Appendix A: Description of DSM-IV Mental Disorders

Introduction
This appendix describes the DSM-IV mental disorders (APA 2000) included in Te Rau Hinengaro: The New Zealand Mental Health Survey.

All mental disorders
The symptoms associated with the individual mental disorders are listed below. These are brief summaries only; they do not itemise all the additional information that was obtained by the survey questionnaire to inform diagnostic classification. For all disorders, to reach diagnostic threshold the one common criterion required is that the individual must report that their symptoms cause significant disruption in their usual social or occupational functioning, and/or marked distress. Because this is common to all disorders, it is not restated in the summaries below.

Anxiety disorders
Panic disorder
Panic disorder involves experiencing recurrent panic attacks and, between attacks, being worried and distressed about the possibility of future attacks. Panic attacks are defined as a period of intense fear or discomfort that arises unexpectedly, in which four or more of the following symptoms develop quickly and peak within 10 minutes:

- pounding heart or accelerated heart rate
- sweating
- trembling or shaking
- sensations of shortness of breath or smothering
- feeling of choking
- chest pain or discomfort
- nausea or abdominal distress
- feeling dizzy, lightheaded or faint
- feelings of unreality or being detached from oneself
- fears of losing control or going crazy
- fear of dying
- numbness or tingling sensations
- chills or hot flushes.
At least two panic attacks plus a period of at least a month of persistent worry about having another attack are required for diagnosis.

**Agoraphobia**
Agoraphobia is anxiety about, or avoidance of, places or situations from which escape might be difficult, or embarrassing, should a panic attack (or panic-like symptoms) occur.

Typically feared situations include being in crowded places, travelling on public transport, and being in shops, elevators or lecture theatres. The feared situations are either avoided altogether (which can then lead to the individual having difficulty leaving the house at all) or are endured with extreme distress. Agoraphobia typically occurs in conjunction with panic disorder (and in such cases it is included in the panic disorder category in this survey), but it may also occur without a history of full panic attacks (in which case it is classified separately as ‘agoraphobia without panic’).

**Specific phobia**
Specific phobia is characterised by an intense and enduring fear of a specific object or situation/s. Encountering the feared situation provokes immediate anxiety or panic-like symptoms. Adults with specific phobia usually recognise that the level of fear provoked by the object or situation is excessive, although this insight does not reduce the anxiety they experience. The feared object is avoided or endured with extreme anxiety.

As with all the anxiety disorders, the diagnosis of specific phobia is made only if the fear or the associated avoidant behaviour causes significant interference with the person’s usual functioning and/or substantial distress.

**Social phobia**
Social phobia represents a strong and persistent fear of social or performance situations in which embarrassment might occur. Exposure to the feared situation provokes great anxiety, so it is avoided or endured with dread. Individuals with social phobia are greatly embarrassed by what they consider to be obvious signs of their anxiety (eg, trembling hands, blushing or sweating). They fear others will observe these signs and judge them to be ‘weak’ or ‘stupid’ or ‘crazy’ as a result.
**Generalised anxiety disorder**

The key feature of generalised anxiety disorder (GAD) is excessive worry and anxiety, occurring on more days than not for a period of at least six months, in connection with several issues or events (i.e., not just in relation to one specific issue or event). The individual with GAD finds it difficult to control the worry, and the worry is accompanied by at least three of the following symptoms:

- restlessness or feeling on edge
- being easily fatigued
- difficulty concentrating or mind going blank
- irritability
- muscle tension
- sleep disturbance.

**Post-traumatic stress disorder**

Post-traumatic stress disorder (PTSD) is characterised by the experience of a specific set of symptoms (see below), of more than one month’s duration, which develop following exposure to an extreme traumatic stressor. The stressor is defined as one in which the person has experienced, or witnessed, an event that involved actual or threatened death or serious injury, or threat of physical injury to the individual or others. In response to that event the person must have reacted with fear, helplessness or horror.

The symptom set that subsequently develops involves three components, all three of which must be experienced to receive a diagnosis of PTSD:

- re-experiencing the trauma, as indicated by one or more of the following:
  - recurrent and intrusive distressing recollections of the traumatic event (e.g., images or thoughts)
  - recurrent distressing dreams of the event
  - acting or feeling as if the event were recurring (including flashbacks and hallucinations)
  - intense distress or physiological reactivity at exposure to cues that are reminiscent of the event
- avoiding stimuli associated with the traumatic event and the numbing of general responsiveness, as indicated by three or more of the following:
  - efforts to avoid thoughts, feelings or conversations associated with the traumatic event
  - efforts to avoid activities, places or people that arouse recollections of the event
  - an inability to recall an important aspect of the trauma
- greatly diminished interest or participation in significant activities
- feelings of detachment or estrangement from others
- a restricted range of emotion
- a sense of a foreshortened future

- persistent symptoms of increased arousal, as indicated by two or more of the following:
  - difficulty falling or staying asleep
  - irritability or outbursts of anger
  - difficulty concentrating
  - hypervigilance
  - exaggerated startle response.

**Obsessive–compulsive disorder**

Obsessive–compulsive disorder (OCD) is characterised by recurrent obsessions and or compulsions (see below) that are severe enough to be time consuming (ie, take more than one hour in the day) or cause marked distress or functional impairment.

*Obsessions* are intrusive thoughts, ideas, impulses or images the person considers inappropriate or abhorrent, and that they feel they cannot control (although they can recognise they are a product of their own mind). Typical obsessions include thoughts about contamination (eg, from touching doorknobs or shaking hands), repeated doubts (eg, about whether they turned the stove off or whether they have hurt someone in a car accident) or horrific impulses (eg, to harm a loved one or shout an obscenity in church). The individual with obsessions usually attempts to ignore or suppress the obsession or ‘neutralise’ it with some other thought or action (ie, a compulsion).

*Compulsions* are repetitive behaviours that are carried out to prevent or reduce the anxiety associated with an obsession or to prevent some dreaded event (eg, washing hands until they are raw to reduce anxiety about contamination or checking doors constantly to ensure they are locked).

**Mood disorders**

**Major depressive disorder**

Major depressive disorder consists of one or more episodes of major depression; that is, a period of at least two weeks in which the individual experiences depressed mood (most of the day, nearly every day), or a marked loss of interest in all or almost all usual activities, plus at least four of the following symptoms every day or nearly every day:
- significant weight loss when not dieting, or weight gain or change in appetite
- insomnia or oversleeping
- psychomotor agitation (restlessness) or retardation (being slowed up)
- fatigue or loss of energy
- feelings of worthlessness or excessive or inappropriate guilt
- diminished ability to think or concentrate, or indecisiveness
- recurrent thoughts of death or suicidal thoughts or plans.

These symptoms should constitute a change from previous functioning in order to be criteria for a major depressive episode.

**Dysthymia**

Dysthyemic disorder involves depressed mood for most of the day, for more days than not, for at least two years, plus at least two of the following:

- poor appetite or overeating
- insomnia or oversleeping
- low energy or fatigue
- low self-esteem
- poor concentration or difficulty making decisions
- feelings of hopelessness.

To meet criteria for dysthymia, during the two-year period the person should not have been without the symptoms for more than two months at a time.

**Bipolar disorders**

Bipolar disorder (subtype I) is characterised by the experience of one or more episodes of mania.

Bipolar II is characterised by the experience of one or more hypomanic episodes, in addition to one or more episodes of major depression.

A manic episode is a distinct period of abnormally and persistently elevated or irritable mood, lasting at least one week, and accompanied by three or more (or, if the mood is only irritable, four or more) of the following symptoms, which should be present to a significant degree:

- inflated self-esteem or grandiosity
- decreased need for sleep (eg, only three hours)
• more talkative than usual or feel pressure to keep talking
• flight of ideas or feeling that thoughts are racing
• distractibility
• increase in goal-directed activity (at work or school, or socially) or psychomotor agitation
• excessive involvement in pleasurable activities that have a high potential for painful consequences (eg, spending sprees, sexual indiscretions, foolish business investments).

Hypomania is a milder form of mania. The symptoms of hypomania are much the same as for mania except they need be present for only four days and they are not severe enough to cause marked impairment in usual functioning.

**Substance use disorders**

The main substance use disorders are substance abuse and substance dependence. This survey collected information that enabled subclassification of the substance use disorders into alcohol use disorders, drug use disorders, and within drug use disorders marijuana use disorders. The summary provided here is generic across these substance types.

**Substance abuse**

Substance abuse is a maladaptive pattern of substance use that involves recurrent and significant adverse consequences, namely, one or more of the following:

• repeated failure to fulfil major role obligations at work, school or home
• recurrent substance use in situations in which it is hazardous (eg, driving or operating machinery)
• recurrent substance-related legal problems
• continued substance use despite recurrent social or interpersonal problems (eg, arguments with spouse about consequences of intoxication, or fights while intoxicated).

**Substance dependence**

Substance dependence is a pattern of use that is characterised by three or more of the following symptoms occurring at any time in the same 12-month period:

• tolerance, as defined by either:
  – a need for markedly increased amounts of the substance to achieve intoxication or the desired effect, or
Appendix A: Description of DSM-IV Mental Disorders

- markedly diminished effect with continued use of the same amount of the substance
- withdrawal (a substance-specific set of physiological, behavioural and cognitive symptoms associated with stopping regular use of the substance) or the taking of the substance to avoid withdrawal symptoms
- the substance is often taken in larger amounts or over a longer period than was intended
- a persistent desire or unsuccessful efforts to cut down or control substance use
- a great deal of time spent in activities necessary to obtain the substance
- important social, occupational or recreational activities given up or reduced because of substance use
- the substance use is continued despite its known negative effect on a physical or psychological problem (eg, an ulcer made worse by drinking alcohol).

Eating disorders

Anorexia nervosa
The key feature of anorexia nervosa is a refusal to maintain a minimally normal body weight (eg, less than 85% of that expected for age and height), accompanied by an intense fear of gaining weight and a disturbance in body weight perception (such that the individual sees herself to be overweight when she is actually underweight). To meet criteria for anorexia a woman who would normally menstruate should have experienced an absence of at least three consecutive menstrual cycles.

Bulimia nervosa
Bulimia nervosa involves recurrent episodes of binge eating (consuming an objectively much larger amount of food than would normally be consumed under similar circumstances), with inappropriate compensatory behaviour (eg, self-induced vomiting, use of laxatives or diuretics, fasting, excessive exercise). The episodes of binging and compensatory behaviour both occur at least twice a week for at least three months. These behaviours are accompanied by excessive emphasis on body shape and weight in the individual’s self-evaluation and self-esteem.
Appendix B: Screening Section Ethnicity Questions

The following question was asked of the participant at the beginning of the interview to determine the ethnic group the participant regarded herself or himself as belonging to. For more information, see 12.12.1.

*NZRDA2 Looking at showcard 1, which ethnic group or groups do you belong to?

- New Zealand European 1
- Māori 2
- Samoan 3
- Cook Island Māori 4
- Tongan 5
- Niuean 6
- Chinese 7
- Indian 8
- Other (such as Dutch, Japanese, Tokelauan, etc) 9

Specify other _____________________________________

Don’t know 98
Refused 99
Appendix C: Guiding Principles for the Kaitiaki Group and Research Team

The following principles were established to provide support and guidance to the Kaitiaki Group and researchers of Te Rau Hinengaro: The New Zealand Mental Health Survey (initially called the New Zealand Survey of Mental Health and Wellbeing). These principles also accompany the Protocol for Access to Māori Data.

The principle of Partnership: The entire research endeavour will actively recognise the Treaty of Waitangi as the basis of a joint undertaking between Crown and Māori; the principle of Partnership will be reflected in research practice and implementation of findings.

The principle of Active Protection: In all aspects of the research process the New Zealand Mental Health Survey will endeavour first and foremost to ‘do no harm’ to Māori and Māori interests.

The principle of Relevance: The New Zealand Mental Health Survey through implementation and application will contribute to health gains for Māori.

The Tikanga principle: All aspects of the New Zealand Mental Health Survey must be consistent with tikanga Māori.

The principle of Reciprocity: The relationships between researchers, participants and communities of interest will ensure reciprocal benefits.

The principle of Development: The New Zealand Mental Health Survey will be consistent with the broad directions of positive Māori development.

The Mātauranga principle: The New Zealand Mental Health Survey will contribute to advancements in knowledge and to other understandings of Māori health. The study is not an end point in itself.

The principle of Human Dignity: Participants in the New Zealand Mental Health Survey will be valued as individuals and afforded due respect.

The principle of Enhancement: The New Zealand Mental Health Survey will lead to an expansion of Māori research capacities, including workforce development and methodological innovations.
Appendix C: Guiding Principles for the Kaitiaki Group and Research Team

The Kaitiaki principle: The New Zealand Mental Health Survey will promote the protection and guardianship of Māori contributions and Māori knowledge.

The principle of Elucidation: The New Zealand Mental Health Survey will contribute to a clarification of Māori mental health status, disability and patterns of health service use.

These principles follow a discussion of the Kaitiaki Group at Ngā Whetu Mārama (Tiaho Mai complex) at Middlemore Hospital on 20 August 1999.
Appendix D: Survey Participant Consent Form

Note: Te Rau Hinengaro: The New Zealand Mental Health Survey was initially called the New Zealand Survey of Mental Health and Wellbeing.

New Zealand Survey of Mental Health and Wellbeing Consent Form

I agree to help the Ministry of Health on the New Zealand Survey of Mental Health and Wellbeing by carrying out the interview.

The survey has been explained to me by the NRB interviewer and I have been given a copy of the brochure to keep.

The National Research Bureau Interviewer has told me that:
- My answers are used only for statistical research.
- My name is not put in or with the questionnaire.
- Nobody can know or find out what my answers were.
- My answers are protected by the Privacy Act.
- Only the survey supervisor may call me to check the interview was done correctly and politely.
- It is my choice to take part. I can stop if I want to.
- There is no disadvantage to me if I don’t take part or stop.
- I have been shown the phone number(s) I can call if I feel upset by the interview.

Signed: __________________________________________________________

Print name: _______________________________________________________

Date: _____ / ______ / _______

Interviewer’s signature: _____________________________________________  Int. No. _____
### Request for interpreters

<table>
<thead>
<tr>
<th>Language</th>
<th>Request in Language</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>English</td>
<td>I wish to have an interpreter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha</td>
<td>Ae</td>
<td>Kao</td>
</tr>
<tr>
<td>Samoan</td>
<td>Ou te mana’o ia i ai se fa'amatala upu</td>
<td></td>
<td></td>
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<tr>
<td>Tongan</td>
<td>Oku ou fiemai’u ha faikatoniela</td>
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<td></td>
</tr>
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<td>Cook Island</td>
<td>Ka inangaro au i tetai tangata uri reo</td>
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<td></td>
</tr>
<tr>
<td>Niuean</td>
<td>Fia manako au ke faka’aoga e taha tagata fakahokohoko kupu</td>
<td>E</td>
<td>Nakai</td>
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Appendix E: Mental Health Research and Development Strategy Website Content

Information about Te Rau Hinengaro: The New Zealand Mental Health Survey and the documents listed below are available from the Mental Health Research and Development Strategy website (http://www.mhrds.govt.nz).


References


References


References


Kessler RC, Ustun B. 2000. World Mental Health 2000 Initiative: mental health can have a serious impact on quality of life. A new initiative has been set up which will study this in more depth. *Hospital Management International*: 195–6.


References


