The Arab Journal of Psychiatry (2012) Vol. 23 supplement Page (28-34)

Problems in Applying Diagnostic Concepts of PTSD and Trauma in the Middle East

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مشاكل في تطبيق المفاهيم التشخيصية لاضطرابات ما بعد الصدمة، والصدمة في الشرق الأوسط

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Abstract

The aim of this paper is to examine the conceptual and cultural validity of the diagnostic concept of Post-Traumatic Stress Disorder (PTSD) as applied to traumatized people in the Arab region, and to consider the implications of this examination for the development of the ICD-11 by the World Health Organization. The transcultural applicability of the diagnostic category of PTSD as currently described in both ICD-10 and DSM-IV has been a matter of extensive debate, both in terms of the category's validity and in terms of its clinical utility for people in the Middle East. Although the diagnostic construct of PTSD describes some features of a universal trauma response, it ignores other, more culturally-specific forms of expressing trauma-related symptoms. These local idioms of distress should be considered in the development of a new classification system intended to be globally applicable. Mental health professionals need this information to more accurately assess illness presentation, to better communicate their understanding and concern, to promote treatment acceptance, and to reduce disease burden. The existing diagnostic conceptualization of PTSD also contributes to the medicalization of suffering and risks diverting attention from understanding and addressing the broader social causes and consequences of traumatic events such as war and genocide. The new classification should consider changing the name of PTSD to "Trauma Reactions", broaden the concept considerably, and discourage its overuse as an explanatory concept for widespread suffering in situations of violent political conflict.

Keywords: ICD-11, ICD-10, PTSD, Trauma, Arab Region, Mental Health
Declaration of Interest: None

Introduction

Post-traumatic stress disorder (PTSD) has been recognized since the 19th century, when trauma syndromes were first identified among combat veterans, and called "soldier's heart", "shell shock", or "combat fatigue". In the World Health Organization's (WHO) International Classification of Diseases and Related Health Problems, Ninth Revision (ICD-9)[1], approved in 1975, "combat fatigue" was listed as an inclusion term under the category Acute reaction to stress, described as "Very transient disorders of any severity and nature which occur in individuals without any apparent mental disorder in response to exceptional physical or mental stress, such as natural catastrophe or battle, and which usually subside within hours or days".

PTSD was first introduced as a diagnosis in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition in 1980[2] to describe the adverse reactions experienced by combat troops returning from the Vietnam War. In the DSM-IV, PTSD is characterized by three main groups of symptoms. First, the traumatic event is persistently re-experienced in recurrent intrusive distressing recollections of the event, for example through "flashbacks, images, or dreams. Second, the person must exhibit avoidance of thoughts, places, ideas, images and persons associated with the traumatic event. And third, the person demonstrates hyperarousal through symptoms such as difficulty in failing to sleep, outbursts of anger, and hypervigilance. The symptoms must have been present for at least one month and lead to significant distress or impairment in important areas of functioning. Researchers and clinicians in the U.S. and elsewhere welcomed the diagnosis and began to routinely apply the newly available diagnosis of PTSD to the effects of trauma they observed in their research and clinical samples.

Accordingly, the category Post-traumatic stress disorder was also added to ICD-10, which was approved in 1990[3]. The ICD-10 definition was similar to the DSM-IV definition in content, but more flexible in not defining precise symptom cutoffs and allowing a greater range of symptomatic presentation. As approved by the World Health Assembly, the ICD-10 definition of PTSD is as follows:

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone….Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In

a small proportion of cases, the condition may follow a chronic course over many years…

Another difference between the DSM-IV and ICD-10 definitions is that DSM-IV required that the stressful event involve "actual or threatened death or serious injury, or a threat to the physical integrity of self or others". ICD-10, on the other hand, specified only that the stressful event had to be "exceptionally threatening or catastrophic". DSM-IV also required that the person respond with "fear, helplessness, or horror" at the time of the event, while no such requirement appears in ICD-10.

Despite these differences, since its inclusion in both the DSM and the ICD, the concept of PTSD has been applied around the world in screening and diagnosis in relation to virtually all major trauma-related events, whether human-made or natural disasters.

Surveys of PTSD Prevalence in the Middle East

Given the high rates of war, violence and trauma in Arab countries over the past several decades, any useful definition of PTSD would need to be applicable to the region. Surveys of current rates of PTSD have been conducted in several Arab countries using different research instruments, and have reported wide range of PTSD prevalence rates. One study of the Occupied Palestinian Territories found a prevalence of PTSD of 34%[4]. Another study done in the Occupied Palestinian Territories that differentiated by severity levels found that 33% of the population had an acute or high level, 49% had a moderate level, and 15.6% had a low levels of PTSD[5]. In southern Lebanon immediately after the 2006 war, the prevalence of PTSD was found to be 29.3%[6]. A study of Kuwaiti children following the Gulf War found the highest rates of PTSD, with more than 70% children reported to have moderate to severe PTSD[7]. A study of Sudanese nationals and refugees found that 48% of those who remained in their villages and 46% of refugees exhibited PTSD[8]. The most common PTSD symptom cluster was found to be increased arousal followed by re-experiencing the traumatic events; the least common symptoms were in the domain of avoidance and numbing. Physical complaints dominated the picture in 23.6% and depressive symptoms were present in 87% of the victims[9]. Another Middle Eastern study showed that avoidance symptoms were reported least frequently, with the exception of trying not to think, talk, or have feelings about the traumatic event. Re-experiencing symptoms were generally reported more frequently than avoidance and arousal symptoms[10].

Category Fallacy and Syndrome Non-Equivalence

The studies described above have used various instruments to measure the prevalence of PTSD in different countries. The items of all these scales are derived from the DSM-IV symptom clusters, based on an unproven assumption that these clusters are culturally and conceptually valid in different sociocultural contexts. Using such PTSD scales that are derived from a U.S.-based conceptualization in other countries, even when they are translated into the local language, does not guarantee that these instruments are identifying equivalent conceptualizations or the same experience of symptoms and mental illness among different populations. The use of such U.S.-derived scales without the addition of culturally appropriate social representations and local idioms of distress may lead to what Kleinman[11] has described as "category fallacy"[12].

Idioms of distress are culturally-specific ways of communicating distress using a symptomatic vocabulary and based on an explanatory model that is culturally understood and, to varying degrees, accepted. People in different parts of the world, including people in Arab countries, express their reactions or "symptoms" within particular social and cultural contexts that are different from professional diagnostic standards and practice[13,14]. The meaning of a particular symptom, for example, chest pain, may be quite different from one idiom of distress to another and may be understood in a specific cultural context in a completely different manner from how it might be understood as a cardiac symptom in the vocabulary of Western medicine. The fact that an Arab respondent in Western Sahara has endorsed the same symptom on a standard PTSD questionnaire as a U.S. respondent in West Los Angeles does not mean that they have the same experience, that they interpret it in the same way, or that the symptom has the same diagnostic meaning.

Social and cultural representation of trauma in Arab culture

In the non-Western world, psychological complaints are presented using certain metaphors that are culturally understood but which psychiatric nosology, so far, has failed to embrace. This also extends to the way in which people discuss and the meaning that they assign to their experience and to traumatic stressors[15, 17].

In an earlier article about social representations of trauma and the meanings assigned to trauma among Palestinians living in protracted conflict situations in the Gaza Strip[13], we described three main types of trauma according to the severity, nature, and course of the symptoms associated with the experience: sadma (trauma as a sudden blow with immediate impact), faji'ah (tragedy), and musiba (calamity). Sadma is used metaphorically to refer to painful events that happen suddenly. Faji'ah is used to describe the reaction to an extraordinary event, mainly the loss of a loved one. Musiba is used when traumatic events are persistent and have long-term consequences. We suggested that Palestinians have placed their suffering in the

contemporary political context in which their suffering ("symptoms") has occurred, and this provides them with options for positive actions within that context.

In Arab culture, anxiety and depressive reactions ("symptoms") are seen as states with which people should learn to live, and complaints are described using certain metaphors and phrases related to internal feelings and emotions. For example, "my heart is dead" is used to describe personality strength or because the person has had a lot of painful experiences and so has become used to hearing bad news. "I am talking to a wall" is used when the listener shows indifference and is not listening well[18]. In a community sample in Dubai, Sulaiman et al.[19] identified [22] expressions used by people to express their depressive state. In Egypt, Hattar-Pollara et al.[20] reported that women described their guilt, anxiety, and dissatisfactions with their performance as mekassara, which means always feeling short in meeting one's goals, and asabiah, which is related to a number of emotional states, including being nervous, emotional, short-tempered, volatile, anxious, angry, having poor impulse control, and rage[13].

These metaphors illustrate that people describe psychological experiences and psychiatric symptoms using a socially-based vocabulary, rather than a universal and biological one, in order to express their suffering, to engage with their social environments, and to interpret their traumatic experiences. As Engel[21] noted in his seminal paper, explaining mental suffering in entirely psychiatric terms is a "reductionist" view of human adversities. Consequently, there is a need for incorporating social, political, cultural and economic factors as important dimensions in formulating and understanding PTSD and other mental health conditions and assessing the overall mental health impact of exposure to continuous, repetitive, and extreme forms of trauma.

Contextual Factors in the Experience of Trauma in the Middle East

As the preceding discussion suggests, applying the current "Western" conceptualization of PTSD to populations in many Arab countries is conceptually and culturally problematic. For example, events that would be widely perceived as traumatic in countries where there is little violence or oppression may not be perceived as extremely distressing in societies living with daily conflict and political violence[22,24,26]. Similarly, whether an event is perceived as life threatening and arouses intense fear, horror, or hopelessness will depend on the context.

One issue this raises relates to the nature and severity of the stressor in relation to PTSD symptomatology. The ICD-10 and the DSM-IV both use the nature of the stressor as a threshold for the diagnosis of PTSD, although the ICD-10's use of it is more flexible. Even so, it is unclear that an event can be considered to be "exceptional" if it happens continually to an entire population, and how this impacts traumatic symptomatology has not been sufficiently considered[25, 27]. Relatedly, the descriptions in both systems appear to assume that the stressful event has ended, and now intervention is needed, which would be an accurate model in most post-conflict or natural disaster situations. But the descriptions do not speak to a situation that has become relatively common in the Arab world, in which the described latency period for development of the syndrome never passes without a new exposure to the traumatic event. Palestinians, Iraqis, and Syrians, for example, have been living in persistent political violence and subjected to multiple, repetitive and continuous traumatic events. How this changes symptomatology and course, and how ICD-11 can accurately encompass and describe these types of experiences and their aftermath should be considered as part of the revision process.

Several studies in Arab countries have taken a more complex and contextual view that can shed some light on what happens in situations of chronic traumatic experiences. One study of Darfuri refugees examined symptoms in relation to a continuum of stressor severity ranging from non-traumatic to traumatic events, as well as a number of contextual factors, and found that having concerns about one's safety and the ability to meet one's basic needs was a stronger predictor of severity of current PTSD symptoms than was the severity of traumatic stressors[28]. In a multi-country study (Algeria, Cambodia, Ethiopia and Gaza), De Jong et al.[29] found that stress may reactivate distress related to past trauma, which is a mediator of the effect of stress on current PTSD symptoms.

A variety of studies have examined factors related to individual vulnerability (e.g., history of child abuse, general health status) and environmental circumstances to contribute to a better understanding of the large variation in individual responses to traumatic stress[16,23,30,31,32]. Despite this, previous studies of trauma have generally failed to consider that many traumatic events are collectively experienced or how the collective response of groups or populations may mediate the individual experience[33,34, 35]. Existing PTSD research has placed insufficient attention on whether traumatic events are experienced as a family system, a subgroup, a community, or a culture, which would also appear to be a distinguishing feature of many of the traumatic events experienced in the Middle East. Collective trauma has broader meanings that are reflected in social processes, and understanding these is essential to accurate clinical formulation and effective intervention[16, 36].

In a pioneering study investigating long term effects of war and political violence on the interpersonal and intrapersonal resources among Palestinians living in

Gaza, West Bank and East Jerusalem, Canetti et al.[37] showed that the loss of interpersonal and intrapersonal resources was a strong predictor of both PTSD and major depression. PTSD was positively associated with age and frequency of exposure to political violence and interpersonal resource loss was associated with occupation and loss of faith in government. The study also showed that men's exposure to political violence was associated with both greater PTSD and depression, while women's greater exposure to socio-political stressors, but not to political violence, and was associated with greater depression, not PTSD. It is one of the few studies that have widened the focus of the traditional intrapsychic perspectives of trauma to the influence of socio-political conditions on mental health.

The Risks of Medicalizing Trauma

Conrad and Barker[38] mapped out the three main roots of "social construction of illness", indicating that certain human behaviors, reactions and expressions of afflictions (i.e. "symptoms") that occur in response to specific social and environmental conditions tend to be medicalized, and this process of medicalization acts to control people's behavior. People who live in political conflicts and whose lives have been constrained and damaged by political violence often do not see themselves as ill. Medicalization in this context effectively depoliticizes their suffering, blunting the demand for change and perhaps hindering their individual recovery. When social suffering is medicalized, the socio-political and economic context of the problem is ignored and marginalized, and suffering is seen as individual. Individualized medical interventions are designed as logically consistent responses to individual reactions or "symptoms". All efforts will be directed towards diagnosing and finding medical solutions, missing the underlying causes of the problem.

Many residents of the Occupied Palestinian territories and some other Arab countries have been flooded with traumatic experiences, but, rather than seeing themselves as victimized by political violence, many see their victimization as related to the underlying social conditions that preceded it. Some actively interact with their political environment and consider their participation in a political struggle to be empowering, which raises their self-esteem[22]. On an individual level, applying a static PTSD approach to this dynamic and complex political process is likely to limit our understanding of the individual's experience because it excludes these socio-cultural and political factors. At a social level, applying the construct of PTSD in certain situations carries a risk of medicalizing human suffering, turning the sufferers into patients and objectifying them. This may decrease social and moral responsiveness to traumatizing events such as war or genocide and divert attention from understanding and addressing their broader social causes and consequences[13,39].

Conclusions

Most existing research on trauma and its impact has emphasized the diagnosis of PTSD rather than the relationship of traumatic events to broader indicators of health. To this extent, the diagnostic construct of PTSD has narrowed the focus of research in a manner that has not been helpful. Trauma and traumatic events encompass much wider experiences than the medically constructed label of PTSD. These include the experience of loss at the personal and community level, the personal and cultural meanings of trauma, the idioms of distress in which reactions are expressed, the collective and political meaning of these experiences, and ways in which all of these factors may contribute to continuing a cycle of violence or to successful coping and adaptation. Trauma research studies, with a much wider focus that can encompass these areas, are urgently needed in communities that are exposed to continuing violence and political conflict situations, as are a number of Arab countries.

Trauma is an emerging and evolving concept, both in the Middle East and globally. Health care professionals must balance the need for standard assessment and diagnostic practices with an appreciation of people's context, strengths, resilience and resources in order to arrive at the most useful clinical formulation and the best available treatment strategies. Although the diagnostic construct of PTSD does appear to accurately describe some features of a universal trauma response, it appears less useful as a clinical formulation for Middle Eastern countries than one that builds on local forms of expressing trauma-related reactions and psychopathology. Sufferers may express in their own idioms of distress, and with their own interpretations, more of the specific qualities of their experience that are likely to be related to broader health indicators and outcomes. Clinicians should use this information to more accurately assess illness presentation and its functional impact, to better communicate understanding and concern, and to promote treatment adherence.

In the opinion of this author, we would do well to stop questioning the cultural validity of PTSD, particularly in the Middle East, because there is no fundamental universality for such a clinical condition. Rather, it is made up of anxiety, depressive, somatic, and dissociative symptoms. Therefore, the focus our analysis should be on the question of the wide heterogeneity of responses to traumatic events, which responses may be most adaptive for what groups, and how this information can be used to develop better and more culturally sensitive treatments to alleviate suffering.

Western psychiatry and psychotherapy are fundamentally individualistic, and some therapeutic models emphasize intrapsychic processes related to past traumatic experiences and the need to "work through" these experiences and unconscious conflicts. In the Arab

context, understanding intrapsychic conflicts and revealing unconscious emotions are not necessarily significant to solving mental health problems, whereas family relationships and social pressures are much more influential and important. Following a Western paradigm can sometimes lead to family and social struggles that result in a negative impact rather than a positive therapeutic effect.

Based on currently available proposals, the DSM appears to be moving in the direction of making PTSD a more inclusive and more heterogeneous category. Phillips[40] has argued that, even with the new additions proposed for the DSM-5, the PTSD construct is not broad enough to encompass cultural differences, local idioms of distress, and explanatory models experienced by the non-Western cultures. If this is the case, the DSM-5 construct is unlikely to be very helpful in understanding how people experience and explain their reactions ("symptoms"), their thoughts and beliefs about these experiences, and how best to help them when they become trapped in maladaptive patterns.

Recommendations for ICD-11

Based on the above considerations, the following recommendations are made for changes to the concept of PTSD in ICD-11:

1. Change the name of Post-Traumatic Stress Disorder (F43.1) to "Trauma Reactions" in order to minimize inappropriate medicalization.
2. Include local idioms of distress and expressions that have been used to describe reactions to traumatic events in the descriptions for stress-related disorders
3. Expand the number of symptoms described to encompass greater variation in how people experience and express distress in relation to trauma.
4. Attend specifically to chronic traumatic circumstances and move away from a model that is based on one-time traumatic experiences that have ended at the time of assessment.
5. Discourage overuse of PTSD as an explanatory concept in situations of violent political conflict.

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ملخص

أن الهدف من هذا البحث هو دراسة الصلاحية النظرية و الثقافية لمفهوم تشخيص اضطراب ما بعد الصدمة كما يتم تطبيقها على الناس المصابين بصدمات نفسية في المنطقة العربية، و كذلك النظر في الآثار المترتبة على هذا الفحص على تطوير النسخة الحادية عشرة للتصنيف العالمي للأمراض، من قبل منظمة الصحة العالمية. أن إمكانية تطبيق الفئة التشخيصية لاضطراب ما بعد الصدمة عبر الثقافات على النحو المبين في الوقت الراهن في النسخة العاشرة للتصنيف العالمي للأمراض و الدليل التشخيصي والإحصائي للاضطرابات العقلية- الطبعة الرابعة، كان موضوع لمناقشة مستفيضة، سواءاً من حيث صلاحية هذه الفئة أومن حيث فائدتها السريرية للناس في الشرق الأوسط. على الرغم من أن التركيبة التشخيصية لاضطراب ما بعد الصدمة يصف بعض الملامح العالمية للإستجابة للصدمة، فإنه يتجاهل ملامح أخرى للإعراض المرتبطة بالصدمة، خاصة بالناحية الثقافية. وينبغي الأخذ بعين الإعتبار المصطلحات المحلية للضيق في تطوير نظام تصنيف جديد يقصد أن يكون عالمي التطبيق. أن العاملين في مجال الصحة النفسية في حاجة إلى هذه المعلومات لتقييم أعراض المرض على نحو أكثر دقة، وللتواصل بشكل أفضل حول مفاهيمهم و همومهم، وللترويج لقبول العلاج، وللحد من عبء المرض. التصور التشخيصي الحالي لإضطراب ما بعد الصدمة يساهم أيضا في إضفاء الطابع الطبي للمعاناة و يخاطر بتحويل الإنتباه عن فهم ومعالجة أسبابها الإجتماعية الأوسع نطاقاً والنتائج المترتبة على الأحداث المؤلمة مثل الحرب والإبادة الجماعية. ينبغي للتصنيف الجديد في النظر في تغيير مصطلح اضطرابات ما بعد الصدمة إلى "ردود فعل الصدمة"، وتوسيع المفهوم إلى حد كبير، وعدم تشجيع الإفراط في استخدامها كتفسير للمعاناة الواسعة النطاق في حالات الصراع السياسي العنيف.

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