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THE HARVARD TRAUMA QUESTIONNAIRE: ADAPTING A CROSS-CULTURAL INSTRUMENT FOR MEASURING TORTURE, TRAUMA AND POSTTRAUMATIC STRESS DISORDER IN IRAQI REFUGEES

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ABSTRACT

Background: Mental health assessments in post-conflict zones have relied heavily on Western psychiatric scales. Yet, a strict dependence on the paradigms of Western psychiatry risks inappropriately prioritizing syndromes, such as PTSD, which, however important, are eclipsed by local concerns.
Material and discussion: In Dearborn, Michigan, home to the largest population of Iraqi refugees in the United States, 60 Iraqi refugee life stories were collected in order to adapt the Harvard Trauma Questionnaire (HTQ) to the Iraqi context.
Conclusion: The methodology described proved to be a useful approach to developing a trauma measure that is culturally grounded in a multi-dimensional model of mental health.

Key words: posttraumatic stress disorder (PTSD), Harvard Trauma Questionnaire (HTQ), Mental Helath Assessment, Iraq, refugees

Mental health has emerged as a core public health concern in complex emergencies. For example, studies of war veterans have revealed the serious mental health effects of conflict. Psychological casualties exceeded physical ones by two to one in the First World War, whereas in the Second World War, 33% of all medical casualties were attributable to psychiatric causes (Armfield, 1994). Ten years after the Vietnam War, 15% of US veterans were still affected by posttraumatic stress disorder (PTSD; see Kulka *et al*., 1990). In current conflicts, over 90% of all fatalities are civilians, typically from the poorest sectors of non-Western societies (Kleber *et al*., 1995). An epidemiological survey conducted between 1997 and 1999 among survivors of mass violence from Gaza, Algeria, Ethiopia and Cambodia reported PTSD rates as high as 37.4% (de Jong *et al*., 2001). Another study focusing on trauma and PTSD symptoms in Rwanda found that among the 2091 participants 24.8% met symptom criteria for PTSD (Pham *et al*., 2004).

There is growing recognition of the value of incorporating culturally specific idioms of distress into assessments of mental health when working in non-Western conflict and postconflict situations, where paradigms are quite distinct from those found in Western nations (Kleinman, 1995; Bolton, 2001). Studies have shown that strict reliance on the language and constructs of Western psychiatry risks inappropriately prioritizing syndromes, such as PTSD, which, however important, are eclipsed by the concerns of local populations for whom indigenous idioms of distress are more salient (Kleinman, 1987; Eisenbruch, 1992; Marshall *et al*., 1999; Summerfield, 1999).[1]

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Indeed, many fundamental issues, such as the impact of traditions on the trauma response, the identification of culture-specific symptoms, and the usefulness of Western psychiatric diagnoses, need to be taken into account.

The United States-led overthrow of Saddam Hussein in 2003 created a window of opportunity to address the mental health needs of Iraqis affected by more than two decades of war and oppression. To date, however, there are no assessment measures that include indigenous Iraqi idioms of distress and no empirically based framework for understanding how Iraqis understand and articulate psychological well-being and suffering. This study illustrates how ethnography informed the development of the Iraqi version of the Harvard Trauma Questionnaire (HTQ), a simple and reliable screening instrument that is well received by refugee patients and bicultural staff. The methodology described represents a useful approach to examining local paradigms and developing culturally appropriate assessment tools in cross-cultural settings.

CROSS-CULTURAL ADAPTATION OF INSTRUMENTS

The Harvard Trauma Questionnaire is an ambitious attempt to balance cross-cultural standardization with cultural specificity in developing assessment tools.

Flaherty *et al.* (1998) have proposed a stepwise validation for cross-cultural equivalence including five major dimensions. These dimensions are as follows:

1. *Content equivalence*: The content of each item of the instrument is relevant to the phenomena of each culture being studied.
2. *Semantic equivalence*: The meaning of each item is the same in each culture after translation into the language (written or oral) of each culture.
3. *Technical equivalence*: The method of assessment is comparable in each culture with respect to the data it yields. Certain cultures may be both uncomfortable and unfamiliar with the data collection methods that seem natural in Western culture, such as a pencil-and-paper test (Flaherty *et al.*, 1998). In some cultures, private interviews, particularly of women, by male interviewers are generally not done (Hammad *et al.*, 1999).
4. *Criterion equivalence*: The interpretation of the measurement of the variable remains the same when it is compared with the norm for each culture.
5. *Conceptual equivalence*: The instrument is measuring the same theoretical construct in each culture.

It is important to note that each of the five equivalence dimensions is distinct from the others; an instrument can be cross-culturally equivalent on one or more of these dimensions and not on others. The goal is to design a scale with cross-cultural equivalence in all five dimensions. Such rigor, however, is the exception rather than the rule in cross-cultural research (Mollica *et al.*, 2004).

A number of studies have been published providing detailed descriptions of the complex process of cross-cultural equivalence (Bravo *et al.*, 1991; Van Ommeren *et al.*, 1999; Beck *et al.*, 2003). In the following sections, we discuss such a process through the adaptation of the HTQ to the Iraqi context.

THE HARVARD TRAUMA QUESTIONNAIRE

In the mid-1980s, Mollica *et al*., at the Harvard Program in Refugee Trauma, recognized a void in the development of standardized measures in the field of cross-cultural psychiatry. The group generated the HTQ, a cross-cultural instrument designed for the assessment of trauma and torture related to mass violence and their sequelae. Its purpose was twofold: to obtain information about the actual trauma events, including torture, experienced by Indochinese refugee patients and to assess DSM-IV (*Diagnostic and Statistical Manual* – American Psychiatric Association, 1994) symptoms and presumably culture-specific symptoms associated with PTSD (Mollica *et al*., 2004). In accordance with Flaherty's outlined criteria for cross-cultural validation, the items of the HTQ were translated from English into Khmer, Laotian and Vietnamese by three bilingual Indochinese mental health clinicians, of whom two were psychiatrists and the other an experienced translator. The final versions were then back-translated blind into English by bilingual workers. A team of Western professionals and bicultural mental health workers familiar with Indochinese patients reviewed both versions. The resulting version was piloted in the Indochinese Psychiatry Clinic (IPC) for one year. Since that time, the HTQ has demonstrated efficacy in the identification of PTSD symptoms and psychological distress in culturally diverse environments (Mollica *et al*., 2004).

Consistent with the current concept of PTSD, both trauma events and associated symptoms are included in the same questionnaire. The HTQ is composed of five parts: (a) trauma events, (b) personal description, (c) brain injury, (d) posttraumatic symptoms and (e) scoring of the instrument. The sections are described in detail in Mollica *et al*. (2004).

A major contribution of the HTQ is its adaptability to context. It is widely recognized that measures of PTSD, depression and anxiety, although documenting core responses to trauma, are not comprehensive in their coverage of the multiple adaptive stresses that characterize the human response to disasters (Silove, 1999; Steel & Silove, 2001). Therefore, in the Original and Revised Cambodian HTQs, DSM-IV PTSD symptoms are followed by a number of items describing other reactions to violence and displacement. Although they are statistically correlated with symptoms of PTSD (Mollica *et al*., 1998), the additional items aim to gauge personal perceptions of psychosocial functioning in response to the complex stresses of persecution, violence and displacement. For people who have been uprooted, preoccupations with current and future roles, social relationships and economic functioning are foremost and may be as pressing as concerns about the psychological impact of past traumas, or even more so (Silove, 1999).

Beginning with the Original Cambodian HTQ, a set of 14 refugee-specific responses was added to 16 DSM-IV (American Psychiatric Association, 1994) PTSD items. This list of 14, which includes two items that describe the symptoms of dissociation, was believed to reflect the feelings and symptoms described to IPC clinicians by refugees.

In the Revised Cambodian HTQ, the 14 refugee-specific items were expanded to 24 items in six underlying domains of social functioning: (a) skills and talents, (b) physical impairments, (c) intellectual functioning, (d) emotional functioning, (e) social relationships and (f) spiritual/existential concerns (Mollica *et al*., 2004).

The HTQ must be modified and adapted to the characteristics of each cultural group. The actual traumatic events as well as the meanings attributed to them vary according to the specific historical, political and social context in which the trauma occurred. Thus, for each new refugee population, a different HTQ should be developed (Mollica *et al*., 1998). First, a new list of traumatic events has to be created that would cover most of the traumatic events experienced by this group. For that

purpose, the specific political and sociocultural history of trauma must be studied by means of historical analysis, oral histories, reports from key informants and focus groups. Second, the *DSM-IV* (American Psychiatric Association, 1994) items have to be translated, back-translated, and tested for semantic equivalence.[2] New refugee-specific symptoms of trauma can be identified by means of ethnographic studies, clinical experiences, key informants, traditional healers and primary care settings. Each newly adapted screening instrument must have its cutoff value determined by comparing the scores on the instruments to a clinical diagnosis.

By 2005, there were six versions of this questionnaire (Mollica *et al*., 2004). The Vietnamese, Cambodian and Laotian versions of the HTQ were written for use with Southeast Asian refugees. The Japanese version was written for survivors of the 1995 Kobe earthquake. The Croatian version was written for soldiers who survived the wars in the Balkans, whereas the Bosnian version was written for civilian survivors of the conflict. To adapt the HTQ to the Iraqi context, we must first understand the effects of trauma on Middle Eastern populations in general and on Iraqis in particular.

TRAUMA STUDIES IN THE MIDDLE EAST

As in all modern wars, the victims of the latest Middle Eastern conflicts have been mainly civilians. A small number of studies have been undertaken with adult war-affected populations in Palestine/Israel, Lebanon and Iraq (many more studies have been conducted on children, which will not be reviewed in this article). Several common findings are of note. First, religious faith, a sense of commitment to a political cause, and psychological preparation for torture all appeared to provide some protection against adverse psychological consequences (Gorst-Unsworth & Goldenberg, 1998; Karam *et al*., 1998; Elbedour *et al*., 1999). Second, in the posttraumatic context, loss of social networks and separation from family members were important factors that seemed to perpetuate psychiatric symptoms, particularly depression and PTSD (Gorst-Unsworth & Goldenberg, 1998; Karam *et al*., 1998; Laban *et al*., 2004). Third, social factors in exile, such as language proficiency, social and economic adversity, fear of repatriation, and situation in the home country, appeared to be influential in preventing recovery from PTSD and other forms of psychosocial distress (Sondergaard *et al*., 2001; Laban *et al*., 2004). Finally, the majority of participants described distinct somatization reactions (Gorst-Unsworth & Goldenberg, 1998; Karam *et al*., 1998; Elbedour *et al*., 1999; Sondergaard *et al*., 2001; Laban *et al*., 2004).

Interestingly, given the severity of the reported traumas, the rates of PTSD in the study participants were neither high nor universal (Gorst-Unsworth & Goldenberg, 1998; Karam *et al*., 1998; Elbedour *et al*., 1999; Sondergaard *et al*., 2001; Laban *et al*., 2004). We will argue that this observation reflects the region's cultural background. In these studies, almost all subjects are Muslims for whom faith is a form of refuge that offers consolation and comfort. A second significant feature of religiosity is related to attitudes toward death and martyrdom. Given that the death of an individual is divinely ordained, one need not bear the guilt of the loss. Moreover, Muslims believe that God will avenge an injustice that befalls the faithful. Hence, the matter is left to God and the trauma is accepted as divine will. Furthermore, interviews conducted with the victims and survivors revealed that they did not feel alone in the crisis and that the calamities that befell them were not only personal but also communal (Gorst-Unsworth & Goldenberg, 1998; Karam *et al*., 1998; Elbedour *et al.*, 1999; Sondergaard *et al*., 2001; Laban *et al*., 2004). This form of family and social support is prominent

among Middle Eastern populations. Although the samples of these studies are relatively small and focused, precluding all epidemiological conclusions on the national level, they highlight certain cultural factors that may have provided partial protection against PTSD in these communities.

HUMAN RIGHTS VIOLATIONS AND POLITICAL VIOLENCE IN IRAQ, 1979–2005

Although violence and repression have been a widespread feature of Iraq's modern history, the ascendancy of Saddam Hussein to the presidency in 1979 inaugurated a period in which human rights violations steadily grew to unprecedented levels, exacerbated in part by Iraq's unprovoked wars against Iran (1980–1988) and Kuwait (1990–1991).

In December 2003, Saddam Hussein was arrested and detained as part of a US-led invasion of Iraq. His overthrow opened the possibility of creating a peaceful and democratic sovereign state. However, the country remains plagued by human rights abuses and violence, albeit of a different nature (Cole, n.d.; Danner, n.d.; Staehlin, 2004).

As Iraqis are suspended between the death of the old system and the uncertainty of the new, they are most likely to experience the emotional consequences of living under Saddam's tyranny and through several wars that must include the ongoing trauma of the current insurgency in the country. Accordingly, understanding how survivors articulate psychological well-being and suffering is crucial for adapting the HTQ.

METHODOLOGY

The goal of this study was to explore the experiences of an Iraqi refugee population in order to adapt the Harvard Trauma Questionnaire for use in Iraq.

Field site

The study was conducted in metropolitan Detroit, Michigan, where approximately 200,000 people of Arab descent live in and around the city. It is home to the oldest, largest and most visible population of Arabs in North America (Baker *et al*., 2004). Seventy-five percent of residents of Detroit were born outside the United States. Virtually all nationalities and ethnicities from the Middle East are represented: Lebanon/Syria (37%), Iraq (35%), Palestine/Jordan (12%) and Yemen (9%). This population is deeply religious, with 58% Christian and 42% Muslim. Most Christians are dispersed throughout Detroit's suburbs, whereas two-thirds of all Muslims live in the ethnic enclave community of Dearborn, Michigan, often dubbed 'Arab Detroit'. Compared to Arabs nationwide, the Arabs of Dearborn are more likely to be young Muslim immigrants, with large families and low incomes. For example, one-quarter of the population report family incomes less than $20,000 per year. Fifteen percent said they personally have had a negative experience after September 11, 2001, because of their ethnicity. These experiences included verbal insults, workplace discrimination, special targeting by law enforcement, vandalism and physical assault (Baker *et al*., 2004).

Since the 1991 Gulf War, metropolitan Detroit has absorbed over 3000 Iraqis a year (Abraham & Shryock, 2000). They have arrived directly from Iraq or via a third country, such as Iran, Turkey, Jordan, Syria, Lebanon or the United Arab Emirates. Although the Iraqis seeking refuge in the United States come from a cross-section of Iraqi society, most are southern Shia Muslims who fled under conditions of political duress. Thus, their lives have been disrupted in significant ways. These men and their wives tend to be poorly educated; struggling with the English language; working in low-wage jobs, such as grocery store clerks and gas station cashiers, without health insurance; and residing in crowded apartments. They live with feelings of remorse and reactions to trauma, not only about the conditions under which they fled their country, but also about their country's political turmoil and their own experiences as refugees. Many of these Iraqis suffer from chronic illnesses that may be a result of the deplorable conditions in Rafha, the Saudi Arabian refugee camp where the majority lived for months or years. The Turkmen and Kurdish refugees, who were mainly based in northern Iraq, fled to refugee camps in Turkey.

The Iraqi community in metropolitan Detroit is not a cohesive unit. In addition to divisions resulting from class, education, economic status, political convictions and ideological beliefs, Iraqis are divided along lines of ethnicity. Three subcommunities live in the area: the Arabs, the Kurds and the Chaldeans. Each has its own community center, voluntary associations and clubs. Upon arrival in metropolitan Detroit, refugees find themselves automatically drawn toward their own ethnic groups and voluntary associations.

Sample

Interviewees recruited from the Arab Community Center for Economic and Social Services (ACCESS) constituted a convenience sample. Since its creation 30 years ago, ACCESS has grown to become the nation's largest and most comprehensive provider of Arab American human services, with nearly 108,000 yearly contacts in 70 different programs as diverse as employment and environmental projects, arts and culture, health programs, and youth and social services activities.

The following inclusion criteria were used in this study: (a) Iraqi-born, (b) Arabic speaker, (c) adult (age 21 and above) and (d) a refugee in the United States after the 1991 Gulf War. Thirty men and 30 women from various socioeconomic backgrounds, representing the ethnic and religious diversity of Iraq, participated in the study (see Table 1).

Although the majority of the participants were Shia Arabs, all Iraqi Muslims interviewed shared many values, customs and norms of behavior. Furthermore, in spite of differences in religious beliefs and rituals, there were no clear cultural boundaries between Iraqi Christians and Muslims. Finally, at the level of the refugee experience, all Iraqis suffer from well-documented problems relating to flight, displacement and uprooting.

Ethnographic interviews

Health professionals can refine their understanding of psychological disturbance in refugees if they recognize both the personal and cultural dimensions of the physical, mental and moral losses that survivors are trying to absorb (Kleinman *et al*., 1997). This anthropological view shows suffering as both an intrasubjective process and a collective experience shaped by background, place and time. These two kinds of suffering are best elaborated through life stories. Given its situational constructed nature, a life story is a strategy for self-representation, an attempt to make sense of the world, and a projection for the future (Geertz, 2000).

Table 1
Sociodemographic characteristics

Variable	Number	Variable	Number
Sex		Widowed	9
Male	30	Never married	3
Female	30	Education	
Age, years		Less than primary	7
18–34	17	Primary	21
35–54	30	Secondary	9
55–64	7	Vocational/university	20
≥65	6	Imprisonment in Iraq[a]	
Ethnicity		Yes	35
Arab	42	No	25
Kurdish	6	Year of flight from Iraq	
Turkmen	6	1990–1995	43
Chaldean	6	1996–2001	14
Religion		2002–2003	3
Shi'a Muslim	48	Time in refugee camp[b] (months)	
Sunni Muslim	6	0–12	17
Christian	6	13–24	10
Place of birth in Iraq		25–36	5
AnNajaf	5	>36	3
Arbil	3	Year of arrival in Michigan	
Baghdad	10	1990–1995	31
Basra	9	1996–2001	21
Diwania	4	2002–2003	8
Kerbala	6	English proficiency	
Kirkuk	7	Excellent	6
Mosul	3	Good	24
Nasiriyah	4	Poor	30
Samawa	6	Employment status[c]	
Sulaymaniyah	3	Working	24
Marital status		Not working	36
Married	43	**Total**	**60**
Separated/divorced	5		

[a] Only eight women were imprisoned.
[b] Thirty-five out of the 60 subjects interviewed lived in refugee camps.
[c] Thirty out of the 36 subjects not working are women.

Drawing on this anthropological framework, the first author conducted 60 interviews on individual life stories in Arabic. The decision to conduct the meetings in Arabic rather than Kurdish or Turkmenian – the other two Iraqi languages – was based on the fact that Arabic is the primary language in Iraq and is understood by the majority of citizens.

In the interviews, the interviewer encouraged participants to provide chronological accounts of their experience of life in Iraq, the decision to escape, the circumstances of their flight, the escape journey and transition in refugee camps, conditions surrounding their acceptance for resettlement by the United States, their early experiences in America, and the nature of their current social

participation within the Iraqi community and the wider host community. As they described each stage of their lives, respondents were asked also to express their emotional reactions to what was happening in their lives at that time. This included their feelings about living in and then leaving Iraq, their hopes and expectations of eventual return, and their degree of satisfaction with life in the United States.

To reconstruct their narratives, Iraqis needed not only the words with which to tell their stories but also an audience willing to hear their words as they intended them. Research shows the importance of open-ended interviews, emotional attunement and genuine curiosity (Suchman *et al*., 1997; Langewitz *et al*., 2002). These characteristics comprise the kind of empathy that is crucial to such interviews. Thus, the task was to become an empathic listener by conveying to the interviewees that they were not alone and that they were being understood. To be empathic, listeners must see the world from the other's perspective, be strong enough to hear without injury, and be ready to experience some of the terror, grief and rage experienced by the interviewees (Langer, 1991; Shay, 1994; Halpern & Weinstein, 2004; Kleinman *et al*., 1997).

At the choice of the participants, the interviews were held in their homes, in ACCESS, in recreation centers, or in mosques. The conversations lasted approximately 1 hour and were conducted over a three-week period in July 2004. The interviewer audio-recorded all meetings. Informed consent forms, which fully described the research, put informants at ease once they realized that the discussions were private and confidential. Furthermore, because this community harbors deep mistrust of authorities, the interviewer offered every assurance of the ultimate anonymity of the interviews. Strong support given by community leaders enhanced the project's success.

The interviews were also transcribed in Arabic and these narratives constituted material for qualitative analysis using a grounded theory methodology (Miles, 1984; Rubin, 2005). This involved a coding procedure with three levels. The first level, the text-based category, coded words and phrases used regularly and repeatedly throughout the text. The second level, the sensitizing concept, coded culturally specific ideas and understandings implicit in the text-based categories. The third and highest level, the theoretical construct, reflected organization of the sensitizing concepts into a theoretical framework. Each level subsumed the level below it. That is, each sensitizing concept is a cluster of text-based categories, and each theoretical construct is a cluster of sensitizing concepts. An Iraqi physician and the interviewer coded the transcripts. As an additional check on our interpretation of the text, we presented our findings to 10 of the 60 men and women who participated in the study. The discussion occurred approximately 7 months after data collection. The subjects confirmed the accuracy of the report.

FINDINGS

Scale adaptation

Part I (Trauma Events), Part IV (Culture-Specific Trauma Symptoms) and the Torture List of the HTQ were adapted to the Iraqi context based on historical, socio-economic and human rights analyses, ethnographic study and key informant interviews with both American and Iraqi cultural experts (historians, anthropologists and psychiatrists) based in Iraq and the United States. Part II (Brain Injury), Part III (Personal Description), and DSM-IV (American Psychiatric Association, 1994) PTSD symptoms (Items 1–16 in Part IV) remained unchanged from the original version.

Trauma events (Part I) and torture list

The trauma and torture sections were divided into two periods, from July 1979 to April 2003 and from May 2003 to November 2005; these periods represent Saddam Hussein's rule and events since the United States-led invasion of Iraq, respectively. To keep the scale as neutral as possible, and in turn to avoid offending the many political, ethnic and religious groups in Iraq, only dates were listed.

Four Iraqi and two American content experts rated each trauma and torture item as relevant, irrelevant or questionably relevant. Items rated by a single member as irrelevant or by two or more members as questionably relevant were eliminated; items receiving one rating of questionable relevance were reconsidered for inclusion. For example, the item 'brainwashing' was excluded from the trauma list. According to content experts, a Muslim who has real faith and conviction in his or her heart will not be vulnerable to manipulations, threats or distress. A Muslim's resistance signifies a moral choice; it serves as a continuing self-assertion of his or her commitment to goodness and justice over evil and tyranny. Thus, the concept of brainwashing does not reflect trauma in Iraqi culture. Indeed, this event was not mentioned by any of the interviewees. Another reconsidered item was the torture event 'sodomized'. The content experts believed that such an item would be very offensive, citing seven references made in the Quran to the story of Lot and the people of Lot (Sodomites). The act of sodomization is equivalent to an action of *Kufr*, which is the most blasphemous act that can be committed by a Muslim. The root word of *Kufr* is *kafara*, which means to conceal something or contest it. Thus, it refers to someone who covers up and challenges the Divine Truth after it has been revealed to him or her. However, because the Taguba Report (Taguba, 2004) reported sodomization as one of the human rights abuses in Abu Ghraib, the item was reworded as 'Forcibly arranged in various humiliating or sexually explicit positions'. Although this translation is not the best paraphrase for the term *sodomized* – a more accurate rendition would have been 'Forcibly penetrated by a foreign object' – the content experts felt strongly that any other substitution in Arabic would have been both culturally and religiously alienating for the targeted population. Either they would not have answered the question or they might have been so insulted that the questionnaire would have not been completed. Thus, we could not ascertain whether or not sodomy had been committed. These examples highlight the importance of ascertaining the broader social and cultural contexts of Islam in this community.

The accepted trauma and torture items reflect the history of political violence and human rights abuses in Iraq. The following items are of special note because of their cultural significance:

'Prohibited from ablution and prayer': Islamic injunctions based on the Quran and conducts of the Prophet Muhammad are outlined for an array of practices, including prayer. Prayer, which is the second most important pillar in Islam, is required of Muslims five times a day and is preceded by a ritual ablution.

'Witnessed the arrest, torture, or execution of religious leaders or important members of tribe': The individual identity in Arab society tends to be much less important than that defined by the family, clan, or religion. Thus, a person's loyalty and duty to his or her kin and religious leaders are central.

'Forced to undress in front of people': Stipulations exist within Islamic law that dictate a specific amount of covering that is required in front of family members and strangers. Short or revealing clothes for both genders, but especially for women, are considered contrary to proper modest behavior.

Trauma symptoms (Part IV)

The following discussion of Iraqi mental health beliefs and practices and local idioms of distress is based on data from the Dearborn interviews and key informant discussions with four psychiatrists in Baghdad.

Background of stigmatization

According to the interviewed psychiatrists, the general concept of mental disorder in Iraq is influenced more by superstition and pagan beliefs than by the teachings of Islam. The similarity between the interpretations relating to causation and treatment among different ethnic and religious groups seems to indicate archaic ideas held in common. However, the psychiatrists pointed out that this description applies mainly to the less educated, rural segment of the population. The more urban the population, the more its concepts of illness approximate those of the West. Nevertheless, all four psychiatrists concurred that some of these pagan beliefs, such as the evil eye, are still rife in the main cities.

Under Saddam's regime, the psychiatrists emphasized that mental illness could not happen to people who were faithful Muslims. They noted the tendency of Iraqi patients with mental disorders to present somatic complaints in place of psychological ones. Because mental illness is stigmatized very highly among Iraqis – its presence in a family can lead to labeling that family's offspring unfit for marriage – the psychiatrists reported that popular labels for mental illness cover only indisputably psychotic behavior and mental retardation. One such label is *majnoon,* which is originally derived from the word *jinn* (supernatural spirit). Minor psychiatric problems – depression and anxiety – most commonly are labeled as medical illnesses. According to the doctors, this labeling provides the Iraqi patient with a medical sickness, which releases him or her from responsibilities and sanctions, while affording care. Furthermore, as there is virtually no psychotherapy available in Iraq and because indigenous healers and nonpsychiatrist Western-style doctors handle the vast majority of minor mental disorders, the psychiatrists indicated that most psychiatric care is given under the guise of medical care.

Despite the severity of the trauma most Iraqis lived through, the four psychiatrists stressed their clients' resiliency. They attribute this quality to Iraq's Arab and mainly Muslim society, where family ties, honor and religion provide a network of healing.

Local idioms of distress

Through the Dearborn interviews, we identified the most commonly mentioned indicators of distress. The items included both indigenous and Western constructs and include the following:

Dayeg: This term encompasses symptoms such as rumination, poor concentration, lack of initiative, boredom, sleep problems, tiredness and various somatic complaints (headache, backache, muscle aches, heart palpitations, breathlessness, dizziness, choking sensation, lump in throat, butterflies in stomach, numbness or poor appetite). The feeling of being *Dayeg* can be associated with problems of daily living, difficulties of uprootedness, feelings of insecurity due to disrupted relationships and uncertainty about one's future, or interpersonal conflict.

Qalbak maqboud: In a variety of expressions, many having English correlates, the heart (*qalb*) is treated as the subject of emotional experience and a symbol of the true essence of the person. This phrase labels a condition associated with a sensation of the heart being squeezed. This complaint is often connected with feelings of sadness, dysphoria or anxiety, stemming from

problems of daily living, insecurity about the future, uprootedness, family illness, death or sorcery. Although somatization is prominent in Arabic culture, the discussion of symptoms in terms of the heart does not seem to be an undifferentiated somatic discourse for Iraqis, but a subtle form of talk about affect rooted in traditional understandings and metaphors of the body.

Asabi: The term *asabi* is derived from the word *asab*, or nerves, which describes a condition of irritability, nervousness, lack of patience and anger outbursts in interpersonal relationships. Someone *asabi* also usually wants to be left alone.

Nafsak Deeyega and *Makhnouk*: The terms respectively mean a feeling of constriction in the chest and a choking sensation. The chest is felt to be too tightly filled with unpleasant feelings to accommodate the inspiration of air. The person feels unable to take a deep breath, so that he or she may feel short of breath and sigh repeatedly. These terms can be used to describe tension associated with daily hardships (poverty, political repression, etc.); difficulties of uprootedness; feelings of insecurity due to disrupted relationships; uncertainty about one's worth, position and future; or interpersonal conflict. Some also use these terms to describe experiences of panic.

Nafseetak ta'abana: The word *nafseetak* is derived from the word for psyche, *el-nafs*, which is a broad reference to human existence, meaning at different times body, behavior, affect or conduct. The term means that a person's soul is tired; it covers a wide range of undifferentiated anxiety and depression symptoms.

Other symptom items of note are: 'Spending time thinking why God is making you go through such events' and 'Feeling that you have no one to rely upon but God': Muslims feel that God keeps a very close watch over them; He will punish them for sinful acts and reward them for good ones. Consequently, Muslims are apt to interpret any ill fortune that befalls them as God's punishment.

Translation

Semantic equivalence of the HTQ was established in accordance with generally accepted guidelines for cross-cultural instrument development (Flaherty *et al*., 1998). Two Iraqis, a psychiatrist based in Baghdad and an experienced medical translator, translated the items of the HTQ from English into Arabic. Both individuals were experienced with Western and Iraqi mental health concepts and familiar with Iraqi patients. Although maintaining accuracy in language, the translations were kept simple and clear to be easily understood by people of all educational backgrounds. This version was then back-translated blind into English by a different Iraqi psychiatrist, with qualifications similar to those of the first one, who also was based in Baghdad. A third bilingual and bicultural Iraqi psychiatrist in the United States resolved any differences in the translations. This psychiatrist rated each item as 'exactly the same meaning in both versions', 'almost the same meaning in both versions', and 'different meaning in each version'. Finally, the first author reviewed the scale while referring to the transcribed Dearborn interviews. The transcripts contained the original language used by local people to describe their distress. Where the translators had originally used more formal language than is used by local people to express the same concept, the local term was substituted. For example, the word *sack*, 'Placed in a sack, box, or small place', has several possible renditions in Arabic. The translators chose *kees*, whereas the men and women interviewed employed *gounia*, the word ultimately used in the scale.

Pretesting

The resulting version of the HTQ was pretested in Dearborn, Michigan, in January 2005. A group of four Iraqi men and four Iraqi women from various socio-economic backgrounds, ethnicities and religions were individually asked to listen to the instrument's items one at a time and then paraphrase them. None of the interviewees suggested that any modifications were necessary to Parts I, II and III and the torture list. In Part IV, Checklist symptom 40 for dissociation, 'Feeling as if you are split in two people and one is watching what the other is doing', surfaced as a weak item in this pretest. Five out of the eight participants thought that the question was referring to episodes of schizophrenia, whereas the rest asked for explanations. The concept is very difficult to translate into Arabic; further piloting is needed to determine the best way to phrase this symptom. Mollica *et al*. (1992) reported that among Indochinese refugees the same dissociation symptom had the lowest endorsement rate, was not as highly correlated with total symptoms as the other items, and did not achieve a statistically significant level of differentiation between PTSD and non-PTSD groups. Mollica *et al*. speculate that either dissociative symptoms are not associated with PTSD in Indochinese refugees or the concept is difficult to translate into Indochinese cultural terms.

All interviewees indicated that they would feel most comfortable discussing sexual trauma with same-sex health professionals. The women also reported the importance of keeping knowledge of rape a secret, especially from their husbands and parents. Community awareness of the rape trauma will stigmatize the victims and their extended families, causing all family members to suffer from severe ostracism. With the understanding that clients may be unable to report culturally sensitive experiences of trauma accurately, the interviewer decided that it was still beneficial to present the question because it might cue the survivor that the therapist is aware of these kinds of experiences and that others have reported them as well. With regard to the torture list, half of the respondents did not have a concept of torture that included the variety of events they experienced. For example, victims might not realize that physical or psychological humiliation can be a component of torture, thus it is important for mental health professionals to ask quite specific questions that will more readily invite a response.

DISCUSSION

The present study describes a set of methods for adaptation of the Harvard Trauma Questionnaire to the Iraqi context. The scale was developed from an ethnographic study on trauma in Iraqi refugees in the United States. This body of qualitative work allowed the investigator to use Iraqis' own experiences, words and meanings as the foundation for the items on the instrument.

This study reflects the mutual challenges of the biological and cultural PTSD paradigms. PTSD is neither a simple reflection in personal experience of psychophysiological processes nor a culturally constituted phenomenon free of organic constraints (Breslau, 2005; de Jong & Joop, 2005). PTSD is of great interest to anthropologists and psychiatrists alike because it offers a prime opportunity for exploration of the interaction of culture and biology. In emphasizing the value of culturally specific assessment measures such as the HTQ, we do not mean to suggest that such measures should replace etic or conventional Western measures of psychopathology in work with non-Western war-affected populations. The concern is that researchers and clinicians have relied almost

exclusively on such instruments, paying minimal attention to local expressions of well-being and distress among the communities in which they are working. These scales may have limitations that miss the varied dimensions of experience that result from traumatic exposure. However, increasingly, a number of researchers are recognizing the limits of imposing Western concepts of phenomena on other cultures. Bolton (2001) used three ethnographic qualitative methods to investigate Rwandans' perceptions of problems following the 1994 genocidal conflict and the local validity of Western concepts and to adapt existing measures, such as the HSCL-25, for local use. The three ethnographic methods were (a) free listing, which provided a list of local terms for mental symptoms and disorders, (b) key informant interviews that supplied more detailed information about these disorders, and (c) pile sorts, which confirmed the relationship among symptoms and disorders that emerged from the other two methods. Manson and Shore (as cited in Kleinman, 1977) developed conceptually equivalent versions of the American Indian Depression Schedule for different Indian groups with different languages and customs. Finally, several Middle Eastern studies have translated and validated psychiatric screening scales, such as the Hospital Anxiety and Depression Scale and the 30- and 12-item General Health Questionnaires (Okasha & Mai, 2001). These studies further reflect the growing awareness of the limitations inherent in any single methodological approach to studying PTSD.

Study limitations

Because of the security situation in Iraq, the study was conducted in the Iraqi refugee community in the United States. Although participants were very familiar with the kinds of traumas reported by their family members in Iraq since the fall of the regime, they did not experience this new wave of suffering firsthand. Furthermore, the subjects who traveled to Iraq after Saddam's capture did so in the early months when the violence had not reached its current peak. It will be important to take note of the category of 'other events' reported by participants when the HTQ is piloted in Iraq.

Although most Iraqis speak Arabic, it is important to field test a version of the HTQ in Sorani or Kurmanji, the dialects spoken by the majority of Kurds, the second-largest ethnic group in Iraq. Such a version will be essential for practitioners and researchers working in primarily Kurdish regions of the country.

Furthermore, the construct validity of the HTQ relies on the construct validity of PTSD as a disease entity that is separate and distinguishable from other psychiatric disorders. Although considerable information has been accumulating regarding the validity of the PTSD paradigm (Keane *et al*., 1987), its strength in non-Western cultures has been challenged and further studies are indicated. Thus, many questions remain unresolved. For example, are the culture-specific items used in the HTQ associated only with the Iraqi experience or are they generic to Middle Eastern refugee trauma or refugee trauma in general? How many additional, yet still undetermined, culture-specific symptoms exist for Iraqi patients? Are the symptoms associated with PTSD criteria core features of a trauma-induced illness in Iraqi culture? A cross-national investigation of PTSD using standardized instruments such as the HTQ can answer these questions.

Finally, grouping and classification of mental disorders in psychiatry has been notably understudied and little attention has been paid to a guiding theory (Parshall & Priest, 1993). This is exemplified by the DSM-IV (American Psychiatric Association, 1994), which avoids any explication of its theoretical basis, yet appears to assume the validity of a biomedical model (Follette & Houts, 1996). According to this model, mental disorders are fundamentally biological in origin, and, given

the common physiology of humans worldwide, psychopathology will be essentially homogeneous, with only superficial variation in presentation across peoples. The prima facie acceptance of the biomedical approach to the understanding of psychopathology is problematic, given that mental disorders have been shown to vary across cultures (Thakker & Ward, 1998). Although the DSM-IV (American Psychiatric Association, 1994) has attempted to extend its scope by acknowledging cultural factors, it is impeded by its reliance on notions of biology and ubiquity, which at this time remain speculative (Thakker & Ward, 1998).

CONCLUSIONS

In the face of complex emergencies, where social, cultural and economic relations are disrupted, it is critical to employ an ethnographic approach to the study of health across societies. Ethnographic methods, which have a long history in anthropology, describe well-being, illness and suffering in relation to the sociocultural contexts in which they occur. This framework requires that researchers attempt to understand the cultural variables that mediate and impinge on the local experience and expression of these notions, such as language, traditional practices and faith. However, although this sort of methodological approach may seem sensible, it is not commonly used (Kleinman, 1992). This is perhaps because ethnography requires more time and probably more money than do traditional epidemiological or psychiatric research methods. Furthermore, anthropological methods seem foreign to traditional medical researchers.

Whatever the reason, there is clearly a need for more context-centered studies that have the depth and complexity to deal with the richness of sociocultural data and to discover both cross-cultural similarity and diversity. We propose to assess the psychometric properties of the HTQ in psychiatry clinics in Iraq. Mental health professionals will estimate internal consistency and construct validity, as well as establish cut-off scores through diagnostic interviews using DSM-IV PTSD criteria. Although we recognize that the PTSD construct reflects a biomedical perspective, the adaptation of the HTQ to the Iraqi context was shaped by the intricacies of Arabic culture and traditions. These influences infuse meaning into the scale's trauma events and symptoms, bringing Western and Arabic physicians closer to the subjective experiences of their Iraqi patients.

NOTES

1. Summerfield, a British psychiatrist, based on his work in the field, has written extensively about his concerns with using Western psychiatric diagnoses. Although controversial, others, particularly from anthropology have raised similar concerns. The issue appears to be less about diagnoses than about the meaning of symptoms across cultures and whether indigenous responses might be more effective in treatment.
2. The HTQ is a validated scale that is based on the DSM-IV; therefore new versions use the same diagnostic system. It is likely that a new scale based on the WHO criteria could be developed and validated.

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