



Patient form Middle East and the Impact of Culture on Psychological Pain-Treatment

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Abstract

Patients from traditional-collective Middle-East cultures have a different understanding of pain and other healing expectations, even in contact with the doctor and psychotherapist, for example, as patients in individualized Western societies. This has not been considered enough in modern multimodal therapy, especially in psychological pain treatment. The pain experience is not limited to a part of the body, but needs to be seen holistically related to the body and the patients can refused any activities, like sports. The slightly access to psychological illness often leads to diffuse and chronic pains. For therapy and the therapist-patient-relationship, it is essential to understand the significance of the experienced pain in interpersonal relationships and cultural, social, collective psychological terms.

Keywords: Pain perception; Disease perception; Traditional medicine; Collective culture; Transcultural psychotherapy

Introduction

The pain treatment model accepted by specialists today is based on the general assumption that biological, psychological and social-culture factors are involved in somatoform pain symptoms. Originally, no significance at all was attached to psychosocial factors in the traditional perception of pain, but then came a long period in which discussion was focused exclusively on psychological processes as the cause of unidentifiable pain, and pain came to be regarded as being "psychogenic" [1]. In the literature first the anthropological-medicine Experts discussed the cultural differences in the expression and experience of [2].

In Great Britain and the USA it was not until the 1950s that the question as to whether the cultural background has a bearing on pain behavior and pain perception and whether it is hence significant for treatment was addressed [3]. Some studies conducted in the USA showed that cultural differences in pain behavior do exist [4]. They revealed that both subjective pain intensity and pain sensation are closely associated with psychological factors such as attitude and motivation as well as with the ethnic background [5,6].

German physicians and therapist's report, for instance, that Turkish patients from rural areas and patients belonging to other ethnic groups from southern European countries present with diffuse whole-body pain more frequently than German patients [7,8].

Pain, like no other sensation, is characterized by cultural influences, which also have a significant influence on the disease perception, the behavior and of the treatment effects.

Pain perception

In archaic and antique civilizations of the Middle East (Babylonian, Mesopotamian, Assyrian and Egyptian medicine), pain perception was based on magic and religious ideas. The belief was that, for example

that headache and facial neuralgia were caused by evil or so-called black ghosts or that they were to be regarded as punishment for their sins [9].

Babylonians and later the Iranians (Mesopotamian and Persian) believed that aches and pains occurring in certain parts of the body were the results of moral and ethics violations for which God hurts those body parts. With different rituals like washing, praying, sacrificing of animals etc., with a combination of magic ceremonies, meditations they tried to heal or at least reduce the pain symptoms. Religion healers or wound healers specialized in spiritual rituals and special treatment methods (natural remedy, massage techniques, prescription of certain kinds of food, etc.) [7].

The development of pain treatment was advanced by the Persian physician Abu Bakr Muhammad ibn Zakariya' al-Razi (865-925 and later by Ibn Sina (980-1037), who developed causal therapeutic, local analgesic and mind-altering treatment methods for more than 15 kinds of pain, which he described in his Canon Medicinæ [10]. Traditional medicine is still used not only in rural region, but also in large cities in Middle East. Various traditional healers are active not only at home but also in countries they migrate to. Such traditional healers include bone healers, religious healers, who work as magicians or sorcerers, Arab physicians carrying on the tradition of the Four Humour Theory, herbalists and women practicing the art of healing for dealing with gynaecological and obstetrical problems [11]. Bone healers, historically a very famous profession, are consulted for the treatment of strains and suspected or actual bone fractures. As a rule, these religious healers are familiar with the Qur'an, but this is by no means a prerequisite. In many countries in the Middle East there are also numerous traditional non-Islamic healers. Religious healers are believed by some to be able to recognize magic influences such as the "evil eye", evil spirits or black magic as causes of a disease. Traditional healers are consulted for a wide variety of problems ranging from psychological, neurological, and psychosomatic ailments such as depression, epilepsy or chronic complaints to family problems, or financial or work-related difficulties [11].

In the traditional medicine of these cultures, certain complain express themselves through specific organs (Table 1).

	Cause	Complaints	Treatment	Linked with
Shift navel	Carry sth. heavy, hard work, hard life, stress	Stomach pain, nausea, vertigo, weakness, fatigue	Belly and back massage, hot plates, pulling the navel to correct position, followed by rest	Hard life, loss of moderation
Burning liver	Sadness, worry, deep sorrow	Liver pain, pain in epigastric region	Meditation, reading religious holly book, visting traditional healers	sadness, longing, problems in relations
Backache	Conflict in relations, worry, role problem, hard work	Dragging back pain, hardly able to move or to lift or carry something	Massages, restrict movement, rest	Sexual disorders, less power, feeling weakness
Rheumatic pain/wind pain, "black/cold wind"	Grief, worry, conflicts, longing	Fatigue, weakness, lack of drive, the pain is in a different part of the body every day	Lying in bed, avoid to move, take a rest	Little acceptance in the family or community, hard life
Feeling of apprehension	Grief, worry, feelings of guilt, longing, anger	Headache, sore throat, claustrophobia, globus symptom, breath problems	Hodja, traditional healers, wearing protective amulets	Anxiety, insecurity

Table 1: Culture-specific syndromes [7,14].

Somatic disorders

Since somatoform disorders of these patients play an important role in the work of physicians and therapist with in- and out patients [12]), we shall consider these disorders as an example and deal with them in greater detail.

One of the central problems involved in providing medical care to migrants is the somatization, or in the word of the patients "psychological pains", of problems of psychological and social origin in the biomedical oriented sub-system of our society's medical culture. Somatoform disorders are a diagnosis of disorders that comprises bod diffuse pain without a sufficient somatic explanation, excessive worry about a physical illness, often associated with depression, anxiety and frequent visits to the physician with negative examination results [7]. In in-patient rehabilitation treatment focused on the treatment of migrants, somatization disorder is one of the most frequent diagnoses [8,13]. The patients from Middle East (Turks, Kurds, Persians, Arabs) concerned describe all complaints as if they were physical and they seem to follow an archaic perception of disease. The subjective complaint can then be symbolically represented by tiredness, crying, use of walking aids, etc.; they present themselves as helpless and powerless people. As a result those patients believe that they are not anymore able to enjoy their life and avoid participating in any domestic activities.

Male patients from these traditional cultures frequently complain of back problems, and women's complain of psychogenic headaches, migraine, stomachache etc. [14]. In general, pain in the rheumatic and arthritic and gastrointestinal categories is also a common complaint. In our studies which gained at the Psychosomatic Clinic in Germany in 2011, there is a manifestly higher incidence of gastric disorders among traumatized refugees, who have experienced torture. It seems that some ethnic groups tend to respond to severe stressors more frequently with body pain like gastric disorders, fainting spells, paralyses, blockages, hypochondriac symptoms and histrionic behavior in conjunction with physical complaints [13].

These strict physical complaints on the background of inner-psychological conflicts can be seen as challenge for the physicians as well for the psychotherapists and need a different approach regarding diagnostic and treatment [8].

Diagnostics and Treatment

Diagnosing somatoform disorders is an interdisciplinary task (comprising various disciplines such as psychology, medicine, psychopharmacology, physiological measures, etc. involved in diagnostics and treatment) for all ethnic groups, top priority being given to searching for a medically treatable cause [15]. As mentioned previously, many pain syndromes are not accessible to causal treatment, which eliminates or reduces the cause of a disease. An example of causal treatment is the use of an antibiotic to kill off bacteria, thereby eliminating the cause of a disease.

The different perception and overcome of illness and their lack of knowledge about the "modern treatment", make the diagnosis for the practitioner very difficult (the Arab-Greek medicine of Four Humor Theory is still regarded as the theoretical basis of the study of diseases) about anatomy and physiology of their body and their traditional notions about pain (magic, curse, punishment, etc.). The pain experience is not confined to a part of the body, but is viewed holistically in relation to the body. And yet an analysis of the circumstances of the first occurrence or of aggravation of the pain, taking into account the individual and collective biography (e.g., ostracism on account of ethnicity and/or religious affiliation in the country of origin, socio-cultural and trans-generational conflicts, etc.) has to be made in order to obtain possible clues regarding the triggering factors. It is important to find out what alleviates or aggravates the pain and what impairments this causes.

In analyzing the behavior of people coming from traditional-collective cultures, it is especially important to identify the compliance, the patient's response to preceding treatments and the medications the patient is taking. On the idea of the fear-avoidance (FA) model [16,17] these behaviors may initially be adaptive, but they paradoxically

worsen the situation when engaged in later on. Avoidance behavior may fuel pain, disability and depression [18]. In addition to possible avoidance and anxiety, the general perception of disease in these traditional collective societies is that when the body is sick it must rest and until the body has not psychological or physical complaints [7]. Families support this relieving behavior, thereby reinforcing the secondary gain from illness. The family thus becomes an important part of the diagnostic process, which should be taken into account, e.g., in the case of indirect anamnesis. The common and well known therapy for reducing diffuse aches and pain are analgesics with risk of addictions as secondary diagnosis. The use of opium, mandrake and henbane for pain relief is still practiced in parts of Iran, Afghanistan and Pakistan. Identifying the consequences of the patient's attitude to pain is another precondition for developing a pain model for him [7].

The patient's attitudes, evaluations and convictions regarding pain must be ascertained, taking into account their cultural character and generational differences in the sense of a cognition analysis. Resources in traditional collective societies such as family support from the social network and traditional methods of alleviating pain can help the patient adopt a favorable behavior to cope in a difficult situation. Motivation analysis relates especially to the patient's readiness to change and his or her expectations of self-efficacy. Many psychosomatic clinics in Germany who treat migrants reported that those patients tend to be less willing to accept active attitudes [8], such as participating in sports and physiotherapy. At this point the question arises how to motivate these patients to adopt such attitudes. A patient's willingness to "try out" a change in his attitude should already be seen as a positive sign.

The notion that pain can be stopped through medication alone can make psychotherapeutic treatment more difficult, because the aim of a pain treatment can be for instance, that the patient should learn how "to live with pain", which can demotivated the patients. In this context, it is very important to take stock of individual and cultural resources (external and/or internal ones) so that they can be applied to bringing about changes in behavior. This means that apart from focusing on the pain, the significance of the context in which the patient lives should not be underestimated. Legacy stress like arranged marriage, female genital mutilation etc. should be paid as much attention to as culture-specific coping strategies (special relaxation and massage techniques from the country of origin, prayer, involving the family in the treatment process, etc.).

However, it is important to consider comorbidity, because in literature authors very often proceed from several psychological and physical diagnoses [14]. For instance, a Swiss study conducted in 2009 on pain in migrants by the University of Basel, which was supported by the national research program of the Health Ministry in Vienna, revealed that apart from pain, migrants from Turkey also suffer from depression, anxiety disorders and trauma. Many patients either do not recognize the connection between the disorders or they have not been sufficiently informed about it yet [17].

As mentioned in the foregoing, the primary objective of psychological pain therapy is to reduce the patient's impairment, which, as a rule, is associated with a reduction in the patient's subjective pain intensity. Psychological variables like Stress, depression, anxiety and trauma as well as emotions, cognitive functioning, and pain behavior play an important role during the treatment [19]. Psychological factors also play a significant role in the cause of diffuse aches and body pain, particularly in the transition to chronic unsolved conflicts. Psychological variables like perception of illness and pain,

personality, culture-specific treatment etc. emerge may be important in distinct developmental treatment aims and time, also implying that assessment need to take an account on these variables [19].

Generally patients from traditional collective cultures present with a pain model that is reduced in the first consultations to somatic influence factors and the present also possible inner-psychological conflicts through their body. They have a different understanding of anatomy and causal and control attributions and notions of magic.

Therefore, psychoeducation is a necessary component of therapy as well as for psychotherapist and physicians whose aim is to reinforce convictions of self-efficacy. This should include the use of media such as self-help brochures and videos in the patient's native language. This psychoeducation is also aimed at explaining to the patient the correlation of physical and psychological processes. However, this means that the therapist needs to ascertain his patients' level of knowledge in order jointly to develop an explanation model. Patients from tradition collective cultures are not used to this kind of joint development of an explanation model, their expectation being that the therapist will provide a complete explanation model after the first examination session. In earlier times, traditional healers developed the explanation model using a combined approach that involved magic, religious and medical aspects. Therefore it is important to inform the patients after the diagnostic work, very clear and simple about the treatment plan and aims.

The activity range and relaxation methods of many patients are considerably limited, so that their life is reduced to the point where it revolves only around their pain and becomes the center of their thoughts and behavior. In patients from tradition-collective cultures, the range of activity is additionally restricted through the assumption that the body must rest when in pain. Therefore, trying to expand the range of action, which is necessary for accept and learn to deal with the pain and change her/his restricted movement with social isolation (diminishing depressiveness and feeling of helplessness) and cognitive limitations, is a challenging task in the first couple of treatment sessions. Building motor activities are of special significance, especially for patients suffering from back pain, so that sport therapy components are an important part of the therapy. It is not only a matter of getting physical fit and mobility through sports- and physiotherapeutic interventions to reduce pain, but primarily of enabling the patient to alleviate anxiety by "confronting" activities previously regarded as harmful and to help him realize that the feared negative consequences do not materialize [18]. Thus, diminishing avoidance behavior has high priority in the treatment.

The culture-specific aspects summarized in Box 1 which should be taken into consideration in the treatment of patient suffering from diffuse aches and pains who come from tradition-oriented cultures.

Culture-specific aspects to be taken into account: Initial examination:	
·	On the first visit, the patient's report may be limited to, and fixed on, physical aches and pains. Inner-psychological conflicts and stresses may initially be rejected. Inadequate fluency in German may make the taking of the case history a challenging task.
·	The patient's feeling that the complaints are not taken seriously enough may intensify the fixation on physical complaints.
·	Turkish patients with somatization disorders or other pain syndromes report about multiple, recurring, fluctuating, physical symptoms occurring in alternating body organs. These migrating aches and pains can be felt in various parts of the body every day.

· Frequent physical and organic complaints include: headaches, pain in the neck, shoulders, backache, gastric disorders, vertigo, accompanied by different depressions symptoms.
Comorbidity
· With the somatization mainly depression, anxiety disorders and medical addiction or abuse, is frequently observed. Many patients do not recognize a possible connection between the disorders or have not been sufficiently informed about it.
Psychoeducation
· Psychoeducation is a necessary component of therapy (understand and acceptance) as well as for psychotherapist and physicians whose aim is to reinforce convictions of self-efficacy.
Family involvement
· Involving members of the family in the treatment can be important for both the diagnosis and the treatment in terms of the secondary gain from illness, family dynamics, etc. The family can be involved in supporting the therapy to improve the patient's skills in the sense of social competence and resources.
Medication
· Medical treatment, especially analgesics preferential treatment in the patient's point of view.
Physiotherapeutic sports activities
· In the first treatment settings sports activities causes often irritation, because from his/her viewpoint his/her body is ill and needs rest. Therefore it can be dedicated to convincing the patient by providing him or her with relevant information about the effect and necessary of sport activities. Despite regular assurances, the question in how far the newly learned movement patterns are integrated into everyday life remains open. However, if there should be no relief from pain, many patients react indignantly, feel offended and not being understood. Passive applications such as massages, thermal therapy, etc. are accepted more readily
Relaxation methods
Relaxation methods such as PMR (Progressive Muscle Relaxation) and other methods of relaxation like hypnosis are accepted, but it is questionable whether these methods are also used in everyday life after the treatment is completed.

Box 1: Culture-specific aspects for the treatment with patients form traditional collective cultures.

In the psychotherapeutic treatment of patients from tradition-bound cultures with traditional ideas of healing, not only the general treatment strategy should be used, but, as described in the foregoing, the patient's personal disease experience and the possible underlying history of the social network of the country of origin with a different interpretation of conflicts, stresses and diseases should be given greater consideration [7].

Concluding Remarks

The use of culture-sensitive treatment of patients from tradition-bound cultures suffering from diffuse aches and pains is indicated when the patient presents with a high degree of impairment and when he/she makes frequent use of health care services, when the diagnosis can verify that psychological factors have a bearing on the pain experience and impairment and conventional treatment methods do not provide sufficient relief due to these patients' different perception of pain. Empirical evidence with respect to the expanded use of therapy of this group of patients still needs to be provided.

The experience gathered by caregivers to date highlights the importance of interdisciplinary and culture-sensitive therapy, with medical pain therapists and psychotherapists working in cooperation with sports therapists, physiotherapists and other professionals and giving due consideration to the patients' cultural aspects according to the rules of the art.

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