are looked down on, but if it is caused by drugs, you are pitied. This goes back to the family concept. Hereditary of such an illness if not left at an individual level, but rather it becomes a family matter. In other words, the family is categorized as being an ill family, and given a bad name.

Interpretation - Transcript #006: Smith

In her delusions, the informant epitomizes the primeval Chamorro psyche to an astonishing degree. While listening to the mother who she overly regards, she slips back to ancient Chamorro times when Chamorros had identity, when true communication occurred with the evidence of Chamorros speaking their language to each other; not just the vernacular (words) as we know it today. She goes on to tell about how taotaomona tries to tell Chamorros today that foreigners should leave the island so that the islanders would keep their "belongings" and not lose it. This ties in with the exclusiveness the woman's family maintains. Here, outsiders would come to know the natural ways of the family (culture) and devalue it, call it mutung. This cannot and will not be allowed by the culture. This unwillingness to share the real cultural self is seen when the interviewer asks about the Chamorro culture. The informant puts up a smoke screen that has to do with dancing, food, and "like this and like that." The last phrase is key to the evasion. "This" is truly Chamorro, and "that" is what the informant sees the Chamorro culture borrowing with ulterior motives in mind (e.g., bingo, alcoholic drink). The informant can benefit from them, but could also be killed, as in the case of liquor.

Interestingly, when the informant talks about what is normal and how everybody encouraged her to be normal, when she talks about the child-mother with mutung children, she seems to celebrate. Could she be affirming the need to remain Chamorro, with stinky ways that the foreigner may not be able to appreciate?

Interpretation - Transcript #006: Boddy

Mother's name is mutung (stinky, smelly). Father and mother married in court, not church. Due to religious identity, living in a Catholic culture, family should marry in church. This already leaves bad name for family. Mutung symbol of dirty or impure marriage.

Talks about this man coming into the bathroom, because he wanted to use it, and how she wanted him to go because she was using it. The odor was smelly, and this reflects feelings of embarrassing family. "People have no respect for people using the restroom" - respect for family, individual base. Person's privacy important because it reflects something about the family as a whole. Can't shame family name.

Taotaomona: cut neck off with a machete; bigger than anyone; if make mad, will cut your neck off too. Telling us that Westerners shouldn't be in our home because they are just telling us how to run our home. "They love their culture." Westernization will destroy the Chamorro culture as it is already beginning to do.

Food: kelaguen, red rice, hot pepper with coconut milk and fiesta reflect her concept of Chamorro culture, gathering of people for religious celebration.

"I wasn't normal because of the cord." She claims to have had a cord caught on her arm during birth - symbol of cut off circulation. Handicapped is when you don't use your brain.

Thinking of crazy things include sex and love (until older). Sex considered taboo in culture, not talked about. She knows of a person who had sex at a young age and had three children. She said the girl's children are stinky - symbolizing impurity; impurity of the girl who engaged in something taboo like sex.

Interpretation - Transcript #007: Smith

The individual demonstrates keen perception of what the Chamorro culture needs: an examination of what finer points may be characteristic of the culture, how the culture could stand to look at its "guilt points." Such an assertion contrasts with the aggrandizements common to cultures seeking to maintain identity. For this, he may be considered "abnormal;" in fact, he considers himself to be a "home" where introspection could freely be carried out.

The words he uses ("dwelling," "turning my cheek," "greater than he") give indications of Christian influences. Perhaps he has come to perceive himself to be a savior of the island culture that avoids self-examination, that he would show it how this is done. Because he has trouble identifying with Jesus, he feels more competent than Jesus to show the culture how to keep the natural high without getting "stuck mentally" and considering that his other brother, his psychic counterpart, was associated with witchcraft. Because the abusive brother was "big, great, strong" and was able to rob the informant of dignity, the informant would never be able to enjoy the peace that comes with a natural high. The informant would always devalue it, having had the arresting influences of abuse in his life.

Interpretation - Transcript #007: Boddy

The informant seems to be justifying the existence of the Chamorro people. "We were like an abstract of all those Westernized things," seems as if he is saying that the Chamorro culture (home) is less developed, modernized. However, that Chamorros are not left in the shadows of the Westernized world, rather, a unique and different lifestyle in itself.

The informant expresses a situation that happened when he was younger involving his brother. Apparently, his brother had hurt him many times, actually attacking him. This left the informant feeling alone, isolated from others, and feeling like a "joke" to his family. The situation that occurred with his brother was "shaking in his bed," using music as his main control. The informant says his brother did this to him. The informant is embarrassed by this. This reflects his lack of respect for himself, just as he claims he cannot face others because of the lack of respect. What his brother did to him was "dirty."

He claims witchcraft to be of a delusional state, and that taotaomonas are beasts, traditionally the souls of his ancestors. These are not factors for his illness.

APPENDIX I

TABLE OF CATEGORIES, SUBCATEGORIES, THEMES AND SUBTHEMES

Table 2

Categories, Subcategories, Themes and Subthemes for Major Category: Symptoms

Category	Subcategory	Theme	Subtheme
Delusions[a]	Persecutory[a]	Witchcraft Poisoning Male perpetrators Religious figures Taotaomona[b]	Powerlessness
	Grandiose[a]	Religious figures Nonreligious figures	Powerlessness
	Persecutory & Grandiose	Harm from others and Protected by powerful force	Powerlessness Fear
	Thought Broadcasting		
	Bizarre	Spaceships	
	Reference	Messages in music	
	Control[b]		
Hallucinations[a]	Auditory[a]	Nonreligious Religious	Shame Powerlessness
	Visual[a]	Nonreligious Religious	Fear Powerlessness
Thought Disorder	Difficulty Concentrating Loose Associations Neologisms		
Affect Disturbance			
Substance Abuse	Alcohol Marijuana Metamphetamines		
Suicidal Ideation			

Note. [a]A Priori categories; [b]A Priori categories not evident in data. All other categories developed post hoc.

Table 3

Categories and Subcategories for Major Category: Explanatory Models

Category	Subcategory
External Stress	Family abuse
	Death of family member
	School problems
	Interpersonal interaction
	Social change
Substance Abuse	Alcohol
	Marijuana
	Prescription medication
Witchcraft	
Biological Factors[a]	Birth trauma
	Brain dysfunction
Childhood Experiences	Media Exposure
	Family environment
Diathesis-Stress Model	
Taotaomona[b]	

Note. [a]A Priori categories; [b]A Priori categories not evident in data. All other categories developed post hoc.

Table 4

Categories and Subcategories for Major Category: Attitudes toward Traditional Beliefs

Category	Subcategory
Witchcraft[a]	Expressed belief
	Expressed disbelief
	Expressed conflicted opinion
Taotaomona[a]	Expressed belief
	Expressed disbelief
	Expressed conflicted opinion
Surohano[a]	Used services - helpful
	Used services - unsure if helpful
	Not used services - expressed belief
	Expressed disbelief

Note. [a]A Priori categories. All other categories developed post hoc.

Table 5

Categories for Major Category: Self Reflection

Category	Subcategory
Frustration or Distress	
Anger	
Loneliness or Isolation	
Description of Symptoms	

Table 6

Categories, Subcategories, and Themes for Major Category: Attitudes toward Treatment

Category	Subcategory	Theme
Inpatient Treatment[a]	Helpful	Relieved symptoms Away from stress
	Not helpful	Control of hospital staff Lack of confidentiality Inability to work/generate income
Day Treatment[a]	Helpful	Keep occupied Ability to work[a] Socialization Staff interactions
	Not helpful	Inability to be with family
	Conflicted opinion	
	Treatment recommendations	Talking therapy Transportation Supportive housing Employment
Psychotropic medication[a]	Helpful	
	Conflicted opinion	

Note. [a]A Priori categories. All other categories developed post hoc.

Table 7

Categories and Subcategories for Major Category: Attitudes toward Family

Category	Subcategory
Supportive[a]	Financial Emotional Practical
Unsupportive	Rejection Mistreatment
Abusive family	Extended family abuse Spousal abuse
Conflicted opinions	
Family shame	

Note. [a]A Priori categories. All other categories developed post hoc.

Table 8

Categories and Subcategories for Major Category: Description of Chamorro Culture

Category	Subcategory
Normative values	
Language	
Traditions and rituals	
Historical context	Influence of World War II American-Chamorro comparison

Table 9

Categories for Major Category: Attitudes toward U.S. Involvement

Category	Subcategory
Positive attitudes	
American-Chamorro conflict	

APPENDIX J

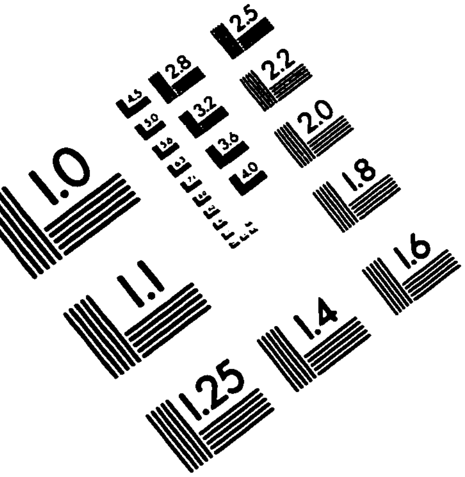
DEMOGRAPHIC GRID

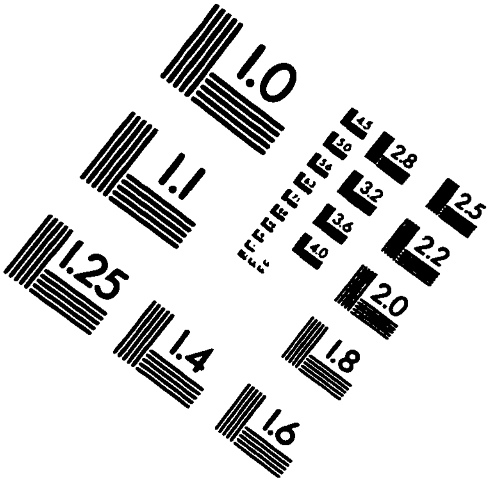
Characteristic	Transcript Number																		
	000	001	002	003	004	005	006	007	008	009	010	011	012	013	014	015	016	017	018	019
Name of Informant	Mary	Joaquin	Mark	Joseph	Jesus	Frances	Carm	Rod	James	Esco	Elaine	Marian	John	Erica	Susan	Jim	Jack	Sharon	Roy	Debra
Demographics																				
Saipan	✓	✓	✓	✓	✓															
Guam						✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Female	✓					✓	✓			✓	✓	✓		✓	✓			✓		✓
Male		✓	✓	✓	✓			✓	✓				✓			✓	✓		✓	
Finish high school		✓		✓																
Lives Alone					✓	✓		✓						✓	✓			✓		
Lives with Spouse										✓										
Lives with Extended Family	✓			✓								✓	✓			✓	✓			
Inpatient		✓	✓				✓		✓											
Married										✓				✓						
Divorced	✓			✓	✓		✓				✓	✓								
Children	✓			✓	✓					✓	✓			✓	✓					
Uses "sick" or "illness"				✓		✓		✓	✓			✓	✓		✓			✓		
Uses "schizophrenia"				✓					✓			✓						✓		
Travelled abroad				✓	✓															
Lived in U.S. Mainland						✓	✓	✓	✓		✓	✓			✓				✓	

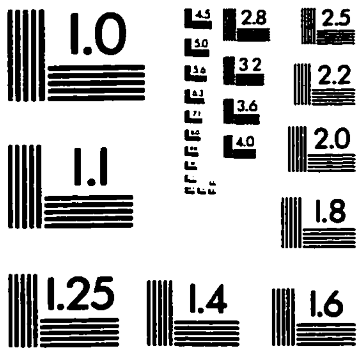
VITA AUCTORIS

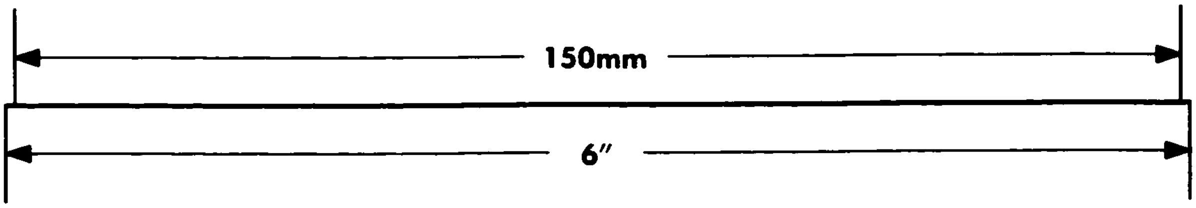
Lisa Keith was born to David and Susanne Keith in North York, Ontario, Canada, on October 3, 1966. She received her Honours Bachelor of Arts in Psychology, with Distinction, from Wilfrid Laurier University, in 1989. She received her Master of Arts in Clinical Psychology from the University of Windsor, in 1991. She received her Ph.D. in Clinical Psychology from the University of Windsor in 1996. She intends to pursue an academic career in cultural mental health.

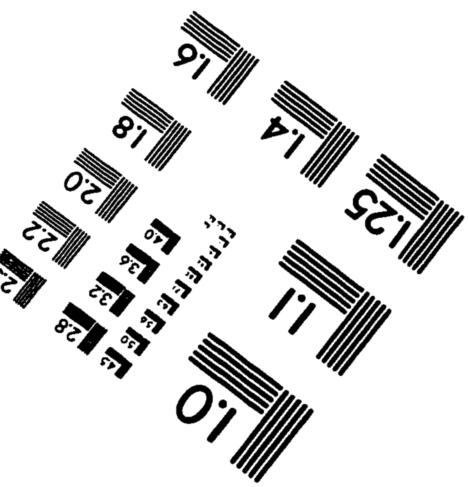
IMAGE EVALUATION TEST TARGET (QA-3)

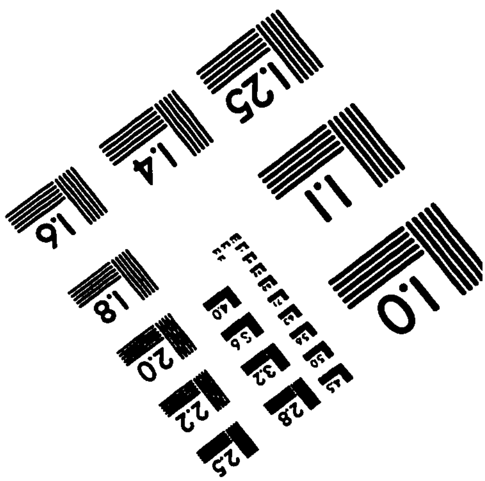












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