traumaclinic counselling

TRAUMATIC STRESS: AFRICAN IDIOMS AND THE VALIDITY OF CURRENT DIAGNOSTIC SYSTEMS

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Course outcomes:

When you have completed this course you will have an understanding of:

- How various disorders, especially PTSD are understood differently according to different parts of the world and different cultures
- What somatisation is and what part it plays in PTSD
- How PTSD is classified according to the DSM and how this compares to cultural understandings and expressions of distress and trauma

CONTENTS

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A note on the learning and teaching approach

This course is built on the principles of supported open learning pioneered by the UK Open University and developed by South African Institute for Distance Education (SAIDE) and The SACHED Trust. Course participants (Students) are asked to do all the tasks as they appear in the text in order to take full value from the course. There are three kinds of task:

Fact check – to memorise key knowledge items

Reflection and analysis – to take time to actively engage with the ideas in the course

Assignments – a chance for an extended written task to consolidate your knowledge and express your views.

OVERVIEW

Western psychodiagnostic categories, as defined in DSM-IV, ICD-10 or DSM-V (still to be finalised), are often not appropriate in non-Western cultures. Western researchers have been inclined to reify a Western culturally constructed concept and use it in cross-cultural research procedures. This procedure is called the category fallacy (Kleinman, 1977; Kleinman & Good, 1985). That is, one first defines the Western category, then starts looking for that category in a non-Western culture, and subsequently finds what was defined earlier. In research practice this means that one is testing the construct validity of the diagnosis in the non-Western culture. Let us examine some of these constructs/diagnoses in an African context.

1 POSTTRAUMATIC STRESS DISORDER

In most studies on PTSD, investigators first define PTSD along DSM-IV criteria, and then search for that “disorder.” However, if they would carefully listen to the phenomenological stories, or narratives, of people, the reported complaints might not match the Western category. Even though most scholars find PTSD around the globe, the conclusion that PTSD is similar in all cultures is false, since the studies did not look for differences that might have yielded so-far-unknown (sub) types or variations of the disorder. For that reason, we cannot rule out the possibility that PTSD is an a priori, culture-bound construct. Several authors therefore prefer the term (post)traumatic stress syndrome [(P)TSS] instead of disorder. It is obvious that a similar reasoning can be applied to most psychiatric disorders.

1.1 Differences in how people perceive and express distress

Even if one agrees that most of the Western categories do indeed apply in low and middle income countries (LAMIC), there can still be considerable differences in the way people perceive or express their plight or illnesses. For example, stress and depression are often

described as “thinking too much” in low-income countries. Globally it might be more appropriate to perceive depression as a loss of vital substance, or of a part of the soul, rather than a “sinking of mood” as it is described in DSM. Another example is the expression of feelings of guilt and shame which can vary from one culture to another.

In many parts of Africa it is quite common that a person has a number of physical sensations, such as heat, cold, or prickling sensations in some parts of the body, pulsating experiences, moving heaviness through the abdomen, discomfort of the heart, creeping sensations under the skin or the skull, or bubbling or scratching sensations in the head. Or alternatively, the distress can be expressed in a variety of dissociative patterns, which even the local culture might find difficult to assess as normal or deviant (for example, when people display what used to be called a ‘hysterical state’ or a possession trance).

These and other behaviours can be seen as typical templates which the culture gives to its members to express their plight. The same holds for the way people express complaints or emotions in their language. The local language or lingua franca can use a number of expressions, metaphors, proverbs, or emotion words to express a complaint or an emotion that are quite different from Western jargon.

Therefore, one has to carefully make an inventory of the expression of distress in other cultures (the “idioms of distress”) before one can conclude that the way people perceive their problem is the same as the DSM/ICD categories. If these diagnostic challenges are not met, various diagnostic errors can occur. Either a clinician can miss the PTSD diagnosis because associated features are most prominent, or the associated features can be overlooked because of the presence of PTSD.

It is important for helpers to realise that the local context shapes the meaning and understanding of suffering while also contributing to its resolution. For a clinician it is more important to understand the meaning of suffering than how the experience fits in a diagnostic category. It is obvious that this is not only a human, but also an ethical issue because real understanding of what the distress means to a person, and what he wants to signal to us, is more important than how the distress fits a biomedical or diagnostic category.

Blank (1994) has written a useful guide for clinicians evaluating posttraumatic responses. He repeatedly emphasizes the variety of reactions to trauma. He says that when assessing the plight of a person, one has to take into account that the reactions to trauma are often intertwined with the cultural transitions they are confronted with, along with acculturative stress, culture shock, and cultural bereavement. This raises questions regarding aetiology and whether one is in fact dealing with traumatic stress, the effects of daily hassles for example among refugees and internally displaced persons (IDPs), or a combination of coping style and acculturation.

1.2 Diagnostic instruments

A diagnostic or research instrument developed in one culture has to be tested before being applied in another culture. This helps to bring understanding of the concepts underlying the items of the instrument, testing them for their semantic and conceptual content, as well as technical validity. This will show if a concept can be relevant in one culture and have

significance in another. How to properly adapt instruments has been described elsewhere (de Jong & van Ommeren, 2002; van Ommeren et al., 1999).

1.3 Epidemiology and treatment

At times research on extreme stress has gravitated toward the epidemiology and treatment of PTSD. Yet, the study of this Western diagnostic category in non-Western contexts can lead to its reification without evidence that this category is the most relevant of all the possible descriptions of local survivors' mental health problems. This has resulted in selective attention to PTSD in many intervention programs at the expense of other types of mental health problems that are elevated as well.

De Jong et al. (2001, 2003) found that PTSD is not only associated with an experience of conflict violence, but also with a range of other stressors, such as the quality of the refugee camps, or daily difficulties (de Jong et al., 2001). We also found that rates of disorder tend to be significantly higher in people who had experienced armed conflict–associated violence. The largest risk ratios were for PTSD, ranging from 10.03 in Palestine to 3.14 in Algeria. Interestingly, for mood disorder, risk ratios were 6.06 in Ethiopia and 4.53 in Palestine. For other anxiety disorders, risk ratios ranged from 2.10 to 3.16 in Ethiopia, Algeria, and Palestine. Moreover, we found that disability was more frequently associated with mood disorder and anxiety disorder than with PTSD. This calls for a paradigm shift among professionals who focus more or less solely on PTSD within trauma rehabilitation programs. Most professionals agree that even in post-conflict we should try to get beyond a narrow PTSD focus and address a wide range of problems and disorders (cf. IASC, 2007).

To conclude, the debate between social science and mental health professionals on the construction of PTSD is generally inspired by a culturally relativistic stance. Despite the presence of the disorder in a variety of contexts and cultures where secondary benefits play a role, some social scientists dismiss any conclusion related to a possible universality or neurobiological core as overly universalistic or as the medicalisation of social problems.

We call for a paradigm shift among those professionals who focus more or less solely on PTSD within trauma rehabilitation programs. Post-conflict programs should get beyond a narrow PTSD focus and address a wider range of disorders and psychosocial problems. One of the challenges of the coming decades would be the compilation of a worldwide inventory of local expressions of unusual or 'deviant' behaviour, including traumatic stress reactions, based on a phenomenological approach employing a combination of qualitative and quantitative research methods. We expect that such an enterprise would yield a neurobiological and universal core at the biological end of a continuum, with a large variety of culturally induced phenomena at the socio-psychological end of the continuum (De Jong et al., 2005).

Fact check

Question 1

List 3 ways in which people in Africa might express distress in terms of physical sensations

1.
2.
3.

Question 2

What happens if the diagnostic challenges in a multicultural setting are not met?

Question 3

Complete the sentence:

For a clinician it is more important to understand the meaning of suffering____ _____

___ _____ than how the experience fits in a diagnostic category.

Reflection and analysis

In a few sentences, discuss the importance of looking at trauma from a cultural perspective as opposed to and/or in conjunction with the DSM criteria.

2 ANXIETY AND PANIC DISORDER

In psychiatry panic disorder is mostly described as a biologically founded disorder which results from hypersensitivity or oversensitivity of parts of the brain that are involved during an anxiety response to threat. During panic a cognitive scheme is activated that facilitates information-processing processes that fit that particular cognitive scheme, and as a result inconsistent or irrelevant information is not processed. The cognitive schemes which occur in panic disorders usually involve vulnerability, loss of control and anxiety sensitivity. Patients are typically preoccupied with thoughts about physical catastrophes (death, heart attack, fainting, shortness of breath, illness or seizure), mental catastrophes (going mad) or behavioural catastrophes (loss of control) (Ottaviani & Beck, 1987; Kirmayer, 2009).

The panic is coupled with attentional narrowing with a focus on the physical sensations that result from arousal of the autonomic nervous system. Typically these physical sensations are interpreted as dangerous, and this misinterpretation intensifies the autonomic arousal, followed by intensification of the panic symptoms which, in turn, confirms the fear. Once the tendency to interpret physical sensations as catastrophic exists the patient attempts to avoid the panic, by permanent vigilance and hyper-awareness of the feared sensations, such as a slight increase of the heart rate, or tinnitus, shortness of breath, heart palpitations and cold extremities that are indicative of hyperventilation.

2.1 The ‘work of culture’.

In the following paragraphs we describe how biological factors relate to the ‘work of culture’ (Obeyesekere, 1981). This is about the interplay between biology and culture, nature and nurture.

Research into the biological causes of the panic disorder has focussed particularly on abnormalities in the functioning of alpha-2-receptors and of benzodiazepine and 5-HT receptors. With regard to the phenomenology of the panic disorder in other cultures, it appeared that some DSM-IV criteria for the panic disorder do not apply in other cultures, for instance, the DSM criteria that the anxiety appears from nowhere, that the anxiety reaches its maximum in the course of a few minutes, or that the key symptoms correspond to the physical sensations which are described in the DSM. As mentioned, catastrophic cognitions play a key role in the cause and recurrence of panic. Because thoughts about disaster are a reflection of cultural models and preoccupations, panic and the panic disorder lend themselves to the investigation of the interaction between physical and social processes in relation to cultural forms of expression of distress.

From comparative cultural research it further appeared that panic syndromes are often linked to memories about trauma and violence, and form part of the psychological experience of people who have survived a war, flight or other disaster. This gives rise to doubts concerning the decision rule of the DSM that the care provider must first exclude a comorbid diagnosis of panic disorder or PTSD. And it also gives rise to doubts about the relationship between panic disorder and PTSD and about the DSM classification of the whole spectrum of anxiety disorders, to which we will return later (Brown & Barlow, 2005; Harwood, 2009).

Panic occurs when anxiety is intensified by attempts to suppress or control the anxiety. When this is not successful, in combination with the fear that the sensation will persist, we have exactly what the person fears the most, namely even more anxiety. This is nicely summarised in an old poem:

Man often suffers most

From the suffering he fears

Yet never comes to pass

So his burden is more heavy

Than God gave him to bear.

Cognitive interventions can break the vicious circle of secondary anxiety. Cognitive interventions strongly resemble Buddhist meditation, because in Buddhist psychology the origin of suffering is sought in the misinterpretation of sensations, where during meditation the sensation is observed without judging or trying to control it (Germer, Siegel & Fulton, 2005).

In order to understand forms of expression of psychopathology it is important to realise that culture provides a blue print for the development of affective systems, and that culture regulates the perception, the expression and the different categories of emotions. Culture provides a context for interactional processes around emotions. Moreover, culture can define the tolerance of particular emotions and indicate how a particular emotion should be managed. Culture also influences the social meaning of emotions and what is experienced as stressful, which culture-specific idioms come to the fore, and how this stress is felt and interpreted ethno-physiologically and ethno-psychologically.

During panic the cultural context, in combination with genetic factors and the life history, determines which cognitive and somatic triggers evoke the emotions, which physical symptoms appear with it and how these are regulated, how the complaints are interpreted in terms of catastrophic cognitions, how these symptoms develop, what the appropriate coping style or reaction of the individual and the environment will be, and finally what is perceived as desirable help-seeking behaviour, either in the lay sector or in the regular or complementary health sector.

Examples from different cultural areas illustrate the diversity of the cultural elaboration of panic.

2.1.1 Case 1

Mohammed, a 35-year-old Moroccan, was referred for treatment by his physician owing to complaints of heart palpitations, nightmares, and chest tightness. His ‘heart fears’ were so great that he was diagnosed as having a cardiac phobia (i.e. fears of a heart attack in the absence of any real cardiac pathology). He had had similar complaints when he was 8 years old after the sudden death of his mother. Following her death, Mohammed was raised by his maternal grandparents. Mohammed’s grandfather died when Mohammed was 11; at that time, Mohammed experienced the same cardiac complaints.

At the age of 18, the patient was arrested and tortured for participating in ‘political gatherings’ in Morocco. He was known as a hard worker and a happy lad. However, in the years before his referral, he unexpectedly lost eight friends and relatives. Mohammed felt that it was hard for him to experience pleasure and that he was becoming increasingly isolated. He finally sought psychiatric help for his complaints. He was diagnosed with a major depression disorder with melancholic features and complicated bereavement.

During his intake interview, Mohammed mentioned a sleep paralysis event. Sleep paralysis is a benign and easily identifiable event: while waking or falling asleep, total or partial paralysis of the skeletal muscles occurs, with the exception of eye and pharyngeal muscles.. Depending on the meaning given to and etiological interpretations of the sleep paralysis, which is largely culturally determined, patients react to the event in specific, as this case description shows (cf. De Jong, 2005).

Mohammed describes an old lady who comes to him without him knowing whether he is awake or asleep. Sometimes it is a being that he cannot describe. It gets on top of him, holds him down and tries to strangle him. During the course of the therapy, this complaint returned. When he was prescribed an antidepressant, the sleep paralysis occurred only once a month, but when he took medication less regularly, his complaints increased in frequency to once a week.

Mohammed described his attack as follows: ‘When I lie on my back I either hear ringing in my ears or I hear people knocking on my door. Sometimes I hear sounds as if there are burglars, or people crying for help. At these times I cannot move. My heart is pounding, and my body feels agitated and trembles as if I am getting shocks. From time to time, it seems as if someone is pressing on my body. Sometimes I see a scary old witch with a skinny head, long dirty hair, dirty teeth and old black clothes coming towards me. She spreads out her hands towards me to strangle me and she is so strong that I cannot push her away from me. In my mind, I tell her to leave. Sometimes I manage to move after which the attack is over.’

Mohammed believed the witch attack to be the result of sorcery (zahar) by a woman, possibly an aunt with whom he did not get along. Spirits (jnun) might also have been the cause of his problem. Placing a folded knife and some salt under the pillow did not chase the nun away; the attacks persisted.

After the therapist explained the characteristics of sleep paralysis, Mohammed no longer feared the attacks and the accompanying visions. He understood that sleep paralysis was benign and would disappear without any consequences. There is a word for it in Moroccan Arabic, i.e. boratat, which means ‘someone who presses on you.’ (Similarly, an English word for nightmare, incubus, is derived from the Latin word ‘incubare’, meaning ‘to sit on’)

The treatment consisted of a grief therapy supported by an antidepressant. During the therapy, Mohammed spoke about his survivor guilt after the death of his friends and relatives. Along these lines, he had many dreams in which friends and family members beckoned him to join them in death. Mohammed explained that in his culture, this dream indicated imminent death. The therapist asked him, despite his doubts, to elaborate his dream through guided imagery. After several attempts, Mohammed was able to visualize another outcome than his own death.

During the therapy Mohammed made a pilgrimage to the tombs of his friends and family members, because at the time of their burial he worked abroad. (Because Islam prescribes a burial within 24 hours, many migrant workers only hear of someone’s death after some time, often resulting in complicated grief). During his pilgrimage, he expressed his repentance that

he could not be present at their funeral, and after some time in treatment, he reported feeling better.

The cultural context provided this patient with the opportunity to express and to define his anxiety around the death of his mother and the subsequent experiences of loss when he faints while hyperventilating. His culture influences what is experienced as stressful, namely the recurring dreams about the deceased beckoning him. The Maghrebin context determines the catastrophic prospect and outcome, namely that the visions from the dream will inevitably lead to his death. His culture of origin seems to have a word for the harmless physiological phenomenon of sleep paralysis, namely boratat. Besides the fact that he must die, he is given the explanation of witchcraft (zahar) or spirits (jnun), alongside treatment in the public health sector.

The second example of panic is Cambodian. Hinton (2001a, 2000b, 2000c; 2002; 2009) describes the occurrence of panic attacks, often in combination with PTSS, among Cambodians in the US. Hinton's work is illustrative of the integration of ethnophysiological and ethnopsychological insights into our understanding of panic in other cultures.

Cambodians believe that a type of vapour-like 'Wind' (khyâl) moves through the body through little canals that look like blood-vessels, and that an obstruction of 'Wind' can be dangerous and potentially life-threatening. This culture-specific belief plays a dramatic aversive role in the experience of somatic sensations linked to anxiety. The interoceptive cues are associated with the obstruction of 'Wind' which can cause death. Muscle tension in the neck, for example, ascribed to long trips with buckets of water on a yoke, can invoke anxiety that the vessels in the neck can tear. Cold limbs or pain in the joints can indicate an obstruction of 'Wind' and mean that someone is in danger of losing an arm or leg; tiredness can indicate a lack of 'Wind' which can lead to a heart attack or death; ringing in the ears can refer to dangerous pressure of released wind; stomach-ache can point at rising 'Wind' which can cause asphyxia, a heart attack or dizziness; and dizziness can invoke the catastrophic cognition that someone is fainting or dying. On the basis of these insights Hinton has developed an individual and group therapy in which he combines behavioural-therapeutic methodologies with culture-specific, Buddhist and mindfulness techniques.

The third example comes from Rwanda. In an intriguing chapter in the book Culture and Panic Disorder (Hinton & Good, 2009), Hagengimana and Hinton (2009) describe that many Rwandan genocide survivors have severe posttraumatic stress disorder (PTSD) symptoms and panic attacks. They focus on a disorder called Ihahamuka, which literally means "without lungs". Ihahamuka is characterized by fear and the frequent occurrence of episodes of shortness of breath. After the 1994 genocide, ihahamuka emerged as the new term to describe fear states, and within a year almost everyone knew this term. Ihahamuka is a panic-like syndrome characterized by episodes of marked shortness of breath, along with palpitations and other symptoms; the person usually falls to the ground, gasping for breath, fearing asphyxia, syncope, and death. During an attack, not uncommonly the person has pain and heat in the head. An ihahamuka attack may occur upon awakening at night, sometimes after a nightmare, sometimes when no nightmare has occurred; a relative may be asked to be a sleep companion to provide assistance during these nocturnal events.

During an attack of ihahamuka a number of actions may be taken to relieve the attack. The left side of the chest may be pressed with one or two hands supposedly to keep the heart from bounding out of the body. The space around the individual may be cleared of people and things to increase air availability. Water may be poured on the body to cool it and relieve sweating. Milk, considered a panacea in the Rwandan culture, may be offered; if regurgitated, death is considered imminent.

Some typical triggers of ihahamuka episodes include witnessing or being involved in an argument, visiting the location of a loved one's murder, having a nightmare, hearing a loud noise, smelling a foul odour, experiencing any strong emotion, engaging in exertion that triggers sensations, encountering a trauma reminder, experiencing the April anniversary date of the beginning of the genocide, and thinking about a financial concern, as in the painful realization that one lacks sufficient money to pay for a child's educational fees. This extensive list demonstrates the importance of trauma reminders in ihahamuka episodes.

Hagengimana and Hinton (2009) describe several cases of which two are presented.

2.1.2 Case 2

In the 1994 genocide, a Hutu soldier killed Mary's parents by bashing in their skulls with a club. He then struck the eighteen-year-old Mary's neck with a machete. Presuming her to be dead, the soldier threw Mary's limp body into a latrine along with a number of corpses that soon started decomposing with maggots. Unable to get out of the latrine, she survived several days by eating avocados that had fallen into the latrine from a tree next to the latrine. She was eventually rescued.

After the genocide, Mary was adopted by a family member. While at boarding school, she developed frequent episodes of ihahamuka, during which she fell to the ground with extreme shortness of breath and nausea. The episodes were triggered by any loud noise or when rice or avocados were served in the school's dining room. Upon collapsing to the ground, she would cry out for help. The nurse and other students would rush to her aid; one of her fellow students would place a hand on her chest to secure her heart. She would smell faeces and urine, worsening her nausea, sometimes to the point of vomiting. The symptoms lasted about twenty minutes, during which she feared dying of asphyxia or from her heart jumping out of her chest. During some of the episodes, images of past traumas came into her mind.

The nurse at the school thought Mary had asthma or a heart disorder, but neither a pulmonologist nor a cardiologist could find any abnormalities and was referred to psychiatry. To get to her first psychiatric clinic visit, she had to walk through a grove of avocado trees, and she suddenly felt short of breath and extremely nauseous. Upon arriving at the clinic, she recounted this episode to her psychiatrist and told him of her other near-syncopal episodes.

Diagnosing her as suffering from panic disorder along with PTSD, he treated her with alprazolam and propranolol and psychotherapy. Her therapist identified the triggers of Mary's panic attacks and their connection to her trauma experiences. The rice reminded her of the small, white maggots in the corpses next to her in the refuse pit; the avocados reminded her of the avocadoes on which she survived while in the latrine; and loud noises reminded her of the sickening thud of her parents' skulls being bashed in and the yelling of the perpetrators.

Mary received psycho-education about how trauma-related cues—for example, the sight of avocadoes—might recall these memories and cause shortness of breath, nausea, and

palpitations by triggering a fear response, even though sometimes the trauma event might not be consciously recalled at the time. The psychotherapist also assured her that she was healthy, that her shortness of breath, palpitations, and nausea were not dangerous but simply resulted from fear; that her symptoms were common in trauma victims; and that she was not going crazy. He discussed with her the difficulties of emotionally adjusting to the death of her parents, of coming to terms with the horrific manner in which they were murdered.

As a result of these interventions, Mary dramatically improved. During the following two years she was able to perform well in school and had only one more severe episode of ihahamuka, triggered by a fight between her adoptive parents. Their hostile exchange evoked memories of the Hutu who attacked her and killed her parents.

Hagengimana and Hinton (2009) also describe how in different parts of Rwanda during 1997 and 1998, mass burials were performed for unidentified corpses; large numbers of orphaned girls and young women attended. During the burial ceremonies, many participants suddenly became short of breath, falling to the ground and gasping for air. In one event a young woman felt extremely short of breath and fell to the ground upon seeing a red belt similar to one worn by her father; soon other girls and young women collapsed. In the years following the genocide, many schools had outbreaks of ihahamuka. In a typical scenario, an orphaned girl or young woman would fall to the ground at the sudden onset of shortness of breath, dizziness, palpitations, and fear of dying; soon others, usually also orphans, would have such episodes. At one school, out of six hundred girls and young women, sixty developed ihahamuka, forcing early closure of the facility, with classes recommencing the following year.

Rwandans greatly fear the symptoms that occur during ihahamuka episodes, especially shortness of breath and worrying about asphyxia. The heart is considered a respiratory organ according to the traditional Rwandan ethnophysiology (Lestrade 1955). Consequently, irregular heart motions, such as palpitations, conjure fears of impaired respiration and increase asphyxia fears. Also, according to the traditional Rwandan ethnophysiology, the heart moves progressively upward from the abdomen during states of trepidation; if it rises too high, death will result from the impairment of breathing or from the heart becoming dislodged, even leaving the body. For Rwandans, smooth breathing evokes health-and-prosperity-bestowing flows, as in menstruation, human lactation, the flow of milk from the udder of a cow, rainfall, a healthy king, and auspicious social relationships; blockage of breathing as in shortness of breath evokes disease-and-disaster-causing blockages, as in irregular or stopped menstruation, lack of milk from mother and cow, drought, an ill king, and a breakdown of social relationships.

Only in this way can one understand and investigate the reticulum (‘network’) that unites the traumatic events, the aesthetic system, the images of greatest horror, the society, and the body - what Hinton (2009) calls the trauma-somatic reticulum, the symbolic bridges, metaphors, and other meanings and processes that join trauma to personal experience, to bodily experience, to somatic symptom; a reticulum that encompasses social processes, ritual action, metaphor, ethnophysiology, and symbol.

Hagengimana and Hinton (2009) call this exploration trauma-somatics, the study of the way in which trauma results in particular symptoms, of the cultural and social links between trauma and bodily state. Only through a delineation of the trauma-somatic reticulum can the manner to heal be understood and sensitively undertaken, such as in attending to burial concerns among Rwandan refugees. Just as a symbolic logic guides the perpetrating of violence and the embodying of symptom, that same symbolic logic can be used to bring about cure, empowerment, and wellbeing and healing. In Rwanda, flow and blockage symbolism shapes ritual, aesthetics, ideas about well-being, stigmatization, the manner in which violence is perpetrated, the somatization of distress, and what are appropriate techniques of cure, for example, attempts to bring about cure and recovery through images of flow in psychological discourse, rituals (such as those honouring the dead), and the memorialisation of genocide events.

Their analysis suggests that to investigate a symptom complaint, one must determine whether that symptom is cognisized and configured, represented, an exemplar of a generative schema, for example, flow and blockage. If it is, one must investigate the ontological resonances of the symptom created by that generative schema, the ontological domains - from ethnophysiology to traumatic memory – that the somatic symptom evokes through its connections to root metaphors. Such a multilevel ontological analysis needs to be researched to investigate the meaning of a complaint. Understanding and empathy begin with an exploration of these levels. Cure may involve an intervention at any one of these levels.

2.2 A biocultural interactional concept for panic disorders

In the development of theory around a biological pathomechanism of fear, neurophysiological theories about a dysfunctional fear network are central (Coplan & Lydiard, 1998; Gorman et al., 2000; Krystal et al., 1996; Sinha et al., 2000). Cultural differences are related to the cognitive catastrophic explanations of physical and psychological symptoms, as well as the traumatic conditioning of a panic response to interoceptive cues. (Cognitive-behavioral treatment for panic disorder relies heavily on interoceptive exposure. Specifically, therapists induce physical symptoms associated with panic in order to produce habituation to those sensations). These three mechanisms, fear network in the brain, cognitive misinterpretations, and traumatic conditioning around interoceptive cues, are sufficiently underpinned to further develop theory around the essential universal and the culturally heterogeneous characteristics of panic disorders (Jacobson, 2009).

Fact check

Question 1

Patients suffering from panic disorders are typically preoccupied with thoughts about physical catastrophes. Name 3 examples:

1.
2.

3.

Question 2

What is trauma-somatics?

Reflection and analysis

In a few sentences, describe your ideas of the importance of knowing and understanding how different cultures present trauma symptoms, in order to decide on an appropriate treatment/ approach to therapy.

3 SOMATOFORM DISORDERS

Somatoform disorders are characterised by the occurrence of physical complaints with no organic basis, or where psychological factors play an important role in physical complaints.

3.1 Somatising

Many believe that people from 'non-western' cultures, in contrast to westerners, somatise their unwellness or distress. In large parts of 'the west', and in the main cities of LAMIC (lower and middle income countries) the expression of affect and openly discussing emotions have become widely accepted. Emotion-TV and soap series are part of a socialisation process in which much is made of the stirrings of the soul. Elsewhere in the world social harmony, and a non-confrontational interaction with each other, has precedence over the expressing of affect. That means that people in other cultures are not only considered as expressing their emotions less quickly, but that they often also see no reason to approach the health services with emotional problems.

Kirmayer et al. (1993) conducted research in Canada among 700 patients who visited the first line of the health system with a depressive disorder or a panic disorder. Only fifteen per cent of the patients, regardless of their cultural origin, were found to express a psychosocial complaint to their general practitioner. But in response to the question what in their opinion was the cause of their somatic complaints, half mentioned a psychosocial cause.

From this and other studies (cf. Üstün & Sartorius, 1995) it appears that (a) worldwide somatising is the rule and not the exception, that (b) complaints of pain of the locomotor organs and tiredness are expressed most frequently, and that (c) cultures vary especially in specific somatisation or somatisation patterns. Here it is important to understand that the sometimes bizarre-sounding complaints of people in Africa about heat, crawling ants, heaviness shifting through the body, and scratching or splashing sensations in the head, resemble symptoms attributed to schizophrenia, while these complaints can be expressed in the context of fear or depression.

3.2 Somatisation disorder

The most important clinical characteristic of the somatisation disorder is the presence of multiple recurring and changing physical symptoms which start before the thirtieth year, are present for a number of years, and which lead to the search for help, or lead to significant restrictions in social or professional functioning. According to the DSM-IV each of the following four criteria must be met, namely (1) four symptoms of pain, (2) two gastro-intestinal symptoms, (3) one sexual symptom and (4) one pseudo-neurological symptom.

What is confusing in seeking to understand the transcultural literature about somatising is the fact that medical sociologists, and anthropologists especially, use terms different to DSM for the description of a form of illness behaviour where somatic symptom presentations prevail over the expression of emotional or social problems (Kirmayer & Young, 1999). Researchers operationalise somatising in their own way, namely: (a) as medically unexplained somatic symptoms (such as in the somatisation module of research instruments such as WHO's CIDI (Composite International Diagnostic Interview) (Janca et al., 1995); (b)

as a hypochondriac preoccupation; and (c) as the somatic presentation of an affective disorder, an anxiety disorder or other disorder.

In turn, a third group, the care providers, use yet another approach to somatising patients. They regard somatising as (1) an indication for the presence of a disorder or of specific psychopathology, (2) the symbolic expression of an intra-psychological conflict, (3) an idiomatic expression of distress or unwellness, (4) a metaphor for a sensation or perception, or as (5) a standpoint in a local context or an expression of social protest or displeasure. These five categories do not exclude each other. But the choice by a care provider of one of these views does have a far-reaching influence on the treatment. We will review these one by one, following Kirmayer en Young (1999).

3.2.1 Somatising as an indication for the presence of a disorder or of specific psychopathology

The preparedness of a care provider to accept that a medical explanation for the complaints exists, even if the disorder cannot be confirmed from a medical point of view, largely depends on the diagnostic fashion of the time, on the personal and professional experience of the care provider, and on the credibility of the patient.

During depression and anxiety some people experience more somatic symptoms in connection with their disorder than others. Sometimes this is related to personality traits, sometimes to childhood experiences where physical complaints were reinforced as a legitimate form of help-seeking and illness behaviour. Presenting physical complaints because of an inability to experience and to resolve emotional conflicts is sometimes referred to as alexithymia. On closer examination, however, alexithymia seemed to be related in the first instance to depression and dysphoria which are the result of the presence of physical illnesses or physical unwellness (Cohen, Auld, Brooker, 1994).

3.2.2 Somatising as the symbolic expression of an intra-psychological conflict

Physical complaints can also be interpreted simply as an indication for the presence of psychological problems. The psychodynamic defence model assumes that somatising during a physical illness is caused by mediating mechanisms which the patient is not aware of. For many patients the psychodynamic model is difficult to apply in care provision. In our daily work it is often less useful to try and get to the bottom of the psychological background of the complaint presented and easier to follow the reverse. In this latter instance the patient is asked to answer which consequences his complaint has for family, marriage or work, an answer that clarifies which stress factors form the background to, or are the cause of, the complaint presented. By way of illustration: when care providers have established that there is no organic cause for a person’s complaints, they sometimes ask their patient quite directly what he or she considers to be the psychological cause of the complaints. Patients often do not know how to handle such a question. It is much easier to ask the patient what the consequences are of his physical complaint. He can for example relate that he is tense when coming home, is grumpy to his children, making his wife reproach him for being an old-fashioned authoritarian father. Yet, by means of circular interviewing it becomes clear in a roundabout way what the psychosocial stress factors are that relate to the physical symptoms.

3.2.3 Somatising as an idiomatic expression of distress or unwellness

The presentation of physical complaints can also be regarded as a cultural disease model or idiom of distress which enables the individual to articulate the complaints and to find an explanation for the symptoms and the associated suffering. As a result of this the complaints become explicable in the social environment of the patient even though the complaints can have a different meaning for an outsider.

3.2.4 Somatising as a metaphor for a sensation of perception

The concept ‘idiom of distress’ can also be more broadly interpreted as a result of which somatic symptoms can provide metaphors for life experiences. A Rwandan with complaints about Ihahamuka does not only express physical sensations around breathing, but also a metaphoric image that has emotional and social meaning.

3.2.5 Somatising as a social standpoint or as a form of social protest or displeasure

The seeking of help and dealing with restrictions as a result of physical complaints can influence family relations and other social roles. Illness can be a protest against a social situation that is experienced as unjust, an injustice experienced as ethnic or racial, or as a plea for the right to be ill. Sometimes physical complaints are the ultimate means to complain about a situation of oppression or repression in which direct criticism is not permitted. Sometimes it is not easy for a carer who is from another culture, to unravel the dynamic of the illness behaviour prescribed by the culture of origin, which to an outsider can come across as theatrically exuberant or as stoically suffering. Apart from that, as far as pain is concerned, a linear relationship appears to exist worldwide between the number of subjectively experienced localised or multiple sites of pain, and the seriousness of a mood or fear disorder (Gureje et al., 2008).

3.2.6 Managing the different interpretations around somatising

Care providers use the five models mentioned above when assessing someone’s problem. Just like their patients they often do this at an unconscious or semi-conscious level. They will try out different approaches simultaneously, or successively, in order to assess which model or combination of models best fits a patient. An experienced care provider is aware of the fact that there is not only one truth and that somatising presents a challenge to find the most suitable approach, in consultation with the patient, in order to arrive at a solution. The following case illustrates this problem.

3.2.7 Case 3

The 36-year old single West-African mother, Ceciel, was referred to the mental health facility due to ‘protracted vague physical complaints for which no organic substrate is found’. During her registration she related that she met a charming man a short while ago. He made her a proposal of marriage to which she answered yes. One day before the wedding he surprised her by removing his clothes from her house, after which the wedding did not happen. She related emotionally that she cannot forget him, even though lately she has also had other friends, and she wonders if this man has ‘put’ something on her. From one of his friends she has heard that he has a relationship with another women with whom he has a child.

On top of all this Ceciel's 15-year old son uses a lot of marijuana and is worried about the future since he has learned that his mother is at risk of losing her job. He has been physically abused by his latest stepfather and is threatening to run away because he wants to live by himself. Patient had two jobs and had been ill at home for three months. She related that her employers are putting her under pressure to resume work.

She complained of pain in her arms, legs and the soles of her feet, pain in the chest, difficulty concentrating, forgetfulness, and she had no energy for anything. She felt empty inside and gets irritated when her son listens to music. Patient was able to cry, but not always, even if she wanted to. In the past she drank sporadically, but for two months she used a lot of alcohol, especially on weekends, which means that she did not manage to turn up at her work on Monday. As far as traumatic events in the past are concerned she reported having experienced incest, assault and rape by her stepfather over a period of three to four years during her youth.

This case history shows how the five dimensions from the previous paragraph manifest themselves in a problem that presented itself as a somatisation problem. Somatising is an indication of the presence of psychopathology in the form of depressive complaints and alcohol abuse (see 3.2.1 above). Somatising is also a symbolic expression of an intra-psychological conflict (3.2.2): patient is eager to have a husband, but she has a pre-history of physical and sexual abuse; she herself does not interpret her attachment-separation dynamic as an ambivalent attitude vis-à-vis men, and she is also not conscious of her 'traumatophilia'. Her somatising is also an idiomatic and metaphoric expression of distress (3.2.3 and 3.2.4) because she externalises her ambivalence towards men in the form of witchcraft as a magic-religious machination ('he has put something on me'). Finally, her complaints point towards a social situation (3.2.5) that for her is unbearable because she is overburdened and under pressure in her job, apart from the problems of her son. In the therapy the care provider will try to use these five interpretations in such a manner that they will clarify the complaints, for the patient as well as for the practitioner.

3.2.8 Epidemiology of somatisation disorder

At population level the somatisation disorder does not occur frequently. In the ECA (Epidemiological Catchment Area) study in the US somatisation disorder was found among only 0.01% of the population, with a higher percentage for African-American women (0.8%) and men (0.4%). The differences between ethnic groups were ascribed to a difference in educational level (Robins & Regier, 1991). Various other studies found slightly higher percentages among non-western groups (Mumford, 1989; Mumford, Bavington & Bhatnagar, 1991).

At the level of primary care, however, Kirmayer et al. (1993) found that a quarter of the patients in all ethnic groups met the criteria of one or more forms of somatisation. The WHO Cross-National Study of Mental Disorders in Primary Care examined 5438 patients in 14 countries in four continents. The study found a high somatisation-average of 0.9% with a dispersion of 0 to 3.8%. The highest percentages were found in the two South-American research locations. The research locations with relatively high numbers showed no correspondence in economic, geographical or cultural characteristics. Somatisation in this study showed no clear relationship with fear and depression, but a clear relationship with weakness, headache and heart palpitations (Üstün & Sartorius, 1995; Gureje, Simon, Üstün et al., 1997).

Fact check

Question 1

Complete the sentence:

Somatoform disorders are characterised by the occurrence of _____ complaints with no _____ basis, or where _____ factors play an important role in _____ complaints.

Reflection and analysis

Briefly describe the various purposes that somatisation may play.

4 IMPLICATIONS FOR DSM-V AND DSM-VI

The concept of the ‘spectrum perspective’ has been widely discussed with a view to the development of the future versions of DSM and ICD. The central question here is whether the current categorical diagnostic system must continue, whether it should be replaced with a dimensional classification, or whether it is better to complement the categorical classification with a dimensional classification.

To understand this discussion it is useful to first consider the rationale of the current categorical classification (DSM and ICD), and to ask the question whether the current classification achieves what it is aimed at. The scientific aim of diagnostic psychiatry is to order, explain, predict and treat the classified symptoms (Kendell, 1989). But do the DSM and the ICD succeed in this? The symptoms of schizophrenia, bipolar disorder, and serious endogenous depression cluster, are reasonably discrete constellations which differentiate them from other clusters. However, serious doubts exist, even for these discrete categories, about the validity of DSM from a cultural, international and LAMIC perspective. The argument for a dimensional-categorical classification is growing (Dutta, Greene, Addington et al., 2007). Nevertheless, these three disorders are reasonably comparable in strongly divergent socio-cultural contexts, but as far as other diagnoses are concerned, anxiety disorders in particular, differentiating between one psychiatric category and another is in a poor state, as is evident from the following considerations:

- The two most prevalent disorders, depression and anxiety, often occur simultaneously, in some studies in up to ninety per cent of cases (Merikanga, Prusoff, Weismann, 1988).
- In population research the association between mood and anxiety disorders seems stronger than between two different anxiety disorders (Kessler, Abelson & Zao, 1998). From these and numerous other studies there appears to be an enormous overlap between depression, phobia, generalised anxiety disorder and post-traumatic stress disorder.
- Moreover it appears that the research instruments which measure depression often measure anxiety as well as they measure depression (Horwitz, 2002).
- Psychiatry attempts to resolve this problem of the overlap of symptoms through the introduction of the concept of comorbidity (Krueger, 1999), but in a population study of comorbidity, it was found that almost half of the respondents had a second diagnosis besides the main diagnosis (Kessler et.al., 1994).
- Also, the fact that the same medications, specifically tricyclic antidepressants and SSRI's, are prescribed for anxiety, panic, obsessions, eating disorders, substance abuse, as well as other disorders, militates against current diagnostics, because it implies that the same underlying neurobiological systems are involved in all of these disorders. Baldessarini (2000), a leading biological psychiatrist, made it clear that SSRI’s do not affect specific symptom constellations, but that they influence general brain systems.

A better explanation for the simultaneous occurrence of depressive, fear and psycho-physiological symptoms in a wide range of disorders, is that the symptoms are non-specific

indicators for a broad, common, underlying vulnerability. The diversity in symptoms is not the product of separate diseases or disease processes, but of contextual factors. From this angle comorbidity is the artefact of a classification system that translates this vulnerability into artificially constructed disease entities.

A similar argument applies when we look at a second objective of a classification system, namely the specification of aetiological factors. Many non-psychotic disorders have a number of indistinguishable risk factors in common: a family history of psychiatric morbidity, the occurrence of early childhood trauma, life problems during the occurrence of the disorder, a weak social support system, a limited coping repertoire, gender, a weak socio-economic position, ethnicity or identity. In this connection it is interesting that when a familial predisposition is present, family members can just as easily develop a depressive, fear or other disorder, and that they are likely to develop another disorder when they relapse (cf. Horwitz, 2002).

This raises the next important question: if people do not develop the classified specific psychiatric disorders, how then do the symptoms which they display come into existence? The answer to this is that different biological, psychological and social factors produce a vulnerability which subsequently, under influence of socio-cultural factors, becomes evident in a particular disorder.

Horwitz (2002) makes a distinction in this regard between three factors. The first he calls the cultural interpretation system. Cultures provide meanings that are publicly available and shared, which reinforce and facilitate certain symptom interpretations and discourage others. Distress is transformed by the culture into disorders which have meaning in a particular cultural community.

The second factor he calls identity categories, following Brown et.al. (1996). People embrace symptoms which fit their social setting and which enable them to place and understand their symptoms and life experiences. The underlying vulnerability and form of expression of a disorder can manifest themselves differently not only in divergent socio-cultural situations, but also in different ways within one culture among men and women, old and young, rich and poor, migrants, refugees and indigenous people.

The third factor Horwitz calls the professional and media templates of the disorder. The media often work together with medical authorities and the pharmaceutical industry to promote the newest psychiatric modes. Patients subsequently often use information from the media and from their informal networks to make a pre-selection from potential practitioners who are sympathetic towards their own ideas about their disorder (Brown et.al., 1996).

The dimensional classification versus the categorical classification is a theme that has already occupied the humanities for 30 years, and its development and implementation are too complex to describe in the scope of this course (for further reading, see Brown & Barlow, 2005). However, it is useful, within the context of this debate, which is in part determined by political and other interests, to briefly dwell on the meaning of a dimensional and categorical diagnosis.

The current DSM is in essence a binary, categorical system that indicates whether someone is ‘positive’ or not (has the symptoms yes/no, the diagnosis yes/no). A dimensional diagnosis

involves a dimensional scale with a number of values (e.g. 0 = no symptoms, 4 = serious symptoms), or a discrete score (e.g. number of drinks/week), or a continuum (e.g. the duration of the symptoms). Moreover the term dimensional is used also for multivariate diagnoses (e.g. the combination of age of onset, duration and seriousness of symptoms).

Most proposals for DSM-V revisions entail the supplementation of categorical with dimensional diagnoses. This should make it easier, for instance, for a practitioner to assess whether a treatment is successful, while a researcher with a dimensional diagnosis can indicate more subtly which aspects of the treatment, and to what degree, progress is being made.

In all discussions about a new DSM-V the assessment of new insights for care provision and research versus the existing simple rules of the categorical classification is important. The DSM-V will probably be based on a hybrid categorical-dimensional approach (Dutta, Greene, Addington et al., 2007). Apart from the countless scientific questions that need to be resolved before the introduction of DSM-V in 2012, there are other obstacles to be overcome and which are linked to political and financial interests. It will be a gigantic task to retrain care providers in the use of the new system. Moreover the interests of the health insurance companies and pharmaceutical industries are so extensive that the dimensional classification will probably only reach the publication of DSM-V in a toned down form. That will mean that the integration of anxiety disorders and depressive disorders will probably have to wait till DSM-VI, while a dimensional classification for personality disorders may well be included in DSM-V.

What will be the possible advantages of a dimensional diagnostic system for the interaction between culture and psychiatry and psychology? Such a new system would enable us to obtain more insight into cultural barriers among different types of clinical populations. For example, if the existing cut-offs which determine only whether a person falls inside or outside a given category, were to be replaced with a dimensional system, it will reveal whether there are problems, and the diagnosis in itself becomes less important. Sub-syndromal symptom categories may surface and this would help us obtain better insight into the gradual transition from normality to pathology in different cultures. It could also help to clarify, and measure more accurately, the meaning of concepts in different subcultures: concepts such as distress, dysfunction, restriction or handicap. It could result in a dimensional assessment of higher order constructs which up until now have not featured in DSM, and which could reveal risk factors for clusters of disorders, and also clarify these disorders. It could become a system that is useful for care providers as well as researchers and that helps to provide more insight into the category fallacy. It would bring psychiatrists and psychologists closer together because psychiatrists are traditionally more interested in the diagnosis and psychologists in the seriousness of symptoms. It would create more insight into the interaction between biology and culture, and into the templates that culture provides for people for the expression of their distress and their complaints. It would clarify the question whether a blank space, clear boundaries or discontinuity exist between the symptom clusters of disorders.

The discussion about these matters has started. However, the questions that need to be resolved for the development of a better system are so extensive and complex that it will

probably take until DSM-VI before a diagnostic system appears that will be culturally more nuanced and more optimal worldwide.

Fact check

Question 1

Completed the sentence:

According to Kendell (1989), “the scientific aim of diagnostic psychiatry is to _____, _____, _____ and _____ treat the classified symptoms.”

Reflection and analysis

In a few sentences, describe your ideas of the important points to bear in mind when undertaking these interventions.

REVIEW

In this course, you have read about the following topics. Check whether you feel you understand each section by ticking the relevant statement. If you feel you need to do more work in the area, re-read the section and do the tasks again.

- Posttraumatic Stress Disorder
- Differences in how people perceive and express distress
- Diagnostic instruments
- Epidemiology and treatment
- Anxiety and panic disorder
- The 'work of culture'
- A biocultural interactional concept for panic disorders
- Somatoform Disorders

- Somatising
- Somatisation disorder
- Somatising as an indication for the presence of a disorder or of specific psychopathology
- Somatising as the symbolic expression of an intra-psychological conflict
- Somatising as an idiomatic expression of distress or unwellness
- Somatising as a metaphor for a sensation of perception
- Somatising as a social standpoint or as a form of social protest or displeasure
- Managing the different interpretations around somatising
- Epidemiology of somatisation disorder
- Implications for DSM-V and DSM-VI

Though you may feel now that you have mastered all the sections, it is worth trying an objective practice test before you undertake the multi-choice assessment. Write your responses to the following questions and check the answers in the key on the next page.

Self-assessment questions

Question 2

To what does lingua franca refer?

Question 3

Name the three types of catastrophes that occupy the thoughts of patients with anxiety and panic disorders. Also list an example of each.

1.
e.g.
2.
e.g.
3.

e.g.

Question 4

Name the most important clinical characteristic of somatisation disorder(a) and list the 4 DSM-IV criteria for this diagnosis(b).

1.
2. a)
b)
c)
d)

Key:

Lingua franca refers to the local language in which a number of expressions, metaphors, proverbs, or emotion words are used to express a complaint or an emotion that are quite different from Western jargon.

physical catastrophes

e.g. death, heart attack, fainting, shortness of breath, illness or seizure

mental catastrophes

e.g. going mad

behavioural catastrophes

e.g. loss of control

The most important clinical characteristic of the somatisation disorder is the presence of multiple recurring and changing physical symptoms which start before the thirtieth year, are present for a number of years, and which lead to the search for help, or lead to significant restrictions in social or professional functioning.

According to the DSM-IV each of the following four criteria must be met, namely (1) four symptoms of pain, (2) two gastro-intestinal symptoms, (3) one sexual symptom and (4) one pseudo-neurological symptom.

Summary

The learning outcomes for the course are:

- Discuss how various disorders, especially PTSD are understood differently according to different parts of the world and different cultures
- Understand what somatisation is and what part it plays in PTSD
- Explain how PTSD is classified according to the DSM and how this compares to cultural understandings and expressions of distress and trauma

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