Amidst Peril and Pain

The Mental Health and Well-Being of the World's Refugees

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THE APPLICABILITY OF THE POSTTRAUMATIC STRESS DISORDER CONCEPT TO REFUGEES

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Posttraumatic Stress Disorder (PTSD) is a nosological tool that may improve understanding of the psychological impact of the refugee experience. It has been used effectively in the diagnosis and treatment of individuals exposed to a variety of traumatic situations such as war, torture, rape, incest, natural disasters, and industrial accidents. In this chapter, we explore the PTSD concept in its own right, focusing on its heuristic value for theory, research, and clinical intervention.

Our remarks address some of the current problems with the PTSD concept, with special attention paid to matters that affect its applicability to refugee populations. We expand the discussion from PTSD per se to the more general concept of posttraumatic stress syndromes (PTSS), because that approach may be more suitable for characterizing the psychological impact of the refugee experience among individuals from diverse ethnocultural backgrounds. Finally, we review practical matters of assessment and treatment of traumatic stress syndromes and evaluate the applicability of such a clinical model to refugee populations.

As described in much of the literature (Holtzman & Bornemann, 1990), including several other chapters in this book, the refugee experience is often a prolonged and complex series of events. The stresses of migration and acculturation are major psychological factors that have been addressed elsewhere (Ben-Porath, 1991; Holtzman & Bornemann, 1990; Hull, 1979; Kuo, 1976). Although it is understood that failure to integrate such experiences can certainly affect the mental health of refugees, that is not the focus of this chapter. Instead, this chapter is concerned with the psychological impact of traumatic events on refugees.

DEFINITION OF TRAUMA

We define *trauma* to mean that the individual has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or injury or a threat to the physical integrity of others. By this definition, traumatic events that refugees may encounter include exposure to war-related violence, sexual assault, torture, incarceration, genocide, and the threat of personal injury and annihilation. We believe that a PTSD or PTSS model is useful in the clinical assessment and treatment of refugees who have been traumatized during the flight from their original homelands. We are not proposing that this model can or should be expected to encompass the totality of the complex refugee experience, but that it may apply to those events that are considered traumatic. Having specified these ground rules, however, it must be stated that such distinctions between traumatic and nontraumatic events may become blurred in the clinical setting because adaptational and acculturational pressures may sometimes exacerbate PTSD and PTSS symptomatology.

POSTTRAUMATIC STRESS DISORDER (PTSD)

Diagnostic criteria for PTSD were first approved for inclusion in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM–III)* (American Psychiatric Association [APA], 1980), were revised in the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM–III–R)* (APA, 1987), and has recently been included in the 10th revision of the *International Statistical Classification of Diseases and Related Health Problems (ICD–10)* (World Health Organization [WHO], 1992). Individuals who meet *DSM–III–R* diagnostic criteria must have been exposed to a traumatic event and must also exhibit symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyperarousal symptoms.

The "A" Criterion—The Stressor

The most difficult and controversial diagnostic criterion is the first, the "A" or stressor criterion. Although it is relatively easy to categorize exposure to extremely stressful events (e.g., war, torture, rape, natural disasters, industrial accidents) as "traumatic" or "catastrophic," it becomes difficult to know where to draw the line between such events and painful but more common stressors that constitute the vicissitudes of everyday life such as divorce, failure, rejection, serious illness, and the like. Furthermore, trauma, like pain, is not an external phenomenon that can be objectified. The subjective experience of trauma is the end result after an historical event has been filtered through cognitive, mnemonic, and emotional psychological processes and appraised as an extreme threat.

As with pain, different individuals appear to have different trauma thresholds; some are more vulnerable to and others more protected from developing clinical symptoms after exposure to extremely stressful situations. When applying the stressor criterion to the refugee experience, therefore, it is necessary to consider how ethnocultural factors, religious beliefs, prior exposure, and future expectations might influence the appraisal process and affect the trauma threshold.

Qualitatively, events that meet the stressor criterion may differ widely. Furthermore, the duration of traumatic exposure may vary widely from a few terrifying moments, as in an automobile accident or physical or sexual assault, to suffering that lasts many years such as that experienced during a protracted war or incarceration in a Nazi death camp. Finally, in the case of prolonged exposure, the time course of traumatic events may be continuous or episodic. Although it has been suggested that differences in the type, duration, and time course of trauma will produce differences in subsequent posttraumatic symptomatology (Figley, 1986; Kulka et al., 1990), empirical evidence of this is lacking. From a theoretical perspective, the PTSD model has been successful in conceptualizing the psychological problems of survivors of other protracted, complex, and catastrophic stressors such as war (Summerfield, 1991), sexual assault (Herman, 1993), the Nazi holocaust (Beebe, 1975; Eitinger, 1961), Khmer Rouge genocide (Kinzie, 1989; Mollica, Wyshak, & Lavelle, 1987), and the atomic bombings of Hiroshima and Nagasaki (Lifton, 1976, 1979). This suggests that the repetitive trauma of the refugee experience may also be usefully understood with the PTSD model.

The "B" Criterion—Intrusive Recollections

The "B" or intrusive recollections criterion includes symptoms that are perhaps the most distinctive and readily identifiable symptoms of PTSD. For individuals with PTSD, the traumatic event remains, sometimes for

decades or a lifetime, a dominating psychological experience that retains its power to evoke panic, terror, dread, grief, or despair as manifested in daytime fantasies, traumatic nightmares, and psychotic reenactments known as PTSD flashbacks. Furthermore, trauma-mimetic stimuli that trigger recollections of the original event have the power to evoke mental images, emotional responses, and psychological reactions associated with the trauma. Researchers, taking advantage of this phenomenon, can reproduce PTSD symptoms in the laboratory by exposing affected individuals to auditory or visual trauma-mimetic stimuli (Blanchard, Kolb, Pallmeyer, & Gerardi, 1982; Malloy, Fairbank, & Keane, 1983; Pitman, Orr, Forgue, DeJong, & Claiborn, 1987). Such symptoms can also be provoked pharmacologically by the adrenergic alpha–2 receptor antagonist, yohimbine, that acts directly on the locus coeruleus in the brain (Southwick, Krystal, Johnson, & Charney, 1992).

The "C" Criterion—Avoidant/Numbing Symptomatology

The "C" or avoidant/numbing criterion consists of symptoms reflecting behavioral, cognitive, or emotional strategies by which PTSD patients attempt to reduce the likelihood that they will expose themselves to trauma-mimetic stimuli or, if exposed, attempt to minimize the intensity of their psychological response. Behavioral strategies include avoiding any situation in which they perceive a risk of confronting such stimuli. In its most extreme manifestation, avoidant behavior may superficially resemble agoraphobia because the PTSD individual is afraid to leave the house for fear of confronting reminders of a traumatic event. Dissociation and psychogenic amnesia represent other avoidant/numbing symptoms by which individuals cut off the conscious experience of trauma-based memories and feelings.

Finally, because individuals with PTSD cannot tolerate strong emotions, especially those associated with the traumatic experience, they separate the cognitive aspects from the emotional aspects of psychological experience and perceive only the former. Robert Lifton, observing this phenomenon in Hiroshima atom bomb survivors and later in Vietnam combat veterans, labeled it "psychic numbing" (Lifton, 1979). It is an emotional anesthesia that makes it extremely difficult for people with PTSD to participate in meaningful interpersonal relationships. We believe that ethnocultural and religious factors may have a particularly powerful and differential influence on the expression of avoidant/numbing symptoms in refugee populations.

The "D" Criterion—Hyperarousal

The "D" or hyperarousal criterion most closely resembles symptoms seen in panic and generalized anxiety disorder. Such an overlap is the reason

why the framers of *DSM–III* classified PTSD as an anxiety disorder. Whereas symptoms such as insomnia and irritability are generic anxiety symptoms, hypervigilance and startle are more unique. The hypervigilance in PTSD may be so intense as to appear like frank paranoia. The startle response has a unique neurobiological substrate (Davis, 1990) and may actually be the most pathognomonic PTSD symptom (Ornitz & Pynoos, 1989).

If an individual meets diagnostic criteria for PTSD, it is likely that he or she will meet *DSM–III–R* criteria for one or more additional diagnoses (Jordan et al., 1991; Kulka et al., 1990). Most often these comorbid diagnoses include major affective disorder, dysthymia, alcohol or substance abuse, anxiety disorders, or personality disorders. A legitimate question is whether the high rate of diagnostic comorbidity seen with PTSD is an artifact of the current decision rules for making the PTSD diagnosis, because there are no exclusionary criteria in *DSM-III–R* (Friedman, 1990). In any case, high rates of comorbidity complicate treatment decisions concerning patients with PTSD because the clinician must decide whether to treat the comorbid disorders concurrently or sequentially (Kofoed, Friedman, & Peck, 1993).

It must be emphasized that the reliability and validity of PTSD as a diagnosis has been demonstrated repeatedly (Keane, Wolfe, & Taylor, 1987), including epidemiological studies, on American veterans of the Vietnam War (Kulka et al., 1990) and civilian residents of a large America city (Breslau, Davis, Andreski, & Peterson, 1991), which showed that PTSD was not uncommon in the samples studied. Neurobiological research indicates that PTSD may be associated with stable neurobiological alterations in both the central and autonomic nervous systems. Psychophysiological alterations associated with PTSD include hyperarousal of the sympathetic nervous symptom, increased sensitivity and augmentation of the acoustic-startle eyeblink reflex, a reducer pattern of auditory evoked cortical potentials, and sleep abnormalities. Neuropharmacologic and neuroendocrine abnormalities have been detected in the noradrenergic, hypothalamic–pituitary–adrenocortical, and endogenous opioid systems. This data is reviewed extensively elsewhere (Friedman, 1991, 1993).

ICD–10 and *DSM–III–R* Criteria for PTSD

Finally, because *ICD–10* rather than *DSM-III–R* is the nosologic framework favored by many clinicians who treat refugees, it is necessary to address the similarities and differences between these two diagnostic schemes as they are related to PTSD. There actually are few differences in the "A" (stressor) and "B" (intrusive recollection) criteria. The hyperarousal symptoms are similar in the "D" and D2 criteria of *DSM–III–R* and *ICD–10* respectively. *ICD–10* restricts its "C" criterion to avoidant symptoms whereas *DSM–III–R* includes both avoidant and numbing symptoms

in "C". Finally, psychogenic amnesia is given greater prominence in *ICD–10* than in *DSM–III–R*. It appears to us that the *ICD–10* is less restrictive and that individuals who have PTSD according to *ICD–10* might fail to have the three avoidant/numbing symptoms needed to meet full *DSM–III–R* diagnostic criteria for PTSD.

APPLICABILITY OF THE PTSD MODEL TO THE REFUGEE EXPERIENCE

The past decade has seen an explosion of research on assessment, epidemiology, psychological processes, psychophysiology, neurobiology, diagnostic comorbidities, and treatment of PTSD. Most of this data has been obtained on individuals or cohorts from Western industrialized nations. As a result, major gaps remain in the understanding of the effects of ethnicity and culture on the clinical phenomenology of PTSD. Vigorous ethnocultural research strategies are only beginning to be applied in order to delineate possible differences between Western and non-Western societies regarding the psychological impact of trauma and the clinical manifestations of such exposure (Marsella, Friedman, & Spain, 1992, 1993). As a result, whether the PTSD model is applicable in non-Western societies in general and with regard to refugee populations in particular is currently a subject of controversy.

There are arguments for and against application of the PTSD model to refugee research and treatment. As we summarize the limited PTSD literature pertinent to these arguments, it should be noted that most published articles concern clinical work done by four independent groups in the United States led by Kinzie, Lin, Mollica, and Westermeyer with Khmer, Hmong, Laotian, Mein, and Vietnamese treatment-seeking refugees from Southeast Asia. There are a few additional articles that focus on Latino refugees from Central America, and Soviet and Ethiopian refugees to Israel, but little else on other groups (see Ekblad et al., Farias, and Lerner et al., this volume).

Arguments in Support of the PTSD Model

The first argument favoring the PTSD model is the fact that the experiences of many Southeast Asian and Central American refugees were clearly traumatic as defined by the first criterion of *DSM–III–R* and *ICD–10*. Such experiences included deprivation, physical injury, torture, sexual abuse, war injury, incarceration, being near death, being kidnapped, forced separation from family, and witnessing death, murder, or torture (Arroyo & Eth, 1985; Cervantes, Salgado-deSnyder, & Padilla, 1989; Kinzie, Sack, Angell, Clarke, & Rath, 1989; Kinzie, Sack, Angell, Manson, & Rath,

1986; Kroll et al., 1989; Lee & Lu, 1989; Lin, 1986; Lopez, Boccallari, & Hall, 1988; Mollica et al., 1987).

Secondly, these articles document the fact that a sizable proportion of traumatized refugees met diagnostic criteria for PTSD. Despite some of the problems in PTSD diagnostic assessment with Southeast Asian refugees, Kinzie et al. (1989, 1990), using a culturally sensitive clinical approach, were able to detect high rates of PTSD in this group. It is noteworthy, however, that despite such clinical data indicating that the *DSM–III–R* diagnoses and Western clinical assessment instruments (Impact of Events Scale and the Hopkins Symptoms Checklist–25) can be used in clinical research with non-Western refugee groups, there is an expressed concern that such approaches do not sufficiently characterize the richness and complexity of the clinical data (Kinzie et al., 1989, 1990; Mollica et al., 1990).

The third argument is that another advantage of the PTSD model is that it suggests a psychotherapeutic approach that focuses on the trauma itself. Such an orientation provides a conceptual context for working through posttraumatic symptoms such as grief, anger, rage, and mistrust (Jensen, Schaumburg, Leroy, Larsen, & Thorup, 1989; Kinzie, 1989; Kinzie & Fleck, 1987; Niem, 1989). This will be discussed in depth later in this chapter.

Fourth, the PTSD model improves the understanding of the refugee experience by extrapolating from the much more extensive literature on other traumatized groups such as war veterans, sexual assault victims, disaster survivors, and so on. (Davidson & Foa, 1993; Figley, 1986; Wilson & Raphael, 1993).

Finally, the PTSD model permits us to search for psychophysiological and neurobiological abnormalities associated with PTSD that may be independent of ethnocultural factors (Friedman, 1991, 1993; Giller, 1990; Wolf & Mosnaim, 1990). In that regard, the PTSD model predicts that traumatized individuals from both Western and non-Western backgrounds will show similar alterations in autonomic reactivity, startle reflex, sleep disturbance, adrenergic hyperarousal, hypothalamic–pituitary–adrenocortical dysregulation, and endogenous opioid system activity. The demonstration of a similar pattern of psychophysiological and neurobiological alterations would certainly suggest a universal response to traumatic stress in the phenomenological expression of posttraumatic symptomatology that might otherwise be obscured by ethnocultural differences.

Arguments Against The PTSD Model

Arguments against the PTSD model include (a) duration of the stressor, (b) pathologizing a normal psychological process, (c) ethnocentricity of *DSM–III–R* and *ICD–10*, (d) narrowness of the model, and (e) questions about *DSM–III–R* diagnostic decision rules and comorbidities. Concerning

duration of the stressor, we have argued above that the protracted and repetitive trauma of the refugee experience can be usefully understood with the PTSD model because it has been successfully applied to survivors of wars, the Nazi holocaust, Khmer Rouge genocide, and the atomic bombing of Hiroshima and Nagasaki.

The second objection, that a PTSD perspective pathologizes a normal psychological process (Summerfield & Toser, 1991), suggests that everyone exposed to traumatic stress will develop PTSD. Proponents of this argument fail to differentiate between acute reactions to trauma (which are catalogued in *ICD–10* but not in *DSM–III–R*) and the chronic or delayed syndromes that are considered *DSM–III–R* psychiatric disorders. Although it is clear that exposure to trauma is a necessary condition for developing PTSD, that alone is not a sufficient condition.

Large-scale epidemiological research on war veterans and urban Americans has consistently shown that many people exposed to trauma do not develop PTSD (Breslau et al., 1991; Kulka et al., 1990). The same is true for Southeast Asian and Central American refugees in the studies cited above. On the other hand, proponents of this argument are correct when they point out that there is not enough data on the normal psychological response to trauma and the longitudinal course following such exposure (Summerfield & Toser, 1991). Like the universal grief reaction that follows a major loss, it is generally recognized that a profound acute psychological response following traumatic exposure is also universal. However, there are limits to what is accepted as a normal time course for bereavement. The same will undoubtedly prove to be the case for posttraumatic reactions. Just as pathological grief is transformed at some point into an affective disorder, traumatic events that cannot be psychologically integrated by individuals become chronic posttraumatic syndromes.

Regarding the third and fourth objections, we agree with others (e.g., Boehnlein, 1987; Lin, 1986; Marsella et al., 1992; Westermeyer, 1987) that ethnocultural and religious traditions will certainly have a significant influence on the subjective experience and psychological appraisal of stressful events. Differences in language will determine how events are characterized and how such characterizations are communicated within each ethnocultural setting. Ethnocultural and religious traditions will modify the significance, interpretation, metaphor, and meaning that are attached to specific events.

For example, Mollica (1991) has observed very low levels of survivor guilt among Khmer refugees living in the Site Two refugee camp along the Thai–Cambodian boarder. He attributes this lack of guilt to the Buddhist orientation of the refugees. A second example is the possibility that Native American rituals, with their cultural emphasis on and acknowledgement of the warrior experience, may promote a different expression of posttraumatic

symptomatology among Native American war veterans in contrast with non-Native American veterans (Marsella et al., 1992).

Generalizing from these examples, we believe that it is prudent to consider the possibility that ethnocultural differences in the expression of traumatic stress may not strictly conform to *DSM–III–R* diagnostic criteria for PTSD. Ethnocultural tendencies (such as guilt, somatization, depression, or denial) may alter clinical phenomenology to such an extent that highly traumatized cohorts will exhibit surprisingly low rates of PTSD.

Indeed, Mollica (1991) has reported that only a small percentage of Khmer refugees at Site Two exhibit the full range of PTSD symptoms despite very high rates of traumatic exposure. Although Khmer refugees receiving treatment in the United States show high rates of PTSD, an epidemiologic study conducted by Jaranson, Holtan, Piasecki, Heegaard, and Egli (1989) in Minnesota showed that severely traumatized Khmer (and Laotian) refugees have a surprisingly low prevalence of PTSD symptoms. One may conclude from such findings, as has Chakraborty (1991), that PTSD is a culture-bound syndrome only to be found among individuals from Western industrialized nations. An alternate position, which we endorse, is that catastrophic events have a significant psychological impact on many, if not most, exposed individuals no matter what their ethnocultural background. In some cases the impact of traumatic exposure will lead to PTSD, whereas in other cases such exposure may lead to a traumatic stress syndrome that overlaps with PTSD but that may also feature symptoms that are idiosyncratic to individuals from specific ethnocultural traditions. Therefore, we believe that the general construct of PTSS, rather than the more rigorously defined PTSD, may offer a more useful conceptual approach to the psychological impact of the refugee experience.

Furthermore, we hypothesize that ethnocultural factors will have their greatest influence on the avoidant/numbing cluster of PTSD symptoms. We take this position for three reasons. First, traumatically exposed individuals from traditional societies, like their Western counterparts, frequently report intrusive recollections such as traumatic nightmares and hyperarousal symptoms such as hypervigilance, startle, and insomnia. Because intrusive and hyperarousal symptoms appear to have a neurobiological substrate (Friedman, 1991; Southwick et al., 1992), one would expect them to be relatively independent of cultural factors, although they could be modified by ethnic and genetic inheritance. Second, even among traumatized individuals from Western nations, failure to meet PTSD criteria is most frequently due to a lack of sufficient number of avoidant/numbing symptoms (Kulka et al., 1990). Finally, ethnocultural factors that influence the meaning and interpretation of stressful events might be expected to influence the behavioral and emotional responses to trauma as expressed by avoidant/numbing symptoms (Marsella et al., 1993).

We believe that the PTSD model is useful in conceptualizing the traumatic experiences of refugees, but it must be broadened to incorporate ethnocultural differences in the expression of traumatic stress. Such a position in no way commits us to abandon the PTSD model, but rather to modify it to PTSS through rigorous cross-cultural and medical anthropological research (Kleinman, 1980; Manson, Shore, & Bloom, 1985; Marsella et al., 1993). In other words, we assert that posttraumatic stress syndromes are universal, although they may differ in their specific expression from one ethnocultural setting to another.

We also believe that the pattern of comorbid diagnoses may vary from one setting to another but that such variations do not invalidate the PTSD conceptual approach. For example, in contrast with American war veterans with PTSD, Israelis exhibit more depression (Lerer, Doleu, & Bleich, 1991), whereas Soviets exhibit extremely high rates of alcohol abuse or dependency (Tsygankov, 1991). In all cases, however, posttraumatic symptomatology cannot be explained away by focusing entirely on the comorbid diagnoses. In fact, when PTSD is associated with a comorbid disorder, both, not one or the other, must be treated concurrently (Kofoed et al., 1993).

CLINICAL ISSUES IN PTSD STUDIES OF REFUGEES

The clinical complexities of PTSD and PTSS in the cross-cultural context of refugees can be reduced to questions regarding (a) the "purity" of the diagnosis of PTSD, (b) the applicability of the diagnosis to refugees, especially those from non-Western cultures, (c) the adequacy of the cross-cultural assessment process, and (d) the ability of the diagnosis to dictate treatment and prognosis. Because we have addressed the first two questions elsewhere in this chapter, we focus here on assessment and treatment of refugees.

Diagnosis

Even if PTSD were a pure diagnosis applicable to refugees from all cultures, the assessment process would still be difficult (Marsella & Kameoka, 1989). In spite of the controversy about the validity and usefulness of the PTSD construct as applied to refugees, most of whom are from or remain in non-Western countries, the clinician does not have the luxury of contemplating theoretical issues. When a refugee seeks help, the clinician must act, often with the aid of an interpreter, to relieve the suffering that may have been present for a long time. The Western clinician, non-Western interpreter, and refugee patient each have a cultural context and a set of experiences and expectations that are often widely divergent (Jaranson, 1991). Due to the complexities of such a triad, the difficulties of adequately assessing and treating the traumatized refugee may seem insurmountable.

A number of authors have written about the clinical issues in cross-cultural diagnosis and treatment (e.g., Jaranson, 1990, 1991; Kinzie, 1985, 1986; Lin, 1990, 1991; Westermeyer, 1983, 1987), issues that apply to refugees but are even more complicated by severe trauma and dislocation. A detailed description of assessment and treatment of the mental health needs of refugees is beyond the scope of this chapter and is adequately addressed in previous literature (Owan, 1985; Westermeyer, 1989b) and in other chapters in this volume. Approaches for assessing trauma, in particular, have been developed (Garcia-Peltoniemi, 1991; Westermeyer, 1989a; Westermeyer & Wahmenholm, 1989). A large portion of literature on traumatized refugees has been written about Khmer children and adults, both in resettlement countries and in Southeast Asian camps (Boehnlein, Kinzie, Rath, & Fleck, 1985; Jaranson, Heegaard, Holtan, & Egli, 1989; Kinzie, 1985; Kinzie et al., 1986, 1989, 1990; Mollica, 1991; Sack, Angell, Kinzie, & Rath, 1985).

The traumatized refugee usually seeks treatment in the host country when severely ill and frequently has multiple somatic complaints, severe depression, or dissociative and paranoid symptoms (Moore & Boehnlein, 1991). The refugee usually delays seeking treatment for months or even years and is frequently disappointed when he or she finally does seek treatment. When first seen by a Western practitioner, the refugee may not trust the interviewer, may fear that confidentiality will be breached, and may be reluctant to share personal information with either the interviewer or the interpreter. In fact, the clinician must be careful to elicit the trauma story at the pace dictated by the refugee, in order to minimize acute exacerbation of PTSD or PTSS. The trauma model for intervention is useful in this regard because without this formula, the clinician might not persist in getting the trauma story (Mollica et al., 1987).

The clinician usually is from a different culture than the refugee, speaks a different language, has higher social status, and may not have much cross-cultural training or experience. The clinician may have great empathetic discomfort asking trauma or torture questions and therefore may avoid them. The clinician who is a medical practitioner may have an advantage over a nonmedical psychotherapist because a medical approach is familiar to many refugees and consistent with their expectations (Jaranson, 1990, 1991). In addition, the medical practitioner is more likely to pay attention to Axis III in *DSM–III–R*, and to identify associated problems such as infectious diseases, malnutrition, and physical or neurological damage caused by torture (van Willigen, 1992). On the other hand, the medical practitioner may be less likely to remember that refugees had lives, work, families, and usually a much more extended social support system than can be reproduced on arrival in their country of final asylum. Consequently, Axes IV and V of *DSM–III–R*, the level of functioning within the preceding year and social stressors, are sometimes neglected.

The bilingual interpreter, usually a refugee, often has difficulty because of tendencies to overidentify with the patient and difficulty maintaining the appropriate professional distance. For example, one of the authors (Jaranson) once used an interpreter who stopped during the telling of the trauma story to explain how much worse her own experiences had been. If the bilingual has a role expectation beyond that of interpretation, such as culture broker or paraprofessional (Mollica et al., 1987), these issues remain potentially troublesome.

Assessment

Despite the difficulty of interviewing refugees, there are some useful psychological tests that have been developed and standardized cross-culturally (Butcher, 1991; Jaranson & Shiota, 1988; Kinzie & Manson, 1987; Williams, 1987). If the process of cross-cultural assessment, with traumatized refugees in particular, becomes more culturally specific and sensitive, we would expect to find increased symptoms of PTSD or PTSS in refugee cohorts.

Treatment

There are a number of approaches the clinician can take to overcome some of the barriers in treating the refugee with PTSS or PTSD. As mentioned, it is important to foster a sense of trust, which is usually difficult to evoke in highly traumatized refugees, and to proceed at a slower pace in therapy than usual. One must remember that symptoms may be exacerbated once the trauma story unfolds, and at some point in treatment therapeutic medication may be helpful in reducing the severity of intrusive and hyperarousal symptoms, allowing the therapeutic process to proceed more effectively (e.g., Boehnlein, 1987; Garcia-Peltoniemi & Jaranson, 1989; Jaranson, 1990).

The individual is usually far less autonomous in traditional cultures, even in many Western cultures, than in the United States. The family and the group assume much greater importance and will probably need to be included in therapy. It has been shown that highly traumatized refugees are often comforted in group therapy. Their sense of isolation is diminished by learning that others have similar responses and that there is a relationship between prior trauma and current symptomatology. Use of more traditional approaches familiar to the indigenous culture such as acupuncture, herbal medicines, religious beliefs, and native healers, when used in conjunction with Western approaches, can be helpful in treating refugees. (See Hiegel, this volume, for more information on use of indigenous healers.) It is important to remember that often the refugee hopes for some concrete assistance, whether it is in the form of oral medication, injections, financial or housing assistance, or transportation.

Some psychotherapeutic themes are, of course, much more common in traumatized refugee populations. Grief over loss of status, money, friends, family, as well as over other losses, is often a central theme in the therapeutic process. The sense of self-worth has been seriously damaged for some, and issues related to the meaning of life and religion are often foremost in their minds (Boehnlein, 1987; Kinzie, 1989). In addition, intercultural conflict, intergenerational stress, and pragmatic aspects of living in the new homeland are likely to emerge. Refugees also seem to be at particular risk for retraumatization and a consequent recurrence of traumatic stress symptoms in their resettlement environment because they often live in inadequate housing and are victims of crime or racial harassment. These issues tend to emerge and then re-emerge in what can be a long process in treating PTSD and PTSS.

There are many variables contributing to the problems of traumatized refugees with PTSD and PTSS. Besides the type, intensity, and duration of the refugee trauma, preexisting factors make a difference in the influence of the trauma on symptoms and other long-term changes. In addition, there is a relationship between both preexisting factors and symptom level and between symptom level and eventual adaptation and adjustment in the host country. One must be careful not to confuse the presence of posttraumatic stress symptoms with levels of function or disability, because there is clearly not a one-to-one correlation. There is some evidence that there are well-defined stressors as well as protective factors that are operative in the eventual adaptation and acculturation of the traumatized refugee. Berry (1990) describes the most successful refugee adaptation as "bicultural," that is, learning the new language and customs while retaining a sense of background and history. Well-adapted refugees can often shift from one world to the next in many aspects of their lives, including the use of medical care.

A COMPARISON WITH OTHER APPROACHES TO TRAUMA

In this chapter we present the PTSD model and argue that it appears to offer a useful approach for conceptualizing the psychological impact of traumatic exposure on refugees. We maintain throughout this presentation that a sensitive cross-cultural approach is essential because we believe that ethnocultural and religious factors may have a particularly powerful and differential influence on the expression of PTSD in non-Western refugee populations, especially with respect to avoidant/numbing symptoms.

Arguing from a neurobiological perspective, we also hypothesize that a universal response to traumatic stress may often be obscured by enthnocultural differences in the phenomenological expression of posttraumatic symptomatology. Finally, we describe the clinical implications of such a

model and show that trauma-focused assessment and treatment must always be offered within a broader context that integrates ethnocultural factors, problems of language, metaphors, and symbolism, and awareness of adaptational and acculturational pressures.

Criticism of the PTSD model includes (a) conceptualizing PTSD as a culture-bound syndrome (Chakraborty, 1991), (b) rejecting PTSD or other stress models for their failure to address the unique psychohistorical dimensions that define the meaning of the trauma (Punamaki, 1989), and (c) rejecting PTSD as pathologizing a normal and healthy rehabilitative process that is more suitably characterized as cultural bereavement (Eisenbruch, 1991).

Culture-Bound Syndrome

Because the purpose of any conceptual model is to suggest that certain therapeutic interventions should prove more effective than others, we address each of these three criticisms from a clinical perspective to determine whether they offer any advantages over the PTSD approach. The implication of a model that labels PTSD a Western culture-bound syndrome is that the therapist should not carry out the trauma-focused assessment and treatment interventions, described above, with refugees (or others) from non-Western ethnocultural backgrounds.

Based on the literature reviewed previously, however, Southeast Asian and Central American refugees who meet PTSD diagnostic criteria appear to show a similar clinical course and response to treatment as do Western refugees and individuals who have been traumatized. In other words, there does not appear to be any advantage to withholding trauma-oriented treatment from non-Western traumatized individuals. Furthermore, it appears that such individuals can benefit greatly from a PTSD approach (Weisaeth & Eitinger, 1993).

Stress Models and Political Violence

The second criticism (Punamaki, 1989) is that stress models are inappropriate for conceptualizing politically induced violence and repression because they reduce social, political, and historical problems to the individual level. The thrust of this argument is that an appropriate psychological coping response under the abnormal conditions of political repression and torture might be labeled pathological by therapists who ignore the sociopolitical context in which the psychological response takes place. We believe that this argument is predicated on a fundamental misunderstanding of psychotherapy and a failure to distinguish political advocacy from therapeutic intervention.

On the one hand, the focus of psychotherapy is generally on the individual and, therefore, both patient and therapist need to generate a conceptual model that encompasses the many complex dimensions affecting behavior, emotion, cognition, and meaning. These dimensions include biopsychosocial factors, developmental issues, and pertinent social, political, and historical factors. We argue that all these factors are necessary components of any psychotherapeutic approach, whether the focus is on trauma, depression, anxiety, or other problems.

Cultural Bereavement

The final criticism is that the refugee experience is much better understood in the context of cultural bereavement (Eisenbruch, 1991) that results from loss of home, social networks, institutions, routines, and surroundings. It is argued that coping with such losses as well as relocation and acculturation pressures can sometimes produce a phenomenological picture that meets *DSM–III–R* criteria for PTSD but is actually a normal and healthy rehabilitative response. We agree that a key to clinical assessment is the understanding of an individual's psychological processes in his or her proper ethnocultural, religious, and sociopolitical context. We also agree that the themes highlighted by a focus on cultural bereavement are of paramount importance.

In our opinion, however, this orientation is complementary but certainly not an appropriate substitute for a PTSD focus. We have maintained from the outset that the PTSD model by itself cannot and should not be expected to encompass the totality of the complex refugee experience but should be restricted to those events that are considered traumatic. We freely acknowledge, however, that traumatic versus nontraumatic distinctions may become blurred in the clinical setting because adaptational and acculturational pressures may sometimes exacerbate posttraumatic symptomatology.

To summarize, having reviewed three criticisms of the PTSD model, we cannot find any reason to reject it. The criticisms themselves are valuable in that they help clarify the conceptual and clinical context in which trauma-focused assessment and treatment should be conducted. But these concerns are easily incorporated into a clinical approach to refugees that is based on the PTSD model. In short, we believe that the PTSD model offers a useful conceptual and therapeutic approach to the psychological impact of trauma on refugees from all ethnocultural backgrounds.

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