

5. In migrants:
- a social support may act as a protector
  - b voluntary migration may be associated with better social networks
  - c social support and networks should be assessed routinely
  - d adjustment should be assessed
  - e culture shock needs to be assessed.

## MCQ answers

1	2	3	4	5
a T	a T	a F	a T	a T
b F	b F	b F	b T	b T
c T	c F	c F	c F	c T
d F	d F	d F	d T	d T
e F	e F	e T	e T	e T

## Commentary

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Bhugra & Jones (2001) refer briefly to refugees as a group of migrants especially vulnerable to mental health problems and they mention post-traumatic stress disorder (PTSD) as an important disorder in this particular population.

Recently arrived refugees in the UK and in the Irish Republic come from diverse cultural backgrounds – Kosovo, Afghanistan, Iraq, Rwanda, Somalia, Sri Lanka and Sierra Leone, among others. They will share the experience of collective trauma, exposure to politically motivated terror, torture and massacre.

Since many of the asylum seekers will have witnessed death and mutilation at firsthand, they invariably meet Criterion A of the DSM-IV definition of PTSD, that is, that they had experienced, witnessed or were confronted with an event that involved actual or threatened death or serious injury and that they had responded with intense fear, helplessness or horror (American Psychiatric Association, 1994).

To what extent does refugee status complicate the diagnostic use and therapeutic potential of the category of PTSD? And in any case does the construct of PTSD have validity across diverse cultures?

In her study of Salvadoran women refugees living in exile in North America, the anthropologist Janis Jenkins (1991) found that all of the women were

suffering from *nervios*, a cultural category that comprises dysphoria (anxiety, fear, anger), somatic complaints including non-specific pains and tremulousness and *calorias* (bouts of a subjective sensation of intense heat). Jenkins argues that these symptoms are not necessarily pathological but represent a culturally normal response to the abnormal conditions of political violence, terror and protracted civil war. The same women also experienced distressing dreams (Criterion B) of specific acts of political violence and of scenes that symbolically represented cruel behaviour. Conversely, avoidance symptoms (Criterion C) were relatively rare and although sleep disturbance was invariable, there was little exaggerated startle response and physical reactivity when exposed to events that symbolised the trauma (Criterion D). Thus, the PTSD construct that formalised war trauma reactions in American veterans of the war in Vietnam fails to do justice to the distress experienced by this group of refugees. To impose this particular diagnostic category as a template for identifying ‘caseness’ in a refugee population is a ‘category fallacy’, defined by Arthur Kleinman as the “reification of a nosological category developed for a particular cultural group that is then applied to members of

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another culture for whom it lacks coherence and its validity has not been established...." (Kleinman, 1987: p. 452).

In his study of Tibetan refugees, Holtz (1998) was unable to find an adequate translation for key Western psychopathological terms and concepts that would have coherence for subjects with a Buddhist ontology. Maurice Eisenbruch, a psychiatrist and anthropologist who has become fluent in Khmer and has worked extensively with Cambodian refugees, cautions against the overuse of Western categories to diagnose refugee distress "which may be a normal, even constructive, existential response rather than a psychological illness ..." (Eisenbruch, 1991: p. 673). He proposes an alternative conceptualisation, which he calls 'cultural bereavement'. This approach is based on the refugees' own perspective. It captures what the trauma meant to the refugees, their cultural recipes for signalling distress, their cultural interpretation of psychological and somatic responses, together with indigenous therapeutic strategies.

Among the Cambodians, Eisenbruch found that cultural bereavement was characterised by a tendency to live in the past, to be visited by supernatural forces from the past when sleeping or awake, to feel guilt over leaving, to be distressed both by intrusive traumatic images and by the fading of positive memories of the past and a yearning to complete obligations to the dead (Eisenbruch, 1990). For those Cambodian refugees and doubtless for many of the exiles and asylum seekers in Britain today, antidotes to cultural bereavement reside in the comfort of religious belief and participation in religious gatherings rather than an inappropriate use of Western psychiatric technologies – selective serotonin reuptake inhibitors and cognitive-behavioural therapy.

Actively encouraging traumatised refugees to talk openly about their distress might conflict with an ethnocultural norm that containment of emotion is a sign of maturity (Kirmayer & Young, 1998). At CASCAID (a South London and Maudsley clinic for people with HIV/AIDS), where about half the patients are refugees, mainly from East Africa, we sometimes hear complaints that other mental health professionals have relentlessly and intrusively insisted that patients talk about what has happened to them, in a misguided belief in the panacea of ventilation and catharsis. Reluctance to talk about witnessed murder, mutilation and rape does not necessarily mean that refugees are using 'primitive' psychodynamic defensive strategies of avoiding, numbing, splitting and denial.

Over the past decade Derek Summerfield has cogently challenged the reduction of the experiences of refugees from war zones to a matter of psychopathology (Summerfield, 1998, 1999, 2000a,b). He

castigates the overdiagnosis of PTSD in refugees as a reframing of understandable suffering into a medico-technical problem that allegedly requires the diagnostic and therapeutic skills of mental health experts. Summerfield's own work in Nicaragua showed that while war-injured ex-soldiers had 'symptoms' that could be construed as PTSD, their own main concerns were with training and jobs (Hume & Summerfield, 1994).

Summerfield's research has implications for psychiatrists working with refugees in this country. Resources must be targeted in the first place at the delivery of adequate nutrition and general health care, decent accommodation, language tuition, safety from xenophobic violence and training for jobs. As Timimi has written in response to the claim that serious psychiatric disorder is present in 40–50% of refugee children, refugees themselves find it unhelpful to have their experiences professionalised and pathologised: "We can learn much more by listening and taking seriously what they tell us is helpful, rather than imposing our Western ideas about what we believe they ought to find helpful" (Timimi, 1998).

## References

- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM-IV). Washington, DC: APA.
- Bhugra, D. & Jones, P. (2001) Migration and mental health. *Advances in Psychiatric Treatment*, 7, 216–222.
- Eisenbruch, M. (1990) The cultural bereavement interview: a new clinical and research approach with refugees. *Psychiatric Clinics of North America*, 13, 715–735.
- (1991) From post-traumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. *Social Science and Medicine*, 33, 673–680.
- Holtz, T. H. (1998) Refugee trauma versus torture trauma: a retrospective controlled cohort study of Tibetan refugees. *Journal of Nervous and Mental Disease*, 186, 24–34.
- Hume, F. & Summerfield, D. (1994) After the war in Nicaragua: a psychosocial study of war wounded ex-combatants. *Medicine and War*, 10, 4–25.
- Jenkins, J. H. (1991) A state construction of affect: political ethos and mental health among Salvadoran refugees. *Culture, Medicine and Psychiatry*, 15, 139–165.
- Kirmayer, L. J. & Young, A. (1998) Culture and somatisation: clinical, epidemiological and ethnographic perspectives. *Psychosomatic Medicine*, 60, 420–430.
- Kleinman, A. (1987) Anthropology and psychiatry. The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, 151, 447–454.
- Summerfield, D. (1998) Trauma and the experience of war: a reply. *Lancet*, 351, 1580–1581.
- (1999) A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, 48, 1449–1462.
- (2000a) War and mental health: a brief overview. *British Medical Journal*, 321, 232–235.
- (2000b) Childhood war, refugeedom and "trauma": three core questions for mental health professionals. *Transcultural Psychiatry*, 37, 417–433.
- Timimi, S. (1998) Refugee families have psychological strengths. *British Medical Journal*, 317, 475.