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Analysing critique on PTSD in an attempt to bridge anthropology and psychiatry

Joop T.V.M. de Jong

When posttraumatic stress disorder (PTSD) entered the DSM, support for the diagnosis was a critical part of advocacy for Vietnam veterans. Over the next two decades, the range of contexts in which this clinical concept was applied increased dramatically. In a recent article, Breslau describes PTSD as a 'prominent cultural model' to account for suffering as well as the synergy between human rights or political advocacy and traumatic stress advocacy. In this article I question the sequence of steps that Breslau took to critique the internationalization of the PTSD construct. I also question Breslau's critique on our work in Nepal. Finally, I will formulate several future challenges for psychiatry and anthropology to bridge their universalistic and relativistic points in relation to psychopathology and psychological distress.

[post traumatic stress disorder, culture and psychiatry, suffering, advocacy, universalism, relativism]

In this paper I will analyse a few aspects of critiques by anthropologists on the construction of PTSD. I will illustrate my points by commenting on a recent paper that was published in *Culture, Medicine and Psychiatry* (Breslau 2004). Breslau describes the synergy between human rights or political advocacy and traumatic stress advocacy. In my view this synergy exists, albeit inspired by different motives than those attributed by Breslau. In addition, Breslau's paper discusses our work with tortured Bhutanese refugees in Nepal as described by Shresta et al. (1998) and Van Ommeren et al. (2001a). I will illustrate and challenge the sequence of steps that the author took to critique the internationalization of the PTSD construct and question Breslau's critique on our work in Nepal. Finally, I will try to formulate some challenges for psychiatry and anthropology to bridge their universalistic and relativistic viewpoints in relation to psychopathology and psychological distress, and point out the mediating role of culture in the process of traumatising and recovery from traumatic stress.

Some critique of anthropology

When PTSD entered the DSM, advocacy for the diagnosis was a critical part of championing for Vietnam veterans (Young 1995). Over the next two decades, the range of contexts in which this clinical concept was applied increased dramatically. Breslau (2004: 113) describes PTSD as a “prominent cultural model” to account for the suffering resulting from a range of traumatic experiences from “automobile accidents to childhood sexual abuse”. Breslau notes that PTSD expanded into the global arena through humanitarian and medical institutions, e.g. in relief work among Asian refugees (Mollica et al. 1987), among providers of relief agencies (Morgan 1994), in former Yugoslavia (Weine et al. 1995), following hurricane Mitch (Caldera et al. 2001; Groenjian et al. 2001), the Kobe earthquake (Breslau 2000), among refugee populations and in post-conflict conditions (De Jong et al. 2001).

According to Breslau this expansion of PTSD into the global arena “has been possible because of the fit between the diagnosis and the agendas within global institutions” (Breslau 2004: 114). He argues: “PTSD is like a narrative tool that seamlessly connects observable psychiatric symptoms with particular antecedent events through the constitutive medium of memory. The disorder thus provides for expression of psychological suffering in terms that are consistent with chartering motivation of much work in international health: direct response to the impact of particular events, be they natural disasters, wars or other humanitarian crises” (Breslau 2004: 116).

Many sources of traumatic stress, ranging from wars to other forms of collective violence have a political or economic background. Psycho-traumatologists are currently intrigued by the question of vulnerability and protective factors that mediate between the traumatic event, the psychological disturbance and the pathway to physical disease or disability (cf. Schnurr et al. 2004a, b). They question why only a portion of a population manifests PTSD symptoms, even when exposed to horrific events such as war or other catastrophic events. In other words, traumatologists are interested to unravel what biological, psychological, social, political, economic and cultural factors mediate between the traumatic events and the possible disorder. This research paradigm accommodates research interests of anthropologists very well. This has been shown by the debate on cultural bound syndromes and idioms of distress in the past (Simons & Hughes 1985; Yamamoto et al. 1993; Kleinman & Good 1995).

Breslau mentions that Young points out that the symptoms of PTSD, such as nightmares and sleep disturbances, can also be symptoms of other disorders (Young 1995, chapter 4). For example, increased need for sleep and insomnia are also symptoms for depression. In the case of nightmares, this is more difficult to argue, but some other conditions such as the parasomnias may present with nightmares or night terrors, even though parasomnias may rather be regarded as neurological conditions. Young refers to the fact that many diagnoses in psychiatry lack validity, which nowadays, more than 20 years after his fieldwork, is well accepted. According to Kendell and Jablensky (2003), diagnostic categories should be regarded as valid only if they have been shown to be discrete entities with natural boundaries that separate them from other disorders. Although diagnostic categories may not be valid, they may still be useful and inval-

able working concepts for clinicians because they provide information about outcome, treatment response and aetiology. The fact that symptoms of PTSD can also be symptoms of other disorders is related to the lack of validity of diagnostic categories. This applies to many other mental and physical syndromes. For example, headache is a ubiquitous symptom of primary care users around the world, but no one denies the validity of diagnoses related to headache such as migraine, a brain tumour, hypertension or tension headache. Apparent overlap of some symptoms does not preclude discrete diagnostic entities with natural boundaries.

Young argues that “the symptom becomes part of a clinical narrative in which it is not simply an indication of an underlying pathology but an eruption into present consciousness of the traumatic event. The connection between event and symptom, in this clinical narrative, is carried by a particular form of memory, the traumatic memory, in which the traces of the event resist the flow of biographical time, breaking through the past into the present”. In psychology or psychiatry, however, the argument that distinctiveness of PTSD among DSM or ICD disorders is characterized as uniquely related to past memories is not valid. Any patient may present a memory that disrupts the biographical flow of time. Translating the past into present is one of the core characteristics of insight oriented forms of psychotherapy. In this regard, PTSD is not different from a conversion disorder or a depression where patients may realize that their symptoms are related to events in the past. Even for possession trance disorder and medically unexplained epidemic illness we showed that affected persons often went through potentially traumatizing events during their youth (Van Ommeren et al. 2001b; Van Duijl et al. n.d.). Young’s argument that the symptoms are not simply symptoms of mental illness, but traces of the traumatic event that preceded them, also applies to a depressed patient who may correctly infer that his depressive illness may be related to a previous event such as a divorce of his parents or the loss of his mother during childhood. Since Freud mentioned that ‘id’ should be substituted by ‘ego’ (“Wo Es war soll Ich werden”), mental health professionals have regarded symptoms as an eruption of the past into present consciousness. Therefore, the reasoning of Young or Breslau is questionable when they depict the connection between past event and symptom in a patient’s narrative as something specific and unique for PTSD.

Constructing the PTSD case of the Bhutanese in Nepal

I will attempt to deconstruct Breslau’s critique on our work in Nepal by following his writing on what he calls a closer study of an example that “can help highlight the mixture of science and politics in survey research on PTSD in the global arena”. I will describe the mechanisms and rhetoric devices that Breslau uses to make his case. By selective attention – e.g. by focusing only on two publications and by omitting others related to cultural psychiatry (Van Ommeren et al. 1999, 2000) – he produces a contradictory interpretation of the research. My reason for addressing Breslau’s critique is that I proposed and mentored part of the research that was carried out by the Nepali team (Shreshta and others). At that time Van Ommeren did his PhD research with

our university and our international NGO called Transcultural Psychosocial Organisation (TPO).

Breslau starts his critique with generous words: “The work of Van Ommeren and colleagues in Nepal is the most sophisticated work that has been done from a methodological point of view, and their work has been published in the most prestigious medical journals (Shreshta et al. 1998; Van Ommeren et al. 2001a)”. Breslau continues (p. 118): “The research was conducted in refugee camps in Nepal, where about 90,000 people have lived since fleeing Bhutan in the early 1990s. These refugees are members of an ethnically Nepalese and religiously Hindu minority in Bhutan, the descendents of people who migrated from Nepal and neighbouring areas of India to do agricultural work in Bhutan beginning in the early-nineteenth century. Facing intensifying discrimination and outright political repression by the Buddhist monarchy, many fled into India and then Nepal, and the camps have been at the centre of an international dispute between Nepal and Bhutan for more than a decade” Breslau then shifts his attention to our research: “PTSD researchers set out to determine the extent to which torture, inflicted by Bhutanese soldiers and police, was a cause of PTSD in this group. Using a diagnostic interview, they compared PTSD morbidity among refugees who had been tortured with that among refugees who had not been tortured” (p. 118). Of note, in these two sentences we are depicted as PTSD researchers interested in PTSD morbidity. This view of our work is skewed and Breslau contradicts himself when he quotes our paper and mentions that we studied a *range* of psychiatric disorders: “In this survey, refugees who had been tortured had a fivefold increase in risk of having PTSD compared with refugees who had not been tortured. Several other disorders were also elevated among the tortured refugees, including persistent pain disorder, severe depressive episode, generalized anxiety disorder, and dissociative disorder. Overall, tortured refugees were 1.6 times as likely to have a psychiatric disorder when compared with non-tortured refugees (Van Ommeren et al. 2001a)”. Breslau mentions:

The authors themselves emphasize that their research extends the field of PTSD research to include a new and important category of population: refugees living outside of the West. Their research, they argue, should lead to future research and intervention based on PTSD in other areas of the globe.

What we did write, though, in the introduction of our paper is an epidemiological rationale for our study:

The literature on refugee mental health has been limited in that most studies of refugees have involved samples with participants who found refuge in the West. These studies have indicated that symptoms of posttraumatic stress disorder, depression, and anxiety, as well as somatic complaints, are common. However, the results may not necessarily generalize to the more than 70% of the world’s refugees living in low-income countries, where refugees experience different problems with respect to hazards, deprivation, and acculturation. Representative data on mental disorder are rarely available.... More work needs to be conducted in sites where most of the world’s refugees live. Similarly, the

study of the impact of torture on refugees has been limited because of lack of access to population-based samples. Obtaining access to representative samples of torture survivors has been difficult (p. 475).

On the same page, Breslau continues by arguing, “that the extension of the range of PTSD also depends on successfully inserting the diagnosis into local political agendas” (p. 119). In my view, inserting the case of torture into local political agendas is an important issue that requires courage and deserves praise in countries like Nepal and Bhutan where human rights violations are rampant. Again, PTSD was not specifically inserted into/ put on the political agenda, because we studied a range of disorders. Breslau continues his critique as follows:

In the context of this political dispute, PTSD plays a symbolic role by conferring innocence on the victims of Bhutanese torture. By studying PTSD rather than other mental health problems and focusing on torture rather than other adverse conditions, the research project plays a role in existing political disputes over the status of refugees” (p. 119).

Yet, we did study other mental health problems. Our research consisted of hundreds of questions, covering a variety of disorders and correlates. The interview did not have a PTSD focus and interviewees were blind to the PTSD construct. We did introduce questions on PTSD symptoms into the local setting but we similarly introduced questions on numerous other variables, covering a range of psychiatric constructs, psychological distress, social support, coping, life events, and physical health.

Some of Breslau’s comments on the political dimension of our work are of concern. Our counterpart organisation, as mentioned in the Shresthta et al. and the Van Ommeren et al. papers, is a local Human Rights NGO called CVICT (Center for Victims of Torture). This NGO has a long track record in exposing human rights violations, including torture in the Kingdom of Nepal. Like other NGOs such as Human Rights Watch, Amnesty International or Physicians for Human Rights, CVICT chooses a politically neutral stance when reporting torture and other human rights abuses. It has done so since the start of the pro-democracy movement in Nepal in the 1990s and continues to be involved in exposing abuses by government and Maoist forces. In addition, CVICT has played a role among human rights NGOs in Nepal by negotiating between the government and the armed forces of the Maoists. By accusing CVICT of “studying PTSD rather than other mental health problems and focusing on torture rather than other adverse conditions, the research project plays a role in existing political disputes over the status of refugees” (p. 119), Breslau undermines the credibility of this human rights organisation. As this paper mentions, CVICT engaged in mental health research focusing on a range of disorders *including* PTSD. The collaboration of CVICT and TPO is on service delivery including physical, mental and psychosocial care. The research of CVICT is meant, firstly, to obtain epidemiological data to refine its interventions and to improve the quality of services. Hence, the aforementioned conclusion by Van Ommeren et al. (2001a):

Although there is increasing evidence of the efficacy of treatments for PTSD, the literature does not yet indicate effective treatment for torture survivors with ICD-10 persistent somatoform pain and dissociative (amnesia and conversion) disorders” (p. 481).

By ascribing an exclusively political motive to this NGO, Breslau potentially endangers the work of the staff involved. Even more so, he incorrectly conjectures the involvement of the Nepali government by saying that “The identification of tortured refugees, from the larger group of refugees, was done by the Nepalese administration of the camp for political reasons before the research was conducted” (p. 119). Shreshta et al. (1998) describe the sampling procedures as follows:

The sample of the study was taken from the Lhotsampa [Southern Bhutanese] refugee community living in the United Nations refugee camps in the Terai in eastern Nepal. ... By the end of 1994, *in cooperation with political parties, human rights organizations, collaborating agencies, and ex-patients*, the center (CVICT) had identified and registered 2331 survivors of physical torture living in the camps. Because the identification process included a hut-to-hut survey, it is likely that virtually all physical torture survivors in the camps had been identified. However, those refugees who were raped by members of security forces may not have come forward because of the stigma involved with this form of violence (p. 444).

This quote exposes several incorrect statements by Breslau. Firstly, it shows that it was the UN and not the Nepali government that was responsible for the refugees. Secondly, it was not the Nepali administration but a consortium of (human rights) organisations, including (newly emerging) political parties, that were responsible for this very extensive hut-to-hut survey. The latter was a complex undertaking since the refugee camps are scattered over large distances in the Terai. Thirdly, the survey did not focus exclusively on torture since the paper states that

Respondents were asked about traumatic events that may have occurred either during their flight from Bhutan or during their pre-flight government repression... including torture, murder of relatives or friends, loss of property, destruction of one’s village, and lack of food and shelter” (p. 444).

It is noteworthy that Breslau’s paper ignores major aspects of the work of the Nepali team, which I believe to be a major contribution to an interdisciplinary approach and a step forwards in culture-informed epidemiology. Even without studying of our papers, Breslau could have determined that much work preceded this study, addressing issues critical to conducting epidemiological surveys in non-western cultures. The paper of Van Ommeren et al. (2001a) references this work, and notes that their group had “completed a narrative study, focus groups and a survey of local idioms of distress” (p. 478). Being aware of the ‘category fallacy’ (Kleinman 1977) and of the risk of solely focusing on western concepts of psychological health, the Nepali team did a case note survey and a narrative study to identify idioms of distress that yielded 62 somatic idioms

and 22 psychological idioms. Focus groups discussions were held in the refugee camps on topics such as social problems in the camps, knowledge of available help, traditional healers, positive and negative coping strategies and individual and community effects of the refugee crisis (Sharma & Van Ommeren 1998). Another preparatory step towards the epidemiological research that was published in subsequent years consisted of a careful preparation of instruments for transcultural use. The team developed a translation monitoring form to enhance the methodical preparation of instruments (Van Ommeren et al. 1998). This monitoring form is a great step forwards to enable researchers to monitor and publish their attempts to create equivalent translation that is understandable, socially acceptable, complete and relevant. The team also described an important source of bias in transcultural epidemiological research by showing that the widely-used Composite International Diagnostic Interview probe flow chart does not appear to function properly in the Nepali context. This is because the chart contains two assumptions that do not hold in Nepali culture, namely that respondents attribute their symptoms to mental, physical or substance-related processes, and that doctors communicate diagnoses to their patients (Van Ommeren et al. 2000). Such observations were later replicated for depression in Chinese American Women (Hsiao-Rei Hicks 2002). In combination with our work in other sites, the research in Nepal resulted in a paper on culture-informed epidemiology (De Jong & Van Ommeren 2002). Moreover, the team completed a study on medically unexplained epidemic illness (Van Ommeren et al. 2001b). In addition they addressed a topic of interest related to the promotion of traditional medicine because allopathic practitioners often look with distrust at traditional practices. Early transcultural studies described shamans as severely neurotic (Devereux 1961) or as psychotic (Silverman 1967), and shamans have been called wounded healers (Halifax 1982). Van Ommeren et al. (2004) did a first-ever, community-based, psychiatric epidemiological study among shamans that indicated no evidence that shamanism is an expression of psychopathology. In short, in my view, the work of the Nepali team stands firmly among that of scholars such as Flaherty, Manson, Weiss, Kirmayer, Kleinman, Good, Del Vecchio Good, Marsella, Westermeyer, Weine, Patel, Bolton, Otto and Hinton. They have all done seminal work to advance the field of cultural psychiatry and psychology and to enrich cultural psychiatric and psychological fieldwork.

Breslau has provided a selective analysis of some aspects of psychiatric anthropology discussed in the papers produced by the Nepali team. For example, Shreshta et al. (1998: 447-8) write the following: "Young has argued that the PTSD construct has often been applied incorrectly when Western patients (and clinicians) mistakenly use trauma as an explanatory model for depression and anxiety symptoms. However, Young's argument may not apply in the context of South Asia, where people typically do not see a relationship between trauma and psychological problems. Rather, patients' explanatory models for distress usually involve supernatural processes. In our experience, the tortured Bhutanese refugees almost always explain psychiatric problems as resulting from bad Karma, spirits, witchcraft, or an offended god. These Bhutanese refugees come from a closed country and are relatively uneducated [in terms of formal education]. They have not been exposed to the Western idea that trauma can lead to men-

tal illness. Nevertheless, significantly more PTSD symptoms were observed among tortured refugees than in a highly similar control group of non-tortured refugees. Thus, we conclude that torture plays a significant role in the development of PTSD symptoms among Bhutanese refugees". These words are of immense importance for the debate that Young started ten years ago and that Breslau takes up in his paper for a variety of reasons: (1) Outside the western context of a American Veterans Hospital where Young did his research, and without secondary benefits such as disability allowances, Bhutanese refugees easily recognized and endorsed PTSD symptoms among more than 100 topics that were addressed in a research design that encompassed approximately 1700 variables; (2) Symptoms of a range of psychiatric disorders such as depressive disorder, anxiety disorder (including PTSD), somatoform disorder and local idioms of distress were interpreted with local explanatory models such as Karma, spirits or offended gods among respondents who had no notion of words such as trauma, traumatic stress or PTSD; (3) Because similar findings appeared from other cultures, these symptoms apparently fit some universal experience; (4) PTSD indeed appears to be – as Young and Breslau state – a 'prominent cultural model' for understanding the suffering of many human beings. However, this cultural model is not limited to the 'western' hemisphere and has meaning as a recognizable diagnostic entity in a variety of cultures. The work of many scholars around the globe has shown this among for example Algerians, Cambodians, Afghans, Ethiopians, Tibetans or Sri Lankans.

Breslau then wonders "to what extent research on PTSD identifies the mental health needs of the population" (p.120). According to Van Ommeren et al. (2001a) the 12-month prevalence of *all* evaluated psychiatric disorders is estimated at 74.4 percent among tortured and 48 percent among non-tortured refugees. Because only four percent of the persons in the camp with a psychiatric disorder are among the group of tortured refugees, Breslau concludes that "on purely public health grounds, a focus on torture as a cause of mental disorders in this population is out of proportion to actual public mental health needs" (p. 120). In my view this statement is not fair in relation to the work that CVICT was doing. CVICT trained Community Health Workers (from among the Bhutanese refugee communities) and health assistants on e.g. counselling skills, mental health, stress management and relaxation. These trainees provided physical, mental and psychosocial services to the Bhutanese refugees in Nepal (Van Ommeren et al. 2002) and were stimulated to use their skills during their daily primary care activities in addition to taking care of torture survivors. Breslau's statement about an exclusive focus on torture is also quite naive because he presupposes that prevalence is the only criterion to select public (mental) health interventions. A recent study showed that US prevalence figures for psychiatric disorders decreased by 17-32% after adjustments were made for help-seeking, life interference and use of medication (Narrow et al. 2002). Three decades ago Morley proposed other criteria than prevalence to select public health priorities, for example needs of the target group and seriousness of a disorder (Morley 1973). In our intervention work we promote the use of nine criteria in addition to prevalence and Disability Adjusted Life Years, i.e. community concern, seriousness, treatability, sustainability, knowledge and skills of (mental) health care workers, political acceptability, ethical acceptability, cultural sensitivity and cost-effectiveness (De Jong 2002:

45-65). With these selection criteria in mind torture ranks high among the priorities of the Bhutanese refugees. Torture is a serious problem that can cause disability and interfere with life. The field workers of CVICT gained expertise in treating its consequences, and it is a politically and ethically important topic to address. Torture survivors are a highly vulnerable group and hence fit the current trend in public (mental) health to develop selective and indicated interventions aimed at secondary and tertiary prevention (United States Committee on Prevention of Mental Disorders 1994; De Jong 2002: 67). In other words, within a current public mental health paradigm there are several valid reasons to pay special attention to torture in addition to other health priorities.

Breslau then continues: “the expansion of PTSD into the international health arena thus involves complicity and interdependence between promoters of the disorder as a privileged window onto human suffering and local actors advancing political agendas on the global stage. PTSD can function in this way because of the symbolic power of medical science... PTSD offers scientific credibility to claims of victimization, while political actors provide contexts for expanding the purview of PTSD” (p. 120). One wonders whether Breslau regards PTSD as a disorder just like any other mental disorder or whether he attributes a special status to PTSD.

In his recent book *Does PTSD damage the Brain?* Bremner posits PTSD as a neurological disorder. He writes: “Stress results in long-term changes in the brain structures and systems that lead to symptoms of stress-related psychiatric disorders, including PTSD” (Bremner, 2002: 222). In contrast with this widely held view, corroborated by a wealth of neurobiological research, Breslau emphasizes that PTSD provides “a privileged window onto human suffering and local actors advancing political agendas on the global stage (p. 120). As we will argue in more detail elsewhere and in contrast with Breslau’s paper, research on PTSD increased substantially long before the global institutions such as the United Nations, the WHO or the World Bank started to show interest in it (De Jong & Osterman 2005). A critical question to be asked is why some anthropologists, psychiatrists and actors advancing political agendas continue to place emphasis on PTSD as a window onto human suffering? The same reasoning applies to scholars who do research on a variety of psychological problems and psychiatric disorders among groups such as women, prisoners of war, resistance fighters or first or second-generation Holocaust survivors. In addition to answering a variety of interesting basic research questions, all these researchers “try to advance political agendas on the global stage” (Breslau 2002: 120). They do so, for example, because they want respect for human rights among prisoners of war, because they wish to prevent rape, domestic violence or femicide, or because they want to prevent another Holocaust or genocide. A similar agenda exists for many physical disorders as well. Thousands of consumer organisations around the world try to get disorders ranging from diabetes, AIDS, cancer, heart disease, or stroke on political agendas. If researchers would *not* try to get these topics on international agendas they would be justifiably accused of neglecting their societal responsibility to sensitize the global community and to contribute to much needed primary prevention.

In short, Breslau’s paper consists of a sequence of statements, many of which are imprecise. He has selected research findings to make a case that is not very strong. He

attributes too much power to imagined PTSD researchers to whom he ascribes political motives. In short, he pays too much attention to PTSD while neglecting a range of mental disorders and psychological problems that also deserve our attention; problems that warrant collaboration between mental health professionals and anthropologists.

Discussion

The debate between social science and mental health professionals on the construction of PTSD can be characterized as a product of projection or, in common English, 'the pot calling the kettle black'. The critique on PTSD is generally inspired by a cultural relativistic stance. Despite the presence of the disorder in a variety of contexts and cultures where secondary benefits do not play a role – and hence the critique on the veracity of the reported traumas becomes questionable (Brown 1995; Loftus 1993) – any conclusion related to a possible universality or neurobiological core is dismissed as overly universalistic or as the medicalization of social problems. On the other hand, Young's observations in the middle of the 1980s took place during the initial development of mental health services by the US Veterans Administration. At that time part of the debate focused on the question whether a psychodynamic or phenomenological view of traumatic stress, as endorsed by DSM, would better fit the plight of returning Vietnam veterans. Since the publication of Young's book (1995), neuroscientific evidence supports a neurobiological substrate of the core characteristics of PTSD. In addition, there is strong evidence that PTSD is easily recognized in a wide variety of cultures by respondents who receive no benefit from the diagnosis. Yet, both epidemiological and neurobiological findings are often dismissed while generalizing Young's time and culture bound critique of the eighties to contexts around the globe. In my opinion, and this may sound somewhat paradoxical, although Young may agree (Young 2002), his critique on PTSD has more importance for the validity of DSM diagnoses in general, framed by the introduction of a new diagnostic category and insights into the consequences of traumatic stress.

In a recent chapter I expressed critique on PTSD mentioning, for example, that we should amplify the PTSD paradigm because research in post-conflict situations tends to gravitate towards the epidemiology and treatment of PTSD, which is much too limited (De Jong 2004). As several others have mentioned, the study of this western diagnostic category in non-western contexts may lead to its reification without evidence that this category is the most relevant of possible descriptions of local survivors' mental health problems (Marsella et al. 1996; Shrestha et al. 1998). This results in selective attention to PTSD in many intervention programs at the expense of other types of mental health problems that are elevated as well and at the expense of pre-existing psychotic disorders or epilepsy. In our epidemiological research we found that PTSD was not only associated with an experience of conflict and violence, but also with a range of other stressors such as quality of the 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. Among those exposed to armed-conflict-associ-

ated violence, risk ratios were not only elevated for PTSD, but also for mood disorders, somatoform disorders and other anxiety disorders as well (De Jong et al. 2003). Moreover, we found that disability was more associated with mood disorder and anxiety disorder than with PTSD. Therefore, I called for a paradigm shift among those professionals who focus more or less solely on PTSD within trauma rehabilitation programs. Post-conflict programs should move beyond a narrow PTSD focus and address a wide range of disorders and especially psychosocial problems (De Jong 2002: 45-64).

One of the challenges of the next decades is a worldwide inventory of local expressions of unusual or 'deviant' behavior using a phenomenological approach employing a combination of qualitative and quantitative research methods (De Jong & Van Ommeren 2002). We expect that this will 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. We propose that this work be carried out by intense collaboration between on the one hand the disciplines of psychiatry and psychology, and on the other hand anthropology and sociology. We regard this work as important to test the cultural validity of psychodiagnostic systems (ICD, DSM), and psychological problem categories. The main aim is to answer the question whether the whole world should accept one universal classification system or whether we may better opt for some major universal categories in combination with subcategories that can be used in specific cultures. For example, in another recent paper we described a series of steps to construct a possible universal core module to capture the consequences of extreme stress (or DESNOS, Disorders of Stress Not Otherwise Specified) across cultures, with local modules that fit culture-specific expressions of extreme stress (De Jong et al. 2005). To develop a cross-culturally useful diagnostic construct we proposed to distinguish Type A, Type B, and Type C symptoms. Type A, or core symptoms, are those that are the same in all cultures. These symptoms (e.g., difficulties modulating anger as a universal symptom of the universal process of affect dysregulation that is one of the dimensions of DESNOS) form the universal items of the instrument (the core module). These symptoms are probably based in universal neurobiological processes, in molecular genetics and molecular biology, neurochemistry, neurophysiology, neuroendocrinology and cognitive neuroscience, and may be considered defining characteristics (Andreasen 2001; Kendell & Jablensky 2003). Type B symptoms are those that are unique to a culture but that reflect universal underlying problems (e.g., self-injury as a cultural symptom of the universal process affect dysregulation). Type B symptoms should be incorporated in the local module. Type C symptoms are expressions of culture-specific processes with specific symptoms (e.g. low self-esteem as a culture-specific symptom of the culture-specific process of disturbances in self-perception). Type C symptoms should ideally also be incorporated in the local module.

Most authors agree that universal characteristics in the presentation of psychopathology are more prominent when bio-physiological factors play a prominent role, and that various other idioms of distress and illness factors are culture-specific and may be better explained within a socio-cultural paradigm (De Jong & Van Ommeren 2002). Therefore, the first step needs to elicit invariable dimensions involved in

neurobiological processes that evolved in the course of the evolutionary history of primates. It is likely that a limited number of Type A or core symptoms will get us closer to a universal construct. The second step could be to deconstruct syndromes that have been used in psychiatry over time (e.g. battered women syndrome, concentration camp syndrome, torture syndrome, shell shock, PTSD, DESNOS). The third step would be to compare all data sets on WHO's category "lasting personality changes following catastrophic stress" with the data on DESNOS. The second and third step may suggest *Type A, B and C symptoms*, because torture has been practiced and described in many cultures, whereas the literature on shell shock or battered women is limited to historical episodes and geographic areas. Subsequently, one could deconstruct those DESNOS dimensions that belong to (other) axis I or II disorders and that contribute to fuzzy boundaries between DESNOS and other disorders and thus lead to a lack of validity. For example, somatization belongs both to somatoform disorder, depressive disorder, anxiety disorder and culture specific illness behavior and contaminates the DESNOS syndrome. Likewise, anger and self-destructiveness also belong to borderline personality disorder, and anger and victimizing others to antisocial personality disorder. Similarly, the second step may include a review and an analysis of qualitative and quantitative data from non-western cultures regarding the sequelae of childhood sexual abuse, rape or spouse abuse that have been collected since the origin of the DESNOS-construct. There are several techniques to distinguish between discrete entities and continuous variation such as a combination of discriminant function analysis and admixture analysis, a "grade of membership" model and others (Kendell & Jablensky 2003).

The third step aims at finding *Type C symptoms* in a variety of cultures and settings, with qualitative techniques. Focus groups can be used as a way of socially generating expressions of culture-specific consequences of extreme stress. Focus groups should be organized among both urban and rural people (e.g. office workers and peasants), among patients, healthy persons, mental health professionals and traditional healers, and among high risk groups (e.g. former combatants and survivors of human rights violations). Because the data yielded by focus groups can be the product of social dynamics within the group, the data from several focus groups sampled from the same population should be compared to protect against this possibility. Upon completion of the focus group work, a panel of the local investigator and the focus group moderator should analyze the focus group transcripts to describe the Type C symptoms in that culture and add them to the developing instrument (cf. WHOQOL group 1995; De Jong & Van Ommeren 2002). A similar approach could be used for a variety of psychopathological constructs or categories. It could result in a new conceptualization of psychiatric classification systems. One might even go one step further and extend this view to all psychiatric diagnoses and think of a global network of researchers that collect and update local expressions and idioms of distress in line with the previous anthropological Human Relations Area File.

In addition, there are many other challenges in understanding the role of culture in the realm of human-made and natural disaster (De Jong 2004). Culture permeates the whole process of traumatising and recovery from traumatic stress. Traumatic stress interacts with culturally-mediated systems of meaning such as religion or causative at-

tribution, and with practices such as cults, rituals and social support systems. Moreover, cultural factors largely determine local variations in the construction of the 'self', in the interpretation of traumatic stressors, the ways in which events are appraised, and in variations of coping strategies in both genders, among adults and children in different developmental stages and in a variety of cultural contexts (De Jong 2004). Other interesting domains of research are the anthropology of the senses and the anthropology of sensations and their relation with idioms of distress and local expressions of suffering. These are only a few examples of the vast unmapped territory of culturally varying moderators and mediators in the domain of traumatic stress. To gain more insight requires intensive collaboration between the mental health profession and social science, especially anthropology. Such collaboration would be an important step to further the discourse and our insight in the cultural expressions of traumatic stress in particular, and possibly of psychiatry in general.

Notes

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