Emotional disorders in a transcultural world

Malek Bajbouj and Maher Al Asasleh

(Freie Universität Berlin and Charité Universitätsmedizin Berlin, Germany)

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Abstract: Emotional competencies and affective disorders share common basic neuronal mechanisms. However, individual differences of behavioral and psychopathological signature are strongly shaped by cultural influences. In this review article, we compare four different clinical syndromes in Western societies and the Arab world each exemplifying a dysfunction of a distinct emotional capability comprising affective disorders with a prominent mood disturbance, anxiety disorders with fear dysregulation, autism with a prominent communication dysfunction, and borderline personality disorder as an example of emotional instability.

CV: Malek Bajbouj is Professor for Psychiatry and Affective Neuroscience at the Charité University Hospital and Freie Universität Berlin. He heads the Research Group "Affective Neuroscience and Emotion Modulation" (ANEM) which focuses on translational affective sciences. He studied medicine in Mainz, Frankfurt and Zurich and received his clinical and adacemic training in the private university Witten-Herdecke, Columbia University New York, and Charité Berlin. **Maher Al Asasleh** is a postdoctoral fellow in the ANEM research group who received his clinical and research training at the Royal University Amman in Jordan.

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We all accept the broad variability among our friends in their ability to communicate, to be empathic, or to cope with aversive emotions and distressing circumstances. In everyday life, we all take this rich diversity of emotional competencies and capabilities for granted and do not question the impact of cultural background. In emotional disorders and affective neuroscience, such individual differences are often ignored and discarded through averaging symptoms and data from a group of participants. Even more, one of the key vectors responsible for such differences, the cultural background of investigated populations is often not exploited in diagnosis and treatment of affective disorders and processes. Even more important, defining feature of emotional disturbances are directly linked to social standards and role expectations, which are highly culture dependent. The present review tries to shed light on this topic by focusing on differences rather than similarities in the signature of emotional disturbances in Arab and Western societies. It tries to take into account the significant differences among the Arab countries in terms of their socio-demographic make-up and health systems, which are in many countries a long way from meeting current needs. To investigate the differences in symptoms of emotional disorders, we aim at describing symptoms of four different disorders each reflecting a dysfunction of a distinct emotional competency: first, we intend to describe the signature of depression as one of the most common affective disorders with a prominent mood disturbance; second, we focus on anxiety disorders with the prominent symptom fear dysregulation; third, we continue with autism with a prominent communication dysfunction; and finally borderline personality disorder as an example of emotional instability.

1. Affective disorders

According to the World Health Organization depression is the leading cause of disability and the 4th leading contributor to the global burden of disease in 2000. By the year 2020, depression is projected to reach 2nd place of the ranking for all ages, both sexes. Depression is common, affecting about 121 million people worldwide and fewer than 25 % of those affected have access to effective treatments. The course of a typical depressive episode is either chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850 000 lives every year. Depression occurs in persons of all genders, ages, and backgrounds. The two standard diagnostic manuals (Diagnostic and Statistical Manual of Mental Disorders, DSM IV; International Classification of Diseases, ICD 10) provide a detailed description of essential clinical features comprising

- depressed mood
- loss of interest or pleasure
- feelings of guilt or low self-worth
- disturbed sleep or appetite

- low energy, and
- poor concentration.

It is daily experience of therapeutically acting physicians and psychotherapists that cultural and ethnic specificity of depressive symptoms influence experience and communication of symptoms and is often the cause of underdiagnosis or misdiagnosis of depression. For example, typical complaints in Asian cultures are weakness, tiredness, or imbalance whereas Middle Eastern cultures often report problems of the heart. *Ekte'ab* is the Arabic word that means depression, other expressions may express related feelings are: "I feel like I have flames inside me" or "I feel like I have a mountain on my chest" or "I hate everything in this life" or "I feel like I want to die". Such symptoms indicate a different embodiment of affective symptoms or –in medical words- that depressive symptoms are largely experienced in somatic terms with complaints of „nerves“ and headache rather than with sadness or guilt. Although, emotional expression is universal, Arabic culture, religion and morals tremendously affect how these emotions are expressed in the abnormal pathological circumstances. Among the typical depressive features described in text books there are culture-independent universal symptoms comprising low mood, lack of interest, lack of energy, feeling down, poor concentration, weight loss, diurnal mood variation, insomnia and early morning waking. Differences are often seen on psychomotor features where exaggeration in body movements, as for walking slowly, bending the neck, heavy and indolent moves, in addition to that, looking down is another symptom which also reflects the low self-esteem and lack of self-confidence are more often described. In addition, shame and guilt may be seen in a picture of a man who was respected by his family members, bringing a gun to them, and he asks to be killed in front of them. He thinks that in this way, he will get rid of the shame he brought to himself and others. Suicidality and self-killing in the Arab world was not broadly discussed and searched. Suicides and its attempted suicide are considered disgraceful acts, and prohibited by religion and norms and remain a taboo in Arab cultures, Drug overdose is the most common used method for doing so, and it increased recently because of the conflicts and the socioeconomic states.
Manic and hypomanic features are known for being more universal, but they maybe differentiated in the way symptoms are expressed, such as sexual disinhibiting which are signs and rarely sexual harassments, also irritability in patents, and hiding from other family members for protection, especially if the patient was a female.

Traditional Arabic culture does have protective as well as harming elements: the typical family structure with family members compensating effects of loss is clearly protective. On the other hand, family members often encourage patients seeking help primarily from traditional healers while at the same time hiding and stigmatizing mental illnesses does not help patients. In addition, there are

communities in the Arab world who consider depression as a normal and legitimate response to life stressful events and conditions. And they will not require medical advice; these beliefs will determine and limit the acceptance of management and the further compliance. In addition, there are strong beliefs in possession states or "spirituomagical" influence these explanatory thoughts lead patients and their families to seek help first from religious people; shaman (*Shaikh*), that need attention from clinician. Finally, the Muslim patients (ones who have strong religious beliefs) show lower rates of adherence to treatment regimens than those with weaker beliefs in addition to the religious taboos, dietary restrictions and fasting in Ramadan, and taking herbs which may interact with psychotropic. In such settings, it is one of the central roles of physicians treating Arab patients in Arab countries as well as in European countries is to promote healthy relationship between professional therapists, patients and family including the discussion of supernatural beliefs, and in addition to the reinforcement by society and traditional therapist.

2. Anxiety Disorder

Anxiety is a physiological reaction to stressful events. Anxiety helps that stressful events are granted a privileged status within the individual memory. Anxiety helps to maintain optimal level of arousal needed to better focusing on and coping with challenging or threatening circumstances in life. When anxiety becomes an excessive, irrational dread of everyday situations, it becomes a disabling disorder. Anxiety disorders are among the most prevalent psychiatric disorders with prevalence rates usually above 10% (Costello & Angold, 1995) in spite of cultural variations in rates. They include a total of five subtypes comprising generalized anxiety disorders, panic disorders, phobias, obsessive–compulsive disorder, and post-traumatic stress disorders. Disease onset is usually in childhood and adolescence. Populations at risk include children of overcontrolling anxious parents, as well as traumatizing events such as child abuse, accidents, violence, or war experiences. Those early adversities usually create a persistent neurobiological vulnerability that predispose to anxiety (as well as affective) disorders.

Anxiety disorders specified in classification systems like the Diagnostic and Statistical Manual (DSM-IV-TR) and the ICD 10 are universally prevalent in human societies, and also show substantial cultural particularities in prevalence and symptomatology. The observed epidemiological variability in Arab and Western societies include lack of measurement equivalence, true differences in prevalence, and limited validity or precision of diagnostic criteria. For reasons of clearness and brevity we will focus here on two types of anxiety disorders, namely the generalized anxiety disorder (GAD) and the posttraumatic stress disorder (PTSD).

Generalized anxiety disorder (GAD) is characterized by a pattern of frequent, constant worry and anxiety over many different activities and events. The main symptom is the almost constant presence of worry or tension, even when there is little or no cause. Worries seem to float from one problem to another, such as family or relationship problems, work issues, money, health, and other problems. Even when aware that their worries or fears are stronger than needed, a person with GAD still has difficulty controlling them. Other symptoms comprise concentration and sleep disturbances as well as physical symptoms as muscle tension, shakiness, and headaches. Specific or typical symptoms in Arab patients are clustered more often and more prominent in somatic symptoms. The same word is used to describe anxiety in Arabic language but there are other words used in the colloquial form of the language, for example, the widely used somatic expressions for symptoms of cardiac and respiratory systems and the night terror are expressed with the word (*Abullobbaid*) that a person wakes up suddenly describing a black person with white long hair, and a slit white eyes and he wants to strangle or put a heavy weight on their chests. This is in line with previous studies investigating symptom variability in a cross-cultural approach in generalized anxiety disorder: several studies have indicated that individuals from Arab and other non-Western societies are very likely to express somatic symptoms as a key aspect of pathological worry. A study that explored "psychological" versus "somatic" presentations of psychiatric disorders among primary care patients in the United Arab Emirates found that patients who meet criteria for GAD are more likely, on the basis of symptom profiles and attributions, to have rather somatic than psychological presentations (El Rufaie et al 1999).

Post-traumatic stress disorder (PTSD) is a type of anxiety disorder occurring after traumatic event that involved the threat of injury or death. People with PTSD show symptom cluster in three domains: (1) repeatedly relive the traumatic event in flashback episodes, recurrent distressing memories and dreams of the event; (2) Avoidance like staying away from places, people, or objects that remind of the event; and (3) Arousal with exaggerated response to external stimuli, excessive awareness (hypervigilance), and irritability or outbursts of anger. In Arab countries like Iraq, Palestinian Authorities, Lebanon etc armed conflicts are more prevalent as compared to Western countries. Numerous lines of evidence have emphasized the negative impact of such armed conflict on the mental health of children and adolescents, in particular in the development of symptoms of PTSD (Qouta et al., 2003). Variance in PTSD rates has been related to level of exposure, type of exposure, measures of posttraumatic stress, and socio-cultural contexts (Solomon and Lavi, 2005). However, interestingly, research has also emphasized that children may be less likely to suffer from overt psychological disorder than one might expect (Gibson, 1989) and may often be impacted upon more by the response and anxiety communicated from their parents (Garmezy & Rutter, 1985).

Factors like good coping strategies, an optimistic attitute as well as socio-emotional competencies are factors protecting against the occurrence of anxiety disorder. Beside those individual factors sociocultural factors like social support system and an intact internal framework of belief, meaning and spirituality reduce the likelihood of anxiety disorders in individuals. Although systematic investigations are missing, it appears that family structures and religious believes are more prevalent than in Western societies. On the other hand, repressive structures and strict social values and norms may be the reason for the heterogeneous results from epidemiological studies. Within Arab societies, anxiety disorders are the most common disorders with prevalence rates of 28.2% in Jordan, 16% in Saudi Arabia, 16.7% in Lebanon and 10% in the United Arab Emirates (El-Rufaie, 1995). Results of a national study conducted in Lebanon show that Lebanon has a 12 month rate of 11.2% for any anxiety disorder, which is higher than most European countries (6.4%) however lower than the United States (18.2%) (Karam et al, 2008).

3. Autism Spectrum Disorder

Autism is a developmental disorder characterized by abnormalities in communication and social interaction, besides a restricted repetitive activities and interests which usually start from infancy, and most cases are manifested before the age of 5 years old. The exact causes of autism remain unknown, albeit a very active area of research. There are probably combinations of factors that lead to autism including genetic and environmental factors. A total of eight clinical entities are included under this rubric in DSM-IV. The incidence of all forms of pervasive developmental disorder was thought to be around 3/1000. Recent surveys suggest much higher incidence. It recognizes that the boundaries between the different disorders are difficult to be determined. Leo Kanner first identified autism in 1943. Autism or Autistic Spectrum Disorder (ASD) is considered now as the fastest growing neurobiological condition in the world. Autistic spectrum disorders that include the whole range of pervasive developmental disorders that occur at all age, racial/ ethnical and socioeconomic groups. Worldwide, 3 to 6 children out of every 1000 have ASD. Males are 4 times more likely to have ASD than females. Although recently ADDM-Autism prevalence report concluded that the prevalence of Autism had risen to 1 in every 70 boys, which caused a media uproar and increase opportunities for the west and east to consider how to serve these families facing - a lifetime suffering with their children.

Main clinical features identified by Kanner are still used to make the diagnosis: Abnormalities of social development, abnormalities of communication and restriction of interests and behavior in children. The clinician and family may notice lack of or delay in Language, repetitive use of language and acts, avoidance of eye contact, decrease or lack peer relationship, Lack of imaginary play. Other

symptoms may include sensory dysfunction, sleep disorders and self abrasive behaviors. The communication may be impaired in language, which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime. If having adequate speech, there will be marked impairment to initiate or sustain a conversation or repetitive use of language and play inappropriately. In Arab countries in comparison with the west countries still relatively less researches and studies made about ASD, its presentation and occurrence and any differences.

Some studies indicate consanguineous marriages as a risk factor. Due to comparably reduced awareness Arab countries show a high percentage of undiagnosed case and a late referral age. The lcore symptom leading to first contact with psychiatrist in Arab countries is communication impairment, in 50% of the cases mental retardation as well as hyperactivity and impulsivity.

Females are older at the time of assessment than males and it is mostly due to the less pressure by the society to seek treatment and that boys in the Arab countries are more often expected to be outgoing than girls. In addition, social and communicational deficits on females may be attributed to shyness. Communication deficits in both males and females are the most important reason behind referral in the Arab world, and this includes lack of speech development, repetitive speech, difficulty to start a conversation, failure to respond to name and failure to follow a direction. Hyperactivity and aggression are further co-occurring behavioral problems and reasons for referral. Depression and anxiety as co-occurring problems are rather rare which may also refer to the child psychiatric services that are not well developed in a relevant proportion of Arab countries.

4. Borderline Personality Disorder (BPD)

Personality Disorders are mental illnesses with symptoms that are enduring and play a major role in most, if not all, aspects of a person's life. While many disorders vacillate in terms of symptom presence and intensity, personality disorders typically remain relatively constant. To diagnose a disorder in this category, symptoms have to be inflexible and pervasive and have been present for an extended period of time. Usually, history of symptoms can be traced back to adolescence or at least early adulthood. The symptoms have caused and continue to cause significant distress or negative consequences in different aspects of the person's life and are seen in thoughts (ways of looking at the world, thinking about self or others, and interacting), interpersonal functioning (relationships and interpersonal skills), impulse control, and emotions (appropriateness, intensity, and range of emotional functioning).

The term ‘borderline personality’ is much older than the concept of personality disorders and was proposed in the United States by Adolph Stern in 1938. Stern described a group of patients who ‘fit

frankly neither into the psychotic nor into the psychoneurotic group' and introduced the term 'borderline' to describe what he observed because it 'bordered' on other conditions. The characteristics that now define borderline personality disorder were described by Gunderson and Kolb in 1978 and have since been incorporated into contemporary psychiatric classifications.

Although borderline personality disorder is a condition that is thought to occur globally (Pinto et al 2000), there has been little epidemiological research into the disorder outside the Western world.

In western countries, the median prevalence rate of Borderline Personality Disorder, in epidemiological studies is 1.5 – 5 per cent with more women affected. In psychiatric inpatients the ratio increases to reach up to 20 per cent. There is converging evidence that persons with borderline personality disorder are more likely to report physical and sexual abuse in childhood.

Criteria of Borderline Personality Disorder can be major symptoms of this disorder revolve around unstable relationships, poor or negative sense of self, inconsistent moods, and significant impulsivity. There is an intense fear of abandonment with this disorder that interferes with many aspects if the individual's life. This fear often acts as a self-fulfilling prophecy as they cling to others, are very needy, feel helpless, and become overly involved and immediately attached. When the fear of abandonment becomes overwhelming, they will often push others out of their life as if trying to avoid getting rejected. The cycle most often continues, as the individual will then try everything to get people back in his or her life and once again becomes clingy, needy, and helpless.

The fact that people often do leave someone who exhibits this behavior only proves to support their distorted belief that they are insignificant, worthless, and unloved. At this point in the cycle, the individual may exhibit self-harming behaviors such as suicide attempts, mock suicidal attempts (where the goal is to get rescued and lure others back into the individual's life), cutting or other self-mutilating behavior. There is often intense and sudden anger involved, directed both at self and others, as well a difficulty controlling destructive behaviors abbreviate as: Identity Disturbance or uncertain Self Image. Unstable relationships, efforts to avoid abandonment, recurrent self harm, chronic feelings of emptiness, paranoid ideations, impulsive liability to anger and violence and affective instability.

Borderline personality disorder was not diagnosed 20 years ago in Arab countries and still prevalence rates seem to be much lower than in European countries and North America. Recently, there is an increasing numbers presenting with BPD that may reflect increasing awareness for the disorder as well as changes in religious and family associated socio-cultural factors indicating a shift from collectivistic to individual society pattern.

Conclusions:

Like in all other regions of the world emotional disorders play a key role in mental health. Prevalence and symptom pattern of emotional disorders like depression, anxiety, autism, and borderline personality disorder are shaped and influenced by current changes, specific expectations and existing rules of Arab societies.

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